MAHU Health & Benefit Legislative Update 2022

1

2021-2022 LEGISLATURE

Minnesota Legislature
Majorities 2021-2022

Senate 34 Republicans / 31 DFL / 2 Independents
House 69 DFL/ 63 Republicans / 2 Independents

2

Reinsurance

History

- High risk pool of 27,000 moved to individual market which spiked premiums
- 2016 individual market falling apart – BC/BS - Blexit
- Other carriers indicating possible exit also
- 2017 legislature passed stop-gap 25% premium credit for 2017 paid to insurance companies to credit invoices
- Reinsurance (MN Premium Security Plan) passed in 2017 for 2018 and 2019 policy years and funded at $217 million per year.
- Like the MCHA Choice plan supported by MAHU in 2012 - Allows consumers to pick plan unlike old MCHA high risk pool

3

Reinsurance

History

- Approved by the federal government with a 5-year waiver
- Later extended by the state for 2020-21. In 2021 extended again for 2022
- Acts as a market subsidy much like to MCHA assessment, but with broader funding mechanism
- Under the old MCHA model, insurers in the fully insured market previously assessed charge for MCHA, but passed charge onto enrollees – market had a shrinking base
- Fully Insured Mkt was 24% in 2010, 19% in 2019
- Controversy when new Reinsurance program was funded in part through the Health Care Access Fund

4

Reinsurance

- According to the MN Department of Commerce the program led to a direct 20% reduction in premiums
- Carriers filed rates with and without Reinsurance since federal approval was unknown – filings had the 20% difference
- More of a subsidy than real reinsurance, but does account for adverse selection of the individual market
- MN Reinsurance Model
  - Uses MCHA Board to Administer
  - Board sets the Attachment Point (minimum $50,000)
  - Board sets coinsurance rate (currently 80%) (dropped to 60% in 2021 session)
  - Board sets the Reinsurance Cap (maximum $250,000)

5

Reinsurance

- Why the partisan divide?
- Feds reduced 2019 pledge by $90.5 M (because the program was so successful in reducing premiums)
- BHP funding from the feds reduced (not held harmless) by $90.5 million for 2018 and $77 million for 2019 (funding keyed to the second lowest price silver plan)
- Walz Admin predicts 20% credit will make individual enrollees whole while not losing BHP funding (Higher premiums save BHP)
- Trump Admin reduced funding for BHP, which was set based on second lowest silver plan premiums (which were reduced by reinsurance)
- State had expected it would be held harmless for such premium changes
- Will Biden Admin change the approach to hold BHP harmless?
- Because individual market remains viable, small group market won't be eroded by public programs with Medicaid/Medicare rates
- New 5-year waiver application currently in front of federal government

6

Reinsurance

- Governor Walz's supplemental budget proposes extension of the program through an assessment on the fully insured market (reinstituting MCHA Assessment)
- This assessment provides a source of revenue that does not obligate general funds
- This has been proposed by members of both political parties
- The problem is that the fully insured market is a narrow and shrinking source of funds
- Many legislators favor the General Fund or Health Care Access Fund as being broader sources so that all Minnesotans participate in helping the sector of the market experiencing adverse selection.
- Walz Admin projects $77.7 million in federal funds per year in 2024 and 2025
- This extension is contingent on the federal government not reducing MNCare federal revenues
- The Department of Commerce submitted the application to extend the waiver in December of 2021

7

Health Insurance Reforms

Gov. Walz 20% premium subsidy

- Replaces the reinsurance program
- Effective for 2020 plan year
- Similar to the 2017 plan to prop up the individual market
- Only available on plans sold through MNsure
- Increases premiums in the individual market (due to no reinsurance), then buys them down 20%
- Boosts funding to MNsure by:
  1) Increasing premiums subject to the 3.5% withhold
  2) Requiring that all persons buy (100% