

ACA Implementation—Monitoring and Tracking

Minnesota

Site Visit Report

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Brigette Courtot, Stan Dorn, Vicki Chen
The Urban Institute



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EXECUTIVE SUMMARY

A long-standing national leader in private- and public-sector health reform, Minnesota is making remarkable progress implementing the Patient Protection and Affordable Care Act (ACA), despite a challenging political environment. When the Democratic Farmer Labor (DFL) party used its majority to authorize an early Medicaid expansion (contingent on a governor's executive order), establish an ACA task force, and direct state agencies to apply for federal grant funding during the 2010 Legislative session, Republican governor Pawlenty opposed implementation of the new federal health reform law. Beginning in 2011, the two elected branches of state government changed partisan control. Newly elected DFL Governor Dayton has actively implemented the ACA in 2011 and 2012, with state agencies taking innovative steps that could serve as useful models to other states. At the same time, the legislature, with both houses shifting to Republican control, generally opposed further cooperation with federal health reform. But with the authorization granted by the 2010 Legislature probably lasting until federal funding expires, state agencies are moving vigorously ahead with ACA implementation.

Health Insurance Exchange: Planning and Implementation—Buoyed with a federal planning grant and two “Level 1” establishment grants, the state's Commerce Department convened a Health Insurance Exchange Advisory Task Force with broad stakeholder representation. Using numerous workgroups to further incorporate interest groups and thought leaders, the Task Force's recommendations include using a mixture of funding sources to support the Exchange, reflecting that the Exchange both helps the entities that use it and benefits the general public; letting insurers and brokers comprise a small minority

of the Exchange's governing board; crafting a range of navigator roles, each with its own certification and payment levels; and finding flexible strategies to meet the objectives of state “good governance” laws while escaping some of those laws' constraining details. State officials expect the Exchange to promote portability of small firm coverage, address health disparities, and leverage quality reporting initiatives to inform consumers' plan choices. Ensuring robust plan participation in the Exchange is not a primary concern, as most of the state's nonprofit plans are expected to offer coverage through the new marketplace.

The state is rapidly creating the Exchange's infrastructure—a call center, web site, etc.—even though many major policy decisions have not yet been made and legislation to establish an exchange has not been passed. Officials understand that changes to this infrastructure may later be needed, but without forceful early action, meeting the ACA's deadlines may become impossible. This pragmatic approach should serve the state well in the future, since it will result in a flexible exchange structure that can be adapted as the policy environment experiences future changes, which are surely inevitable.

Health Insurance Exchange: Enrollment and Subsidy Determination—State officials are developing a single, integrated system to handle eligibility determination and enrollment for all insurance affordability programs, including Medicaid/CHIP and advance premium tax credits and cost sharing reductions through the Exchange. Rather than select one vendor to develop all information technology (IT) solutions, the state asked multiple vendors to create prototypes showing how they would fulfill specific IT functions. Based on such prototypes, a final vendor

team will be chosen, with each vendor representing the “best in breed” for a particular task, and one vendor responsible for overall integration.

The agencies administering Medicaid and the Exchange formed a joint team to develop integrated IT solutions. Federal review of each IT component is likewise proceeding in integrated fashion, with simultaneous review and approval from HHS staff dealing with Medicaid and exchange IT. Multiple stakeholders and bipartisan legislators support minimizing bureaucratic obstacles and streamlining eligibility and enrollment. The legislature has thus provided the resources necessary for Medicaid to “draw down” 90 percent federal matching funds and develop the IT needed for a more data-driven, less red-tape-bound system for Medicaid eligibility determination and enrollment.

Private Insurance Reforms—Almost all early insurance reforms were implemented smoothly, due in part to strong consumer protections already in place, which lessened the magnitude of necessary change. In addition, the Pawlenty Administration’s Commerce Department implemented reforms via insurance form review, winning plaudits for rapid and effective action. The biggest challenge was the collapse of the child-only market due to the Commerce Department’s failure to approve carriers’ proposal for a common open enrollment period. That period was suggested for implementation after ACA provisions took effect requiring insurers to offer coverage to children with pre-existing conditions. Even when the carriers’ preferred solution could not be implemented, state officials devised another solution, letting children join the state’s long-standing high-risk pool, which features premiums up to 25 percent above standard levels.

Because of the high-risk pool—the country’s largest—and insurance reforms already in place, respondents were unfazed at the prospect of larger insurance reforms slated for 2014 implementation. Fearing that the 27,000-member high-risk pool’s rapid dissolution

could destabilize the individual market, officials planned to let the pool diminish through gradual attrition, convinced that the sickest enrollees will be the most reluctant to shift to the Exchange.

Medicaid Policy—The ACA let the state achieve budget savings by (a) changing state-funded coverage of childless adults into federally-matched Medicaid and (b) claiming prescription drug rebates for Medicaid managed care enrollees. Minnesota’s current broad eligibility standards for public coverage mean that the ACA will not qualify new adults for Medicaid, leaving the state with the likely challenge of transferring existing beneficiaries from its MinnesotaCare and Medicaid programs into new subsidy systems. The optional Basic Health Program (BHP) is being seriously considered along with other options for low-income populations above 138 percent of the federal poverty level, as a way to preserve current benefits and cost-sharing protections. Consultant estimates suggest that the state could face cost increases rather than savings under BHP, but some within the state were skeptical of that analysis because they thought it had overstated certain costs and ignored some potential cost savings associated with the BHP.

Providers and Insurance Markets—Minnesota’s provider and insurance industries position the state well for ACA implementation. Most hospitals and physicians are affiliated with one of the state’s many large, nonprofit integrated hospital and health systems. This high degree of integration and consolidation among providers supports the rapid spread of best practices. It also means that much of Minnesota is already served by a system that is organized in a way that aligns with the ACA’s vision for coordinated, accountable health care delivery.

The state’s insurance industry is competitive, and no single health plan dominates the private market. At the same time, Minnesota health plans share a rich history of collaboration on statewide initiatives to improve health care quality measurement and

promote innovative payment methods. The state's unique law requiring all Health Maintenance Organizations (HMOs) to be nonprofit is credited in part with supporting both a collaborative tone and an emphasis on high-quality, high-value patient care. Another distinctive Minnesota law requires HMOs to participate in Medicaid as a condition of licensure. As a result nearly every health plan already serves both public and private markets, which should facilitate coverage transitions for families who move between Medicaid and exchange-based coverage after 2014.

These characteristics of Minnesota's provider and insurance markets put the state far ahead of many others in implementing payment and delivery reforms. Minnesota had already established many of its own

such reforms when the ACA became law, beginning with private initiatives and continuing through a landmark 2008 state law that invested in systems to improve transparency in health care price and quality data.

Conclusions—Minnesota's ACA implementation has been greatly helped by close collaboration between officials from multiple state agencies as well as stakeholders developing consensus to overcome what, in other states, have been contentious technical issues about how to structure reform. A long history of state-based reform has left a legacy of knowledge, relationships, and skills that leaves the state well-positioned to benefit from new federal resources and policy opportunities under the ACA.

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia to help states, researchers and policy-makers learn from the process as it unfolds. This report is one of 10 state case study analyses. The quantitative component of the project will produce analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

BACKGROUND

A Long-standing Leader on Health Issues

Minnesota has long been a national frontrunner on state-based health reform. The state's bipartisan tradition of covering the uninsured—featuring the 1988 creation of the Children's Health Program, later renamed MinnesotaCare (MNCare) and expanded to become a premium-based public program that supplements traditional Medicaid—contributes to an uninsured rate (9.1 percent) that is one of the lowest in the nation.¹ Minnesota also boasts one of the country's oldest and largest high-risk pools (the Minnesota Comprehensive Health Association, or MCHA). Long before the Patient Protection and Affordable Care Act (ACA) was signed into law, the state established numerous consumer protections in its small group and individual health insurance markets, including the early enactment of small group market reforms, a rigorous rate review process, medical loss ratio requirements, and restrictions on premium variation due to health status and demographic factors. Minnesota is a pace setter in health care quality improvement strategies that also slow cost growth. With the state's nonprofit HMOs playing a lead role, the Institute for Clinical Systems Improvement (ICSI) was created in 1993 to develop quality-based clinical guidelines. This led to the health plan-initiated Community Measurement program, which established statewide quality measures to be reported uniformly across multiple payors and provider groups, starting in 2004. Additionally, a number of features in Minnesota's

health care environment—including a highly integrated provider community and a requirement that all HMOs must be nonprofit—have supported progress in payment and delivery reforms like the 2008 statewide health care home initiative and quality incentive payment system, which involve both the public and private sectors.

In the decade leading up to the ACA's 2010 enactment, Minnesota policy-makers considered a number of comprehensive state health reform initiatives, all of which contained components resembling key pieces of the federal health reform law (see text box). Ultimately, the recommendations in the 2008 reports of the governor's Health Care Transformation Task Force and the Legislative Commission on Health Care Access formed the basis for landmark state health reform legislation, which passed later that year. The state's 2008 health reform law focused primarily on health care payment and delivery system reforms and made major investments in systems to collect and report data on price and quality and in initiatives to support health care redesign and the restructuring of payment systems.^{2,3} Specific provisions of the 2008 law—which included creation of an all-payer claims database, establishment of a statewide quality reporting and measurement system with “provider peer grouping” that ranks providers based on cost and quality, and promotion of health care homes for people with complex or chronic conditions—are discussed in greater

detail in the Provider and Insurance Market section of this report.

Key informants emphasized that implementation of the state's own health reform initiatives—in particular, the 2008 law—was occurring in tandem with ACA implementation in Minnesota, with the ACA's focus on access to affordable health insurance complementing the state law's focus on rewarding quality and expanding payment reforms. One informant noted, "When we think about ACA implementation, we also think about Minnesota's own health reform package that intellectually precedes the ACA and probably contributed to it."

Initial Implementation of Federal Health Reform: 2010

While Minnesota's state-crafted health reforms have moved forward, ACA implementation has faced serious opposition. In August 2010, five months after the ACA became law, Minnesota's Republican governor Tim Pawlenty issued an executive order declaring that all state agencies and executive branch departments, except where required by law, must obtain approval from his office before applying for grant funds made available through the ACA.⁴ The action reflected the governor's opposition to the ACA—referred to in the order as a "dramatic attempt to assert federal command and control over this country's health care system." Minnesota was one of just two states that did not initially apply

Minnesota State Health Reform Initiatives Over the Past Decade

- In 2004, the governor Pawlenty-appointed Citizen's Forum on Health Care Costs convened a series of town hall style forums throughout the state and ultimately recommended six overarching principles for health system reform. These principles ranged from ensuring transparency in health care costs and quality to assuring universal participation in the health care system.
- The following year, the Minnesota Medical Association's Health Care Reform Task Force released the Physician's Plan for a Healthy Minnesota, a comprehensive health reform proposal that called for (among other things) a requirement that individuals obtain coverage, creation of an essential health benefit package, guaranteed issue and statewide community rating in the private insurance market, and tax incentives to help individuals purchase health insurance coverage.
- The 2007 Legislature required governor Pawlenty to convene a Health Care Transformation Task Force comprised of legislators and key health care stakeholders. The Task Force's 2008 report included recommendations for health care payment reforms, establishment of a nonprofit health insurance exchange where individuals and small groups could compare insurance options and purchase coverage, subsidies to improve the affordability of coverage, and a requirement that all Minnesotans obtain health insurance.
- The 2007 Legislature also created a Legislative Commission on Health Care Access, charged with making recommendations to the legislature on how to achieve the goal of universal health coverage. The Commission issued its report in 2008, which included many recommendations similar to those in the Health Care Transformation Task Force report (released in the same month).

Minnesota Citizens Forum on Health Care Costs. "Listening to Minnesotans: Transforming Minnesota's Health Care System." February 23, 2004
<http://www.health.state.mn.us/divs/hpsc/hep/transform/resourcebook/citizensforumtab7.pdf>

Minnesota Medical Association. "Physicians Plan for a Healthy Minnesota." Report of the Minnesota Medical Association Health Care Reform Task Force. March 2005.
http://www.mnmed.org/portals/mma/publications/reports/physicians_plan_for_a_healthy_minnesota_the_mmas_plan_for_health_care_reform.pdf

Health Care Transformation Task Force. "Recommendations submitted to: Governor Tim Pawlenty and the Minnesota State Legislature." January 2008.
<http://www.health.state.mn.us/divs/hpsc/hep/transform/ttfreportfinal.pdf>

The Legislative Commission on Health Care Access. "Recommendations Submitted to the Minnesota State Legislature." 85th Legislative Session, St. Paul, MN. February 2008.
<http://www.commissions.leg.state.mn.us/lchca/HCAC%20Report%20final%202-08.pdf>

for a federal health insurance exchange (exchange) planning grant. The state also chose not to apply for a federal Cycle 1 grant to support health insurance rate review and opted to let the federal government run the ACA-funded high-risk pool (the Pre-Existing Condition Insurance Plan, or PCIP) that served Minnesota residents. The 2010 Legislature required the governor to convene the Minnesota Health Care Reform Task Force, which was charged with making recommendations for state law, program changes, and implementation. In December 2010 (after meeting just once, according to key informants) this Task Force published a report concluding that “development of specific recommendations regarding state implementation of the ACA” was “premature given the limited availability of federal guidance and regulations.”⁵

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At the same time, most of the ACA’s early insurance market reforms were smoothly implemented by the Department of Commerce through its long-standing form review process, winning widespread approval from a range of stakeholders, as explained below. The 2010 Legislature also authorized the Executive Branch to take various steps to implement the ACA, including applying for and spending federal grants related to the ACA and—contingent upon a governor’s later executive order—implementing Medicaid coverage of childless adults before 2014. While the Pawlenty Administration did not take advantage of this authority, it proved critically important to the (subsequent) Dayton Administration’s much more aggressive implementation of the ACA.

ACA Implementation in the Executive Branch: 2011 & Beyond

Governor Pawlenty’s successor, Mark Dayton, whose term began in January 2011, took a very different approach to the ACA. One of Governor Dayton’s first actions as new Governor was to issue an executive order directing the Commissioner of Human Services

to implement a Medicaid expansion for adults without children, taking advantage of the authority granted by the 2010 Legislature. The expansion, which transitioned indigent adults from a purely state-funded, limited-benefit program into federally-matched Medicaid, was implemented in March 2011.

Governor Dayton was the first Democrat to serve as Minnesota’s governor in many years. Despite the inevitable learning curve, intensive state-level efforts, along with support from the U.S. Department of Health and Human Services, resulted in the state’s receipt of a health insurance exchange planning grant in February 2011 and an Exchange Establishment grant in August 2011. Though key informants noted that some state staff had already been “working behind the scenes” preparing for exchange planning, building on the state’s prior health reform efforts, exchange development did not begin in earnest until the state secured federal funding.

In October 2011, Governor Dayton issued an executive order charging newly-appointed Minnesota Health Care Reform Task Force members with improving access to care, lowering health care costs, and improving health outcomes for Minnesotans; according to key informants, this group (which is generally referred to as the “Governor’s Task Force” and includes Commissioners of the Departments of Commerce, Health, and Human Services) is responsible for guiding overall health reform.⁶ The same executive order authorized the Minnesota Department of Commerce to convene a Health Insurance Exchange Task Force. Officials believed that a separate group was required to guide exchange development work at an accelerated pace to meet the ACA’s deadline for demonstrating exchange readiness by January 2013.

ACA Implementation in the Legislature: 2011 & Beyond

While the change in gubernatorial party leadership in 2011 meant increased support for ACA implementation in some quarters, concurrent changes in the state legislature led to the opposite outcome elsewhere. In the 2010 general election, the Republican Party gained control of both legislative chambers for the first time since the 1970’s, and the incoming 2011 Legislature included many Tea Party-influenced freshman legislators who had campaigned on platforms opposing the ACA.⁷ As a result, the legislature has not approved legislation implementing a state-based exchange.

The challenges of this new legislative dynamic are reflected in the composition of the two task forces

described above. The governor's Task Force called for two members from each legislative chamber to be appointed by House and Senate majority leadership. All four appointees are Republicans. According to key informants, members of the Democratic-Farmer-Labor Party (DFL) "were not invited to participate." The Exchange Task Force, by contrast, includes four legislators appointed by the state's Insurance Commissioner. The Commissioner invited both majority and minority legislators to serve as exchange Task Force members, but the majority party (Republican) declined to appoint any representatives, so only DFL legislators sit on this Task Force.

Cooperation between Legislative and Executive branches continued on select issues, however. Notably, the 2012 budget provides resources that allow the Medicaid program to draw down enhanced federal matching funds to upgrade eligibility technology and streamline enrollment procedures. Such simplification measures have long enjoyed bipartisan support in Minnesota as reducing needless bureaucracy while helping eligible residents qualify for assistance.

Coverage Estimates

In 2011, 65 percent of Minnesota's 4.5 million residents under age 65 had employer-sponsored health insurance coverage, according to estimates from the Urban

Institute's Health Insurance Policy Simulation Model (HIPSM). More than six percent had non-group coverage, and nearly 18 percent had Medicaid, Children's Health Insurance Program (CHIP), or other public coverage. Just over 10 percent of the population was uninsured. Once the ACA is fully implemented, HIPSM projects that 416,000 individuals will gain health coverage through the Exchange (227,000 non-group and 189,000 employer-sponsored). Medicaid and CHIP enrollment is projected to increase by 97,000, reducing the uninsurance rate to 6.4 percent.

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HEALTH INSURANCE EXCHANGE: PLANNING AND IMPLEMENTATION

A Chronology

Health insurance exchanges had been a subject of discussion and debate in Minnesota long before enactment of the ACA, as noted earlier. But following the ACA's passage, several bills were introduced during the 2011 Legislative Session to create a state-administered exchange in Minnesota. Although one proposal came from a Republican Committee chair, the Republican leadership decided to prevent any exchange legislation from advancing even to a formal committee hearing.

This Legislative opposition did not prevent the governor and Insurance Commissioner from moving forward through the exchange Task Force, as noted above. With 15 appointees representing a broad range of stakeholders, staffed by the Commerce Department, and chaired by the Insurance Commissioner, the exchange Task Force began meeting in November

2011. The Task Force created 10 work groups, each of which included state staff, Task Force members, and other Minnesota stakeholders and experts. The work groups addressed such issues as combatting adverse selection, defining the roles of navigators and brokers, governance, and exchange financing.

By the time of our site visit, Minnesota had received a \$1 million exchange planning grant and a \$4.2 million Level 1 Exchange Establishment grant. In February 2012, after our site visit, the state received a second Level 1 grant, this one totaling \$26 million.

It is not clear whether the 2012 sessions of the legislature will see action on an exchange bill. Many stakeholders, including representatives of health plans and the business community, are urging creation of a state-administered exchange, rather than allowing the operation of a federally administered exchange in Minnesota. Notwithstanding

such support, most informants expected that exchange legislation would not be enacted, given the strong opposition of Legislative leadership.

An important open question involves the fate of the Exchange if the legislature does not pass authorizing legislation. Since the 2010 and 2011 Legislature already allowed the Executive branch to seek and spend federal exchange grants, most informants believed that, without any further steps by the current legislature, the Governor already has the legal authority to create and operate an Exchange as long as federal grants are available to cover operating costs—that is, through the end of 2014. Other informants were unsure about the Governor's legal authority. And regardless of whether such authority exists, no decision has been made about whether it will be used. Almost all officials and stakeholders with whom we spoke expressed a strong preference for exchange legislation that reflects agreement among the state's policy-makers, rather than continued Executive action without Legislative cooperation.

Moving Forward Despite Uncertainty

A central feature of the state's development of an Exchange is the decision to create infrastructure before important policy issues are resolved. To paraphrase Hoagie Carmichael's lyrics in *As Time Goes By*,⁸ a call center is still a call center. The fundamental things apply, regardless of how the Exchange is ultimately financed and governed. State staff are moving ahead briskly to create the human and technological infrastructure that will be needed to operate an exchange. Their goal is to create flexible institutions that will allow later changes after further federal guidance has been issued and state policy makers have made additional decisions.

State staff believes that the Exchange will operate in an ever-changing environment. Flexibility thus needs to be built into the new entity's DNA. Officials hope that the same kind of supple institutional design that now allows forward movement despite uncertainty will make the Exchange more effective in the future, long after today's open questions have been resolved.

Task Force Recommendations

The Task Force has begun making recommendations. According to state officials, these recommendations are likely to be incorporated into the Exchange's operating rules. Generally reflecting a broad consensus among

diverse members, the Task Force's recommendations to date reflect a careful and nuanced approach to issues involving adverse selection, financing, governance, and navigators and agents/brokers. Key recommendations issued in January 2012⁹ include the following:

Adverse Selection

- Market rules and certification procedures should be the same within and outside the Exchange, to help prevent adverse selection against the Exchange.
- Market rules should encourage the participation of small firms, guarding against higher risk levels and premiums for fully insured employers that could result from increased use of self-insurance by firms with disproportionately young and healthy workers.
- Using the state's all payer claims database, Minnesota should pursue a state-level risk adjustment model.
- Adverse selection, stability, and premium variability should be carefully monitored. Regulatory agencies should have the ability to react quickly if problems emerge.

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Financing

- Financing mechanisms should reflect that the Exchange both (a) serves particular entities (such as plans offered in the Exchange and consumers who receive coverage through the Exchange) and (b) furnishes public benefits to the state as a whole (such as by providing increased information about quality, determining exemptions from the individual coverage requirement, providing transitional coverage for people moving between jobs, etc.). Some funding should thus come from the groups that benefit, such as through the Medicaid program and from withholds to premiums paid for exchange coverage (so long as adverse selection effects can be avoided). Other

funding could come from broader assessments on providers or insurers, General Fund dollars, etc.

- Federal law requires exchanges to be self-supporting beginning in 2015. Navigator services will be required beginning in July 1, 2013, leading up to open enrollment for the 2014 plan year. The state will need to fund this activity, since the ACA bars the use of federal exchange grants for navigators.

Governance

- The Exchange's governing board should have the following characteristics—
 - 15-20 members serve staggered, term-limited periods;
 - A mixture of appointed members and members chosen by the Board are selected using the state's open appointments process;
 - A majority of members represent the interests of consumers and small business and offer a range of relevant expertise; and
 - Rigorous conflict-of-interest rules apply, and members with potential conflicts of interest (such as insurers and brokers) comprise at most a small minority of Board membership.
- A non-taxable entity capable of participating in intergovernmental transfers and interfacing satisfactorily with Medicaid eligibility determination, the Exchange should be bound by rules that achieve the goals of various statutory requirements that apply to state agencies, albeit with increased flexibility about the methods used to reach those goals. For example:
 - Requirements of the state's Open Meeting Law and Data Practices Act should apply, with carefully crafted exceptions;
 - Procurement must be responsible, but the Exchange should not be required to comply with state procurement laws; and

A range of navigator roles should be allowed, including some that focus specifically on the needs of disadvantaged populations. Different certification and training requirements and compensation models should apply to different navigator roles.

- Consumers and industry should have opportunities for input into policy decisions, but statutory rulemaking requirements should not apply.

Navigators and Brokers

- A range of navigator roles should be allowed, including some that focus specifically on the needs of disadvantaged populations, and others that include duties like those currently performed by insurance agents and brokers. Outreach and marketing should be included as important navigator functions.
- Different certification and training requirements and compensation models should apply to different navigator roles, with room for performance-based compensation. By meeting applicable requirements, one entity or individual could qualify to perform multiple roles.
- Navigators should not benefit from enrolling individuals in plans offered by specific insurers.
- Consumers should seamlessly be transitioned between navigators when they need different types of assistance.
- The navigator program should build on existing infrastructure, including community-based organizations, while filling significant gaps in the current system.
- Funding priorities should be determined based on consumer need.

An important goal is permitting small firms to wash their hands of current complexities involved in choosing coverage, letting them simply write a check and permit each employee to select a plan that meets his or her needs.

Other Anticipated Policy Directions

State officials articulated several policy directions they envisioned for the Exchange, subject to future clarification by the Task Force and its work groups. As part of a broader strategy to fight against adverse selection in the Exchange, state staff recognized the need for brokers to receive similar levels of compensation within and outside the Exchange.

Also, state officials envisioned the Exchange as playing a critically important role in facilitating portability. They accordingly wanted to make the Exchange a friendly and flexible environment for small business. For example, small firms could provide a defined dollar contribution for all their employees, who could then select from among individually rated plans; employers could pay a percentage of premium rather than a specific dollar amount, or structure their contribution as a combination (such as a percentage of premium up to a capped maximum); employers could designate a single plan for all their workers, permit their workers to select from among the full range of plans in the Exchange, or provide access to something in between; and multiple firms could use the Exchange to aggregate premium contributions for common employees, such as people who work part-time at several jobs. An important goal is permitting small firms to wash their hands of current complexities involved in choosing coverage, letting them simply write a check and permit each employee to select a plan that meets his or her needs. Recognizing that, as explained later, so-called “private exchanges” are likely to compete with the state’s Exchange and might harm the Exchange’s risk pool by attracting relatively healthy consumers and firms, state staff viewed the state’s Exchange as offering the comparative advantage of letting consumers retain the same health plan as they move from employer to employer or from employer-sponsored to individual coverage.

State officials also envisioned the Exchange as playing a critical role improving quality. When consumers choose from among plans in the Exchange, they should easily be able to obtain information about the quality of the plan’s participating providers. Such information will be particularly important if, as some informants

expect, one or more plans try to increase their market share by offering narrow provider networks and lowering premiums below their competitors’ levels. These consumer information mechanisms will build on the considerable quality and data work already done in the state, through both the cooperative efforts of plans and providers, described later, and the 2008 reform legislation described above in the Background section.

In terms of the Exchange’s relationship to private coverage as a whole, state officials wanted to ensure that insurers and providers could continue to innovate. They expressed the hope that innovations unfolding outside the Exchange could be brought within the Exchange as well, thereby benefiting the employers and individuals who use the Exchange for their coverage.

Carrier Participation

Insurers have not yet committed to a level of participation in the Exchange. According to some informants, participation will depend on how the Exchange is structured. No clear decision has been made about where the state’s Exchange will fall along the “active purchaser”/ “market organizer” continuum, which could greatly affect insurers’ willingness to serve the Exchange’s members.

Other informants anticipate widespread participation by the state’s carriers, pointing to a long tradition of nonprofit Minnesota HMOs that serve public programs. By state statute, offering coverage within the Medicaid program is a condition of licensure for HMOs, which are legally prohibited from operating for profit. Some observers indicated that it would be very surprising if these plans did not offer coverage in the Exchange.

HEALTH INSURANCE EXCHANGE: ENROLLMENT AND SUBSIDY DETERMINATION

General Vision

State officials consistently articulated the same basic vision: a single, integrated eligibility determination system that will serve all insurance affordability programs in Minnesota. However and wherever consumers seek assistance, a single system will conduct relevant data matching, and one rules engine will sort each applicant into the right program, whether that is Medicaid, CHIP, subsidies in the Exchange, or the BHP (if the state decides to pursue that option).

Stakeholders as well as state officials voiced enthusiasm for this approach. And as noted above, the legislature appropriated state resources for the Medicaid program to access 90 percent federal matching payments for developing IT needed to implement a new, more streamlined, less bureaucratic model of 21st-century eligibility determination, driven whenever possible by electronic data matches rather than consumer-proffered paperwork processed manually by public employees.

To help their pursuit of this vision, state officials are participating in broader, multi-state efforts, including the

User Experience (UX) 2014 project being funded by the California HealthCare Foundation and other philanthropies, and work on consumer plan selection undertaken by the Pacific Business Group on Health and supported by the Robert Wood Johnson Foundation. Minnesota officials are also tracking the work of states that received “early innovator” grants from CMS to develop IT needed for effective exchange operation.

Collaborative Implementation Across Agency Boundaries

An interagency team has been developing the mechanisms that will apply to enrollment and eligibility determination across the range of insurance affordability programs. The team includes representatives of the Department of Commerce working on exchange implementation as well as Medicaid experts from the Department of Human Services. An interagency agreement formalizes a working relationship with joint agency control. But in some ways more important, decades of state reform efforts have left the team’s members from different agencies knowing, respecting, and trusting each other. The Department of Commerce and Department of Health are also in the process of establishing an interagency agreement that would outline each agency’s role and authority related to use of data from the statewide quality reporting and measurement system and the provider peer grouping system. The agreement would also authorize a collaborative approach to the potential use of the all payer claims database for risk adjustment within the exchange, if such use is eventually authorized.

State officials have extended this collaboration to their efforts at securing federal funding. For each IT component that serves both the Exchange and Medicaid, the state proposed a cost-allocation plan that divides expenses between federal exchange grants and 90/10 federal Medicaid funding. The allocation was based on the estimated number of consumers who will participate in each insurance affordability program. At the request of state officials, each IT component has been reviewed simultaneously by the Center for Consumer Information and Insurance Oversight (CCIIO), which oversees exchange development, and the Center for Medicaid and CHIP Services (CMCS), which administers Medicaid. Obtaining simultaneous approvals for both federal funding streams has allowed IT development to move forward in an integrated fashion, with a single system that will serve both Medicaid and the Exchange.

IT Development Strategies

Minnesota has been pursuing a highly innovative approach to IT development. State officials identified multiple IT tasks that will need to be performed in the Exchange, including:

- Determining eligibility for the Exchange, for all insurance affordability programs (including Medicaid), and for exemptions from the individual requirement to obtain health coverage;
- Enrolling consumers into health plans and (as applicable) with providers;
- Interfacing with small firms;
- Health plan and navigator/broker certification and display;
- Provider display, including data about quality measurement and provider peer grouping data;
- Fund aggregation and payment; and
- Account administration.

Minnesota is using a two-stage “proof of concept” approach to procurement. Vendors have qualified to develop prototypes for specified IT tasks. Each prototype costs the state \$10,000. Now that prototypes have been completed and made publicly available for comment, the state will select a vendor for each module to translate the prototype into an operating system, along with an “integrator” vendor to pull all components together.

Minnesota is using a two-stage “proof of concept” approach to procurement. Vendors have qualified to develop prototypes in these areas. Each prototype costs the state \$10,000. Now that prototypes have been completed and made publicly available for comment, the state, with input from consumers and stakeholders, will select a vendor for each module to translate the prototype into an operating system. The state will also select an “integrator” vendor to pull all components together.

State officials see this approach as offering several advantages over more traditional IT procurement methods:

- Seeing a prototype in operation provides useful information about how the eventual computer system is likely to function under the potential vendor’s approach, enabling better-informed vendor selection.
- Different vendors have different strengths. Breaking up the IT work into multiple tasks allows each task to be performed by the “best in breed.”
- If the Exchange works with a team of IT vendors, rather than a single vendor, it is less likely to be constrained in the future. With a single vendor, poor performance or high price can be difficult to remedy if the alternative possible vendors lack experience with the state’s

approach. With a team of vendors, by contrast, one existing team member taking over another’s responsibility is likely to face a less steep learning curve, which means that the state will be less dependent on a single vendor for affordable, reliable performance.

On the other hand, state officials recognize that operating an IT team with multiple vendors will require careful attention to efficient and effective coordination. Selecting a single vendor to oversee such coordination should prove helpful, according to our informants, along with clear state standards for interoperability of IT modules.

INSURANCE REFORMS

Implementation of Early Market Reforms

In many ways, Minnesota’s insurance laws were already largely compliant with the insurance market reforms the ACA made effective in September 2010, with only minor changes required. For example, dependent coverage was required to be offered to adult dependents up to age 25 in Minnesota, compared to up to age 26 under the ACA. To make the changes that state insurance officials believed were needed, the Department of Commerce’s insurance regulator required carriers to file new forms affirming each health plan’s compliance with the specific requirements of federal law, such as provisions involving adult dependent coverage, preventive services without cost-sharing, and annual and lifetime limits. Our informants, both inside and outside state government, agreed that the Department of Commerce did a superb job providing information to carriers and the public, processing the form filing very quickly so that carriers could rapidly sell coverage under the new rules.

Along similar lines, state officials and private-sector informants agree that the state was already largely in compliance with the ACA’s medical loss ratio (MLR) requirements that became effective in 2011. Nominally, the state’s thresholds were slightly different than the federal levels, and the state calculated MLR differently than the approach taken under the ACA. For example, Minnesota classified as administrative expenses certain quality-related costs that the ACA places in the same category as payment of health care claims. As a practical matter, most of the state’s carriers have very high MLRs, though some informants expected that a few carriers may not meet the federal standards and so may wind

up owing rebates to their Minnesota members for the 2011 plan year.

However, two early market reforms posed a challenge. First, the prohibition of preexisting condition exclusions and the requirement of guaranteed issue for children’s coverage, unlike the reforms discussed earlier, represented a major departure from prior state law. Carriers were understandably concerned about adverse selection. If one or two insurers wound up serving the bulk of children with special health care needs, the financial consequences for those carriers could be significant.

To avoid this problem, the state’s health plans proposed a common open enrollment period during which parents could purchase coverage for their children without discrimination against children with special health care needs. This approach would have prevented families from delaying enrollment until their children developed a need for health care, thereby lessening the degree of total adverse selection. Moreover, all plans would have simultaneously offered a special enrollment opportunity, lessening the extent to which any one plan shouldered a disproportionate load of costly children.

Officials at the Department of Commerce did not approve this proposal, for reasons that are not entirely clear. Some informants suggested that federal guidance allowing approaches like those proposed by Minnesota plans was not issued until it was too late to implement the carriers’ recommended approach via formal rulemaking. Others attributed the rejection to governor Pawlenty’s broad opposition to any implementation of the ACA.

Whatever the reason for the state's failure to approve the carriers' proposal, the state's private market for child-only plans collapsed soon thereafter. Fortunately, the effects were not devastating. The child-only market had always been small, primarily covering children of low-income workers whose employers did not offer dependent coverage on favorable terms. Further, it is not clear that any children who otherwise would have received coverage became uninsured. Children already enrolled in child-only plans retained that coverage, and children could still be added to their parents' coverage. Critically important, the state's high-risk pool, MCHA, accepted children whose only access to coverage, in the past, would have been through child-only private plans. One of the populations served by MCHA consists of state residents unable to obtain private insurance, typically because of health conditions that make coverage unavailable or unaffordable. In this case, however, MCHA ruled that, under its governing legislation, it could cover children who were unable to obtain private insurance because child-only policies were not being sold in the state. As explained below, premiums in MCHA exceed standard market rates by 15 percent, so some families may have had to pay more for child-only coverage. Put simply, child-only coverage remained available, but its cost rose for some residents.

A second early market reform that created some consumer confusion involved the ACA's requirement to cover preventive services without out-of-pocket cost-sharing. If such a service detects a health problem, treatment for that problem can be subject to cost-sharing. A number of consumers voiced confusion, particular when a preventive screen and follow-up treatment were combined in a single procedure. For example, if a colonoscopy shows polyps, the surgeon will typically remove the polyps while the patient remains under anesthesia for the colonoscopy. The colonoscopy is exempt from cost-sharing, but the polyp removal may involve copayments. In addition to experiencing confusion, some consumers argued that it seemed unfair to begin charging copayments and deductibles precisely when the insurer knows that the enrollee needs services.

Recent Changes to Insurance Markets

Whether in response to early market reforms, anticipation of future reforms, or factors entirely independent of the ACA, respondents reported several significant developments in insurance markets.

First, many informants noted the increasing prevalence of less comprehensive benefits and higher deductibles,

in both individual and group markets. These informants suggested that such increasingly popular insurance products might not meet the ACA's minimum requirements for covered benefits and actuarial value. They worried that some consumers and businesses may be unhappy once they realize that they must purchase more comprehensive and costly coverage.

It is not clear, however, that this assessment was based on a clear understanding of the ACA's minimum requirements. Regardless of how essential health benefits are defined, the federal legislation permits coverage with an actuarial value of 60 percent. Almost all group coverage, and the majority of individual coverage, exceeds this threshold today.

Second, several informants described the emergence of "private health insurance exchanges" that seek to offer small firm coverage on favorable terms. Most such exchanges are sponsored by a single carrier, which gives employers a range of plans in which their employees can enroll. Some are more cooperative ventures that offer products from multiple carriers. A number of interviewees viewed this as a positive development that will force the state Exchange to do a better job with small firms than would have happened without competition. Others expressed the concern that adverse selection and fewer consumer gains could result if, because of private exchanges or other factors, plans compete against the state-sponsored Exchange, rather than against each other. If private exchanges include group plans that attract the lowest-cost private firms and individual plans that attract the lowest-cost purchasers of unsubsidized nongroup coverage, all of whom will, by definition, have incomes above 400 percent of FPL, they could raise the average risk level in the public exchange's small group and individual markets.

Third, some insurance agents have been selling their practices and "getting out of the business." This appears to reflect a fear that increased government involvement in insurance markets will inevitably threaten brokers' earnings. Other agents, however, are seeking to influence the development of the Exchange, convinced that their skills and their relationships with employers will continue to allow them to add value and earn a living.

One particular concept that emerged in our discussions involved brokers serving employers by helping employees who are not offered ESI enroll into insurance affordability programs and the Exchange. Some of these employees are part-time workers who are ineligible

for ESI that their firms offer to full-time employees. Others work for companies that do not provide health insurance but use brokers to purchase other types of insurance. In either case, brokers reimbursed by the Exchange could enroll workers into coverage, providing a free service to employers and helping the ACA achieve its enrollment objectives.

Fourth, several informants reported that carriers have been gearing up to sell more individual market policies, based on the expectation of increased demand in 2014 and beyond. It is not clear whether this expectation results from the individual mandate, subsidies in the Exchange, beliefs that employers will drop coverage, or other factors.

The fifth and most worrisome development spotted by our informants involved the increased movement of small employers from full insurance to self-insurance. For example, some insurers, acting as administrative-service-only (ASO) agents, are helping employers purchase stop-loss coverage as they hold employer dollars in reserve to pay health claims, with the ASO refunding unspent dollars if claims fall below expected levels. Through these and other arrangements, small firms retain the immunity from state regulation that results from self-insurance while gaining the protection from risk that, in the past, was limited to full insurance products. State policy-makers fear that, if small firms with predominately young and male workers become increasingly self-insured, such firms will realize savings because of their more favorable risk pool, and costs for the remaining fully insured, small group market will rise, both within and outside the Exchange. Flight from the small group, fully insured market is limited by current state policies that regulate stop-loss coverage—among other things, to require minimum attachment points. State policy-makers intend to monitor this issue as it evolves, to see if additional safeguards are needed.

Brokers could serve employers by helping employees who are not offered ESI enroll into insurance affordability programs and the Exchange. Reimbursed by the Exchange, brokers would provide a free service to employers and help the ACA achieve its enrollment objectives.

High-Risk Pool Coverage

Founded in 1976, the state's high-risk pool, MCHA, is one of the country's largest and most successful risk pools. It serves approximately 27,000 residents, including consumers whose health conditions make it impossible or unaffordable for them to obtain individual coverage in the general private market. Premiums may not exceed 125 percent of standard rates in the individual market, but they now average 115 percent. Health plan assessments generate 55 percent of MCHA funding. The remaining 45 percent comes from enrollee premiums.

Rather than expand MCHA to include the new federal high-risk pool program—the Preexisting Condition Insurance Program, or PCIP—governor Pawlenty let the federal government establish a separate risk pool, which garnered few enrollees. At the time of our visit, PCIP had enrolled roughly 200 Minnesota residents, by far the program's high-water mark. Our respondents indicated that, although state agencies regularly informed consumers about the federally-administered pool, very few residents needed the services PCIP offered. The better-known MCHA option, along with the state's relatively generous public programs, substantially reduced the demand for the federal pool. PCIP's appeal was further reduced by the required 6-month minimum period of uninsurance as well as premiums that exceeded MCHA levels. In addition, brokers are reimbursed for enrolling clients in MCHA; our informants did not know whether that was also true of the federally-administered pool.

A much more important issue to Minnesota policy-makers involves the fate of MCHA under reform. According to projections from state contractors, if all MCHA consumers entered the individual market in 2014, average risk levels and premiums for individual coverage would rise dramatically. If one or two carriers enrolled the lion's share of people leaving MCHA for the Exchange, the impact on those insurers could be destabilizing.

These risks are likely to be addressed through gradual attrition of MCHA's current members. It is not clear whether, starting in 2014, new applicants for MCHA coverage will qualify as lacking access to individual coverage because of their medical conditions. If not, most new enrollment into MCHA will end. Current enrollees will be free to leave MCHA for the Exchange, and some will do so, particularly if they qualify for tax credits and cost-sharing subsidies, which can be used only in the Exchange. But the MCHA members with the most serious health problems tend to resist changing plans, for understandable reasons. If existing coverage

is working well for someone who desperately needs it, the risks of change can easily appear enormous to the consumer, even if other coverage is subsidized. Many informants thus expect that, soon after the Exchange begins operating in 2014, a relatively small group of comparatively healthy MCHA members are likely to leave the program for the Exchange. Over time, as plans in the Exchange become familiar and trusted, moving to the Exchange will appear less risky, and somewhat higher-cost members will leave MCHA for the Exchange. If attrition proceeds as expected, the sickest MCHA enrollees will not join the Exchange until several years have passed, at which point the individual market is expected to be much larger than it is today, and the impact on average risk levels will be of much lower magnitude. MCHA has already begun educating its members about the ACA and plans to continue doing so, helping MCHA enrollees make informed judgments about whether and, if so, how to change their coverage arrangements in 2014 and beyond.

A relatively small number of comparatively healthy high-risk-pool members are likely to leave the program for the Exchange. Over time, as plans in the Exchange become familiar and trusted, moving to the Exchange will appear less risky, and somewhat higher-cost members will leave the pool for the Exchange. The sickest high-risk-pool enrollees will not join the Exchange until several years have passed, at which point the impact on average risk levels will be of much lower magnitude.

Rate Review & Insurance Oversight

Minnesota has a tradition of rigorous rate review. During the Pawlenty Administration, the state did not avail itself of federal grants to improve its rate review process, as noted earlier. However, the current Administration sought and received federal funding. These resources are being used to hire additional staff and increase transparency to consumers. Already, the forms that non-HMO insurers file to describe their products and justify their rates can be accessed on the internet and downloaded as

PDF files. Further efforts at providing public information are envisioned as achieving multiple goals, including helping consumers select health plans in the Exchange and elsewhere. Among other things, the Department's transparency initiative aims to help consumers analyze how their individual health conditions and usual patterns of health care would be affected by particular health coverage options.

In Minnesota, health insurance oversight is divided between two agencies. The Department of Health regulates HMOs, and the Department of Commerce regulates other insurers. However, under an interagency agreement dating to 1999, actuaries from the Department of Commerce help the Department of Health analyze rates and solvency for proposed HMO products.

State policy-makers understand that the roles performed by both agencies—the Department of Health's analysis of HMO network adequacy and quality, for example, and the Department of Commerce's analysis of rates and marketing—will overlap with functions to be performed in the Exchange. Our informants were committed to working efficiently, as a single team that would apply the same certification procedures inside and outside the Exchange, even though the precise institutional arrangements for that collaboration have not yet been devised. Informants believed that, in such a partnership, each entity's strengths could be leveraged to achieve efficiencies for the state, consumers, and plans. For example, the Department of Commerce has access to an electronic form filing system available through the National Association of Insurance Commissioners. In the past, the system has not been available to the Department of Health. As a result, HMOs have filed paper forms, while PPOs and indemnity plans filed their forms electronically. As part of moving toward 2014, policy-makers plan to make this electronic system available for all health plan filing, which will also facilitate the above-described effort to increase transparency and public information about health coverage in Minnesota.

Moving Toward 2014's Broader Reforms

Our informants were not worried about the effect on markets of the much broader insurance reforms that become effective in 2014. They felt that, between the limits on risk-rating allowed under current Minnesota law and the role played by MCHA in providing individual coverage to high-risk consumers, the transition to fully guaranteed issue and more limited risk-rating under the ACA should be manageable.

One unresolved question involved, as a legal matter, precisely how the 2014 reforms will be implemented. It was not clear to our informants whether the state would follow the same form-review strategy that it used to implement the early market reforms that became effective in September 2010. Across the board, our informants expressed a preference for legislative action to bring the state laws into conformity with ACA, if such action becomes possible.

Another unresolved question involved the state's choice of essential health benefits (EHB). At the time of our site visit, the state had solicited public input and gathered information about the details of particular possible benchmark packages. Our informants were concerned that a limited benchmark could (a) require the state General Fund to pay for mandates that exceed EHB and (b) provide residents with less generous coverage than is consistent with state norms. On the other hand, some interviewees worried that an overly generous benchmark could expose small firms to unaffordable insurance costs and potentially induce some to drop coverage. Several informants expressed exasperation that the federal

guidance on EHBs, which gives states considerable latitude in deciding EHB details, has added to the issues that states must quickly resolve. In the months following our site visit, Minnesota's Access Work Group (charged with making recommendations on EHB to the governor's Task Force) recommended that the Task Force urge the federal government to provide additional regulations (for example, to furnish more specificity on benefits like dental, pediatric hospice and home care) that would allow the state to make fully informed choices about EHB as soon as possible. The Access Work Group also concluded that there were not significant differences between the benchmark plans that, per federal guidance, are available to serve as the basis for Minnesota's EHB.¹⁰

Numerous informants were focused on structuring policies and procedures to prevent risk-selection. The general consensus was that the ACA's mechanisms for sharing risk across the individual market—reinsurance, risk-adjustment, risk corridors, and the requirement for carriers to pool all their members in each applicable market—should be helpful but will not represent anything like a complete solution.

MEDICAID POLICY

Role of Public Programs

Minnesota has a strong history of expanding access to health coverage, reflecting a broadly shared commitment to devote significant public resources toward helping low-income residents afford insurance. As a result, the state's public programs are among the most generous in the United States. The state covers children, parents, and pregnant women with incomes up to 275 percent of the federal poverty level (FPL), very young children with incomes up to 280 percent FPL, childless adults with incomes up to 250 percent FPL, and aged, blind, and disabled individuals up to 100 percent FPL.

The precise arrangements for subsidized coverage have evolved over decades and are complex. The state's two major programs are Medical Assistance (MA), which is a fairly traditional Medicaid program, and MNCare. Historically, eligibility for the programs has been determined by both state and local government agencies, and their funding sources have been somewhat different. They have primarily used a managed care delivery system. For some MNCare populations, benefits and cost-sharing safeguards are the same as in MA; for other MNCare groups, coverage is more limited.

One additional program that existed until the current Governor took office, General Assistance Medical Care (GAMC), covered indigent, childless adults with incomes at or below 75 percent FPL. Until recently, both GAMC and MNCare coverage of childless adults were funded entirely with state dollars. Historically the two programs included some overlapping eligibility, and childless adults with incomes up to 75 percent FPL could choose to enroll in either GAMC or MNCare.

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Federal funding under the Children's Health Insurance Program (CHIP) is used to provide Medicaid to uninsured children under age 2 in families with incomes between 275 and 280 percent FPL, to unborn children of uninsured mothers ineligible for Medicaid with incomes up to 275

percent FPL, and to provide additional federal match for Medicaid and MNCare children in families with incomes above 133 percent FPL.¹¹

During the Pawlenty Administration, one legislative response to the state budget crisis limited GAMC benefits and participating providers, and the governor adamantly opposed converting the program into federally-matched Medicaid. The Dayton Administration took a very different approach, ending GAMC as a state-funded, limited program and moving beneficiaries into a federally-matched MA program with standard Medicaid benefits and health plans, using the ACA's new option for covering childless adults before 2014. In addition, the state obtained a waiver through which federal Medicaid funds now help finance MNCare coverage for childless adults with incomes between 75 percent FPL and 250 percent FPL. It is unclear what will happen to MNCare-covered adults above 138 percent FPL in 2014. At that point, the state can continue claiming federal matching payments for the group, but 100 percent federal funding would be available in the exchange (or—for those with incomes up to 200 percent FPL—in a state-implemented BHP if the state cut back Medicaid eligibility to 138 percent FPL.

At this juncture, GAMC no longer exists as a separate program. The state's two major programs—MA and MNCare—have distinct “brands” to the public and elected officials, but they both are funded through a combination of federal Medicaid matching funds and state dollars. Health plans and administrative structures for the two programs have been growing increasingly similar over time. Table 1 shows the populations covered by the two programs.

Table 1: Eligibility for MA and MNCare, by Household Characteristic and FPL: 2012

	MA (At or Below)	MNCare (At or Below)
Pregnant Women	275% FPL	275%
Infants (under age 2)	280%	275%
Children Ages 2-18	150%	275%
Youth Ages 19-20	100%	275%
Parents	100%	275%
Adults without Children	75%	Over 75% & at or below 250%

Source: Kaiser Family Foundation, Income Eligibility Limits for Children, Low-Income Adults, and Pregnant Women as a Percent of the Federal Poverty Level (FPL), Available at <http://statehealthfacts.org/profileind.jsp?cat=4&sub=54&rgn=25>

Whether they are covered through MA or MNCare, children and pregnant women receive full Medicaid benefits, without any copayments. MNCare beneficiaries pay premiums on a sliding scale based on income, with the exception of children in families with incomes up to 150 percent FPL, who pay a flat \$4 premium per month. Parents in MNCare with incomes up to 215 percent FPL receive benefits that are almost as comprehensive as those in the MA program. Parents above this income level and all adults without children receive substantially less coverage of inpatient hospital and residential drug and alcohol treatment services, which are subject to a \$10,000 annual limit. Key informants consistently reported that Minnesota's “culture of coverage,” reflected in the state's high eligibility levels for MA and MNCare (and in its higher-than-average proportion of residents with employer-sponsored coverage), helps explain the state's low rate of uninsurance, which was approximately nine percent of the nonelderly population—half the national rate of 18 percent.¹²

The state's share of funding for these programs comes from different sources. The State General Fund pays for the MA program. MNCare, in contrast, is financed through the state's Health Care Access Fund, which is supported by a two percent tax on health care providers and a one percent HMO premium tax.

Budget Pressures & Savings

Minnesota has struggled to balance its budget every year for the past decade. Going into 2010, the state had a \$5 billion budget deficit. Though a total of \$1.6 billion was cut from the DHS budget, maintaining eligibility and benefits for all populations served by public coverage programs was the Dayton Administration's priority.¹³

The ACA allowed the Administration to achieve savings in several areas. State officials project that implementing the early Medicaid expansion option will save \$1.7 billion over 5 years (FY2011-2015) by changing state-only GAMC into federally-matched Medicaid. The ACA's authorization of prescription drug rebates for Medicaid managed care plans also saved the state significant additional sums, as did the federal government's reinsurance subsidies for early retiree coverage. In addition, the ACA has provided Minnesota with enhanced 90 percent federal matching funds for health home services, which play a key role in the state's efforts to integrate behavioral health and primary care.

Outside the ACA's parameters, state policy changes generated additional savings. Previously slated for 2011 implementation, rate increases for nursing facilities and hospitals were repealed. Critically important, the state's

shift from administrative rate setting to a pilot program of competitive bidding for Medicaid managed care organizations (MCOs) in the Twin Cities is projected to yield \$175 million in state savings for FY 2012. In the rest of the state, administrative rate-setting continues to apply, with modifications to reflect the competitive bidding experience. Supplementing this reform, Governor Dayton held Medicaid MCOs to a one percent profit “cap” for the 2011 contract year. This limitation received bipartisan support after policy-makers learned that health plans earned over three percent in profits from state public program contracts in 2010. In response to the resulting controversy, one health plan (UCare) also agreed to provide a one-time, \$30 million contribution to the state in 2011.

When the ACA is fully implemented, Minnesota state officials expect that the number of uninsured will decline, but the state will need to continue to support a safety-net system for a significant uninsured group.

Many key informants wondered whether, going forward, the state would have any more latitude to cut Medicaid provider rates, which have not been adjusted for inflation over the past decade. Some informants characterized fee-for-service rates as below cost for some non-clinic providers. Others noted that the MCO capitation rate reductions have led to operational challenges for Medicaid managed care plans, who “have to do more with less” since, in addition to increases in enrollment, plans face increased administrative burdens for reporting and data management.

Thanks in part to these steps, Minnesota reached a balanced budget agreement for the next biennium (FY2012-2013). Also contributing to state budget balance was better than expected revenue for FY 2011 and borrowing \$1 billion from local school districts.

Another initiative that appears promising in terms of potential cost savings involves “dual eligibles,” or poor seniors and people with disabilities who qualify for both Medicaid and Medicare. This population accounted for roughly \$2.8 billion in Minnesota MA spending on 2010.¹⁴ As the first state to develop a statewide integrated model for care and financing for dual eligibles, Minnesota was

well-positioned to participate in several ACA initiatives in this area. The state is one of just 15 to receive a CMS contract to develop integrated service and payment models for dual eligibles. Minnesota is also participating in discussions with CMS around integrated financing strategies. The expectation is that integration will allow both improved quality and slowed cost growth, with the state and federal government sharing in resulting savings.

Finally, a bill enacted in the summer of 2011 authorized DHS to seek 12 new waivers¹⁵ for additional federal funding, including maintenance of effort waivers to change the eligibility system for Medicaid long term care services and supports and waivers to modify legacy mental health institutions.

Reforming Provider Payment and Health Care Delivery

Minnesota’s Medicaid program has initiated a number of payment and health care delivery system reforms to help alleviate budget pressures and to join a larger statewide effort to transform and improve health care delivery. One recent example is the Health Care Delivery System (HCDS) demonstration, which is a state-initiated effort. Eight large integrated health systems and one network of Federally Qualified Health Centers are participating in the HCDS demonstration, with each implementing a care delivery model that involves shared risk and shared savings based on reducing total cost of care while meeting quality and patient experience benchmarks. The state also operates a separate demonstration effort called Hennepin County Health, which serves the Twin Cities area and includes the state’s largest safety net hospital, to provide an integrated service delivery model including physical and behavioral health care and social services for a high-need adult population that frequently uses county resources. For this program, which officials described as similar to an Accountable Care Organization (ACO) model, the state pays the medical center a global capitation rate that includes the cost of services covered under the Medicaid benefit, and the county will also track the cost of certain social services (such as housing and food support) and county-funded behavioral health care services. In its initial stages, this pilot project is focusing on the early MA expansion population (that is, adults without children who have incomes up to 75 percent FPL).

Other Anticipated Policy Directions for Minnesota's Public Programs

The state has begun analyzing eligibility issues to anticipate the demographic make-up of Minnesotans in 2014, new gaps in coverage, needed changes in state law, and other factors. When the ACA is fully implemented, Minnesota state officials expect that, as with Massachusetts's 2006 health reform law, the number of uninsured will decline, but the state will need to continue supporting a safety-net system for a significant uninsured group. Beyond this general analysis, state officials are exploring a number of specific questions about the future of public programs, described in turn below.

MNCare Over 138 Percent FPL

Determining the future of the MNCare program is one of the biggest policy decisions that the state faces. In particular, the state must decide the fate of the population currently served in MNCare with incomes greater than 138 percent FPL, the new federal minimum that ACA establishes for Medicaid. Unlike children's coverage, for which the ACA requires maintaining eligibility until 2019, current Medicaid coverage for adults can be eliminated above 138 percent FPL, beginning in 2014. All states that serve adults over 138 percent FPL will need to decide how to approach this group, but this question is particularly pressing in Minnesota because of the breadth of coverage it offered before the ACA.

A number of informants expressed concerns about benefit reductions and cost increases that MA and MNCare consumers could experience if they were transferred to subsidized coverage in the Exchange. While no decisions had been reached, officials were considering the BHP option, described below, as well as using state dollars to supplement federal subsidies for low-income exchange enrollees.

All states that serve adults over 138 percent FPL will need to address how to approach this group, but this question is particularly pressing in Minnesota.

Recent policy changes may influence the state's approach. Legislation enacted in 2011 terminated the MNCare provider tax, effective in 2019; required reductions in MNCare provider tax rates whenever annual revenues

exceed MNCare costs by more than 25 percent; and transferred a small number of MNCare-covered adults without children with incomes between 200 and 250 percent FPL into a premium-assistance program (whereby the state provides premium support for private coverage offered by employers).

Medicaid Provider Payments

Currently, Minnesota has not decided whether it will increase provider payments beyond the federal increase for 2013 and 2014. But officials stated a greater willingness, as a general matter, to pay for higher quality, rather than to provide a general across-the-board raise.

Medicaid Benefits

Another important issue involves potential changes to Medicaid benefits in 2014, when newly eligible adults can receive so-called "benchmark benefits," rather than standard Medicaid adult coverage. Informants uniformly described the state's current Medicaid benefit package as generous, and most expressed a desire to maintain comprehensive benefits. Some informants expressed concern about how essential health benefits would be defined and how they might compare to current MA and MN Care benefits. No decisions had been made on Medicaid benchmark benefits at the time of our site visit.

Outreach & Enrollment

Plans for outreach and enrollment assistance related to the ACA Medicaid expansion need to be addressed before 2014, according to many of our informants. Though Minnesota has yet to develop a formal plan for this effort, a work group in the Exchange Task Force and a subcommittee in the governor's Task Force are working on developing an outreach campaign. Because of Minnesota's unusually expansive coverage, many of those whom the ACA qualifies for subsidies, as a matter of federal law, were already eligible for state programs. Accordingly, officials believe that communicating about transition (e.g., if MNCare or MCHA enrollees transition to exchange-based or BHP coverage) will be more important than educating uninsured residents about their eligibility for ACA coverage expansions. Though no marketing strategies have been definitively adopted, informants also indicated that they would focus on communication methods, not just messages. For example, DHS is considering text messaging and other communication strategies that, for a state agency, are innovative.

Medicaid Managed Care

Many informants also did not believe that Medicaid plan capacity would be an issue when coverage expansions are implemented in 2014. This reflected two key facts: Minnesota's expected enrollment increase is relatively small, given the state's existing programs; and numerous plans already participate, including the nonprofit HMOs that play a central role in the state's commercial markets.

At the same time, some informants expressed the fear that, if the state's above-described competitive bidding for Medicaid HMOs expands beyond the Twin Cities, plan capacity may not be sufficient to meet the demand. If increased capacity turns out to be needed in the coming years, the state may be able to help meet the demand by contracting to provide administrative services (though this option was not under consideration, other than as a potential contingency, at the time of our site visit). The Minnesota-based UnitedHealth Group is an example of a carrier that, while it does not operate an HMO in the state, could serve as a third-party administrator for Medicaid.

Basic Health Program

At the time of our site visit, policy-makers had not decided whether or, if so, how to implement the BHP

option in the ACA. One analysis by Jonathan Gruber and Bela Gorman,¹⁶ released in November 2011, found that federal BHP funds would not cover the cost of furnishing BHP-eligible adults coverage like that currently offered by MNCare. Some observers questioned these results, suggesting that the analysis may have overstated MNCare costs under BHP and ignored potential state cost savings from substituting fully federally funded BHP for state spending on MNCare.

Respondents identified several potential BHP advantages. By shifting adults from MNCare to the BHP, the state could eliminate its spending on these populations without reducing their covered benefits or increasing their costs. In addition, a BHP modeled after MA or MNCare could help the viability of Medicaid MCOs.

However, in the absence of dispositive federal guidance, informants were unsure whether federal BHP dollars would cover BHP administrative costs or the differential risk mix of this population. In addition, policy-makers feared that BHP implementation might adversely affect the Exchange's average risk level. Ultimately, some officials believed that the determinative question will be whether BHP implementation would favorably or unfavorably affect the state budget.

PROVIDER AND INSURANCE MARKETS

Minnesota's Health Care Providers

Minnesota has a number of large, nonprofit integrated hospital and health systems, most of which are centered in the Twin Cities of Minneapolis and St. Paul, with linkages to other areas throughout the state. The majority of these systems also operate in neighboring states. The largest is the Mayo Clinic Health System, with 11 hospitals and over 2,600 beds in the state. (Mayo also operates in Wisconsin, Iowa, and Georgia.) Other major systems include: Allina Hospitals and Clinics, which has 11 hospitals and over 100 clinics and ambulatory care centers throughout Minnesota and western Wisconsin; Essentia Health system, which includes 17 hospitals and 67 clinics across Minnesota, Wisconsin, North Dakota, and Idaho; Sanford Health, a rapidly-growing system that focuses on rural areas and has a presence in eight states; and Fairview Health, which includes ten hospitals and over 40 primary care clinics in Minnesota. Fairview Health System (which partners with the University of Minnesota) and the Mayo Clinic are the state's only academic health systems.

The state's largest safety net hospitals, the Hennepin County Medical Center (HCMC) in Minneapolis and Regions Hospital in St. Paul, have experienced recession-related increases in uncompensated care over the past several years. They were also harmed by the above-described 2009 funding cuts to the GAMC program, which established a block grant payment structure that shifted much of the risk to hospitals and drastically reduced overall program funding. But the March 2011 early Medicaid expansion, which extended full Medicaid benefits to most GAMC enrollees and more favorable (Medicaid) reimbursement rates to providers, helped the hospitals.

Key informants suggested that, while safety net hospitals in the state are concerned about ACA-related reductions in federal Medicaid and Medicare Disproportionate Share Hospital (DSH) payments, Minnesota already receives fewer DSH dollars than many other states, so the reductions may have less of an impact in the state than elsewhere. The advantages of ACA-related coverage expansions appeared to eclipse hospitals' concerns over

DSH reductions; as one key informant noted, “the fact that the GAMC and childless adult population will be covered up to 133 percent FPL with federal dollars and not be at risk for state budget cuts is something that [the safety-net hospitals] are very happy about. Ten percent of HCMC’s total revenue comes from that population.”

Provider Consolidation

Many Minnesota providers have been consolidating through mergers of hospitals and health systems and through affiliations between hospital/health systems and individual practitioners. While most consolidation happened more than a decade ago, it still continues, especially in rural parts of the state. Informants pointed in particular to the aggressive growth of Sanford Health System. Though created in 2009, Sanford is already the country’s largest rural nonprofit healthcare system, present in Minnesota and (as noted above) seven other states. According to key informants, around 80 percent of Minnesota physicians are affiliated with one or more large integrated health systems, and few areas of the state fall outside such systems’ catchment areas.

Stakeholders thought consolidation of Minnesota’s provider market benefited the state, mainly because consolidation facilitates the rapid spread of best practices in health care delivery.

Key informants suggested that the shrinking number of physicians who still maintain independent practices “are very wedded to that model” and might prefer avoiding affiliation with a large system, but these practitioners are swayed to join systems for several reasons. These include greater financial stability (important at a time when many providers are experiencing recession-related revenue decreases) and fewer administrative hassles, since large systems benefit from economies of scale involving medical billing and the adoption of electronic medical records. Another important factor is the desire to minimize risks surrounding uncertainty about ACA delivery system reforms.

In general, stakeholders thought consolidation of the provider market benefited the state, mainly because consolidation facilitates the rapid spread of best practices in health care delivery. Several informants suggested that the success of ICSI (a plan- and provider-sponsored entity, described above, that develops and disseminates clinical care guidelines) results in part from provider affiliations with health care systems through which best practices can be communicated. Key informants noted few disadvantages to Minnesota’s provider consolidation, though some suggested that providers’ increased market power could be problematic for health plans when trying to negotiate payment rates, particularly in the Twin Cities and the southern part of the state.

Consolidation did not appear to be a hindrance to competition; the state’s hospital market was described as quite competitive, especially in the Twin Cities. Key

Minnesota’s Prevention and Public Health Activities

The ACA includes efforts to develop a robust healthcare workforce to provide services in a health care environment experiencing rapid transformation due to demographic change, new payment models, and an increasing focus on team-based and patient-centered care. The law also incorporates funding to strengthen the public health infrastructure and encourage health promotion and prevention. In Minnesota, activities related to assessing the strength and distribution of the healthcare workforce have long been under way at the Minnesota Department of Health, and the 2008 package

of bipartisan health reforms included the establishment of the Statewide Health Improvement Program (SHIP), a grant program administered by MDH that is designed to support comprehensive initiatives for preventing tobacco use and obesity. Minnesota has also benefitted from receipt of Community Transformation Grant funds under the ACA, to support similar activities. These activities position Minnesota well to continue its public health and prevention work under the ACA and to take advantage of new federal opportunities.

informants suggested that the success of ACA delivery system reforms could create excess hospital capacity, which could prompt facilities to modify service offerings or close. Even in this competitive environment, however, most health systems enjoy collaborative relationships; one key informant observed, “most of the systems are nonprofit, and so they spend more time working together than against each other.”

Provider Capacity & Access

Most key informants described a statewide shortage of primary care providers (PCPs), noting that the problem was especially severe in Minnesota’s rural areas, where attracting and retaining providers is a challenge. The state’s worst provider shortages involve behavioral health; according to key informants, even the Twin Cities have too few beds for inpatient behavioral health services.

State officials and other stakeholders in Minnesota are working to address provider capacity concerns, particularly in light of the 2014 ACA-related coverage expansions that are expected to further strain the system. The governor’s Health Reform Task Force has created a workgroup to explore ways to strengthen the state’s provider workforce, though key informants noted that the legislature, facing budget problems, has not recently been interested in devoting additional state funds to this purpose. Health plans in the state are pursuing innovative approaches to provider shortages, including “e-visits” (where providers consult with patients via electronic means, such as Skype) and telemedicine. In addition, the University of Minnesota is shifting some residency slots from specialty to PCP training.

One approach to addressing PCP and other provider shortages is to expand opportunities for mid-level practitioners, such as advanced-practice nurses and physician assistants. Minnesota is considered a national leader in this area. In April 2011, for instance, the state established a new certification for Emergency Medical Technicians (EMTs) in Community Paramedicine; community paramedics are trained to monitor and provide some treatment to patients with chronic diseases and to perform minor medical procedures in the home to prevent the need for ambulance or emergency room services. In 2009, after what key informants described as a highly controversial debate fueled by opposition from the state’s dental association, Minnesota became the second state (after Alaska) to license dental therapists, mid-level dental professionals who work under the supervision of licensed dentists.

Minnesota’s Health Insurance Industry

Minnesota’s health insurance industry was described as competitive. When discussing the commercial market, some termed the competition, “cutthroat.” The state has three major health plans—Blue Cross Blue Shield, Medica, and Health Partners—that each have between one quarter and one third of the market. Smaller plans include UCare, Sanford Health Plan, and Preferred One. Plans that serve the commercial and Medicaid markets significantly overlap, in no small part because state law requires HMOs to bid for Medicaid business as a condition of licensure. Of the six plans named above, only UCare participates solely in the public sector, and only Preferred One is limited to private markets. However, Minnesota also has several County-Based Purchasing Plans that participate exclusively in Medicaid—key informants described some of these plans as having mixed success and suggested that some had struggled with financial sustainability.

Key informants’ assessments of the insurance industry were overall quite positive, with most suggesting that Minnesota has many high-quality health plans that are interested in improving patient care and outcomes. As noted earlier, the state has a unique law requiring all HMOs to be nonprofits, which was credited with setting a tone of collaboration and an emphasis on patient care (rather than profit). At the same time, key informants were quick to point out that the state’s health plans are “still businesses” that follow rules for denials and premium underwriting. A few informants worried that health plans have too much political power, which could impede state efforts to move to alternative approaches for care delivery that might not rely so heavily on the health plans.

Looking ahead to the 2014 ACA coverage expansions, key informants were not concerned about the capacity of existing health plans to absorb the newly insured. Most informants predicted that the majority of plans will participate in the Exchange. Because nearly every health plan in the state already serves both public and private markets, informants also expressed very little concern about disruptions in coverage when families move between Medicaid and the Exchange after experiencing income changes.

Key informants were very interested in how health plans’ role might evolve as implementation of payment and delivery reforms unfolds. Specifically, they wondered whether ACOs, which consist entirely of providers, might eventually take over many health plan functions. These informants suggested that, to avoid this result, some

plans were positioning themselves to be the “go to entity” for upcoming delivery system reforms.

Payment & Delivery System Reforms

As noted in previous sections of this report, Minnesota had already established many of its own payment and delivery system reforms before the ACA became law, beginning with private initiatives and continuing through the 2008 state health reform law. These reforms are still being implemented, and while key informants uniformly agreed that they hold a lot of promise for both improving the quality of care and containing health care costs in the state, there were mixed opinions on how successful some of the reforms had been so far.

The 2008 law created a Provider Peer Grouping (PPG) system that relies on data from a new All Payer Claims Database (APCD). At least once every six months, health plans, third-party administrators, county-based purchasers, and the Minnesota Department of Human Services must submit adjudicated claims data to the APCD. Using these data, the Department of Health has developed metrics for comparing quality and cost across providers through the PPG. One goal is to equip payers and consumers to choose high-quality, high-value providers and plans. Key informants described the APCD data as having incredible potential, but some expressed frustration with the restrictions that the 2008 law places on how the data can be used. One informant explained, “The ability to construct [the APCD] required a very limited focus, to make it politically palatable. But it could be used in so many more ways.” Of the states with existing APCDs, Minnesota has the most restrictive data release policies, limiting data access to state government only.¹⁷ Currently, state officials are authorized to use the APCD data only for the PPG system.

Another promising element of the 2008 law established bundled payments for several different “baskets” of health care. This approach makes a single payment for the total cost of care related to a specific procedure, like hip replacement. Key informants conveyed some disappointment in how this reform had been implemented. One observer explained, “It’s been very disappointing because it hasn’t been aggressive enough to capture high-cost procedures and to give better value. For instance, we created [a bundled payment] for pregnancy care and it doesn’t include delivery.” The 2008 reform law also led to the creation of a set of statewide quality measures and a reporting system to serve as the basis for a new Quality Incentive Payment System (QIPS), with the goal of setting up a consistent way for all payers

(public and private) to implement quality incentives. QIPS is currently being used by the state employees’ health benefit plan and Medicaid, but state officials noted that they were actively coordinating with other purchasers who might be interested in using the system.

Minnesota’s 2008 health reform law also included an important initiative to promote care coordination via health care homes (also known as patient-centered medical homes). Key informants reported that the initiative has been widely embraced by both the public and private sectors. One informant shared anecdotal information about the early success of the health care home model in the state, relating a story of a rural physician practice that adopted the model and realized efficiencies through better use of nurses, care coordination, and reduced redundancy in care delivery; the rural practice has reportedly become so efficient that it now may need to lay off staff. At the same time, another informant argued that the health care home initiative had not yet gone far enough to incentivize real changes in the way that care is delivered, noting, “Billing and reimbursement haven’t changed much. There are just as many complaints as before, and it is still a volume versus quality issue...it’s not clear whether this is really resulting in better care.”

Minnesota is far ahead of many other states when it comes to payment and delivery reforms. Along with its highly integrated provider market, the state’s previous reforms position it well to implement many ACA strategies to improve quality and slow cost growth.

In addition to the various components of the 2008 health reform law, Minnesota’s Medicaid program has launched its own payment reform demonstrations, as described in the Medicaid Policy section of this report. These include nine HCDS demonstration contracts with health systems and (in one case) a network of Federally-Qualified Health Centers. They also include a separate demonstration with the state’s largest county and safety-net hospital to test a global payment model that key informants described as resembling the ACA’s ACO approach.

Some key informants stressed the accomplishments of the state’s private initiatives. Through ICSI and Minnesota

Community Measurement, a common system of health care improvement goals and measures is implemented across payors. Such coordination both gives providers more of an incentive to implement reforms and makes it easier for them to do so, lessening the need to sort through competing measurement systems and incentives. At the same time, some stakeholders also commented that tensions have on occasion arisen within the provider community about the process for developing and implementing new measures, especially as the number of measures increases.

Stakeholders noted that innovative payment methods are continuing to emerge in the private sector, with plans and providers developing shared savings models meant to incentivize quality and slow cost growth. This tradition of innovation was cited as an important cause of Medicare costs in Minnesota that fall below the national average. Some stakeholders believed that the private innovations were more effective than the state's 2008 reforms in providing useful information, which officials plan to incorporate into the design of the Exchange, as noted above, but others suggested that private payment methods and models lack the consistency and

transparency of a publicly-led, statewide approach. In any event, some informants perceived the ACA's delivery system and payment reforms for Medicare as less advanced than the strategies being applied in Minnesota, worrying that the resulting conflicting signals to providers could make it more difficult for state reforms to succeed.

In summary, Minnesota is far ahead of many other states when it comes to payment and delivery reforms. Along with its highly integrated provider market, the state's previous reforms position it well to implement many ACA strategies to improve quality and slow cost growth. One key informant explained, "Many systems in Minnesota are already organized like ACOs, and other are moving toward ACO-like structures without even thinking about it. There isn't a huge worry about that up here." Collaboration among health plans is a key factor to successful implementation of payment reforms, with another informant noting that in Minnesota, "The health plans have agreed to measure and reward [health care quality] in the same way because of the support tools and ICSI. This has led us to move almost all of our payment methods to something *other* than fee-for-service already."

CONCLUSION

Minnesota has long been a leader in improving access to health care and promoting health care quality, with expansive public programs, relatively low uninsurance rates, many integrated health care systems, consumer protections in the private insurance market, and a host of existing tools (with more under development) aimed at improving health care quality and value. The many strengths of Minnesota's health care system put the state in a unique position with regard to ACA implementation. Compared to many of its peers, Minnesota has a much shorter distance to go in implementing federal health reform. At the same time, the state's political environment

hindered Minnesota's early progress, and even as the state enters the third year of implementation political challenges continue. The state's ability to accomplish as much as it has—including the creation of two task forces, securing multiple grants to support different pieces of ACA implementation, adopting the early Medicaid expansion, implementing early insurance reforms, and taking vigorous steps toward building an effective exchange in time to meet challenging federal deadlines—testifies to remarkable collaboration between multiple state agencies and stakeholders in transforming the state's health system.

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Brigette Courtot is a research associate, Stan Dorn is a senior fellow, and Vicki Chen is a research associate in the Urban Institute's Health Policy Center. The authors would like to thank the many officials and stakeholders in Minnesota whose generosity with their time and insight made this report possible.

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About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic and governance problems facing the nation. For more information, visit www.urban.org.

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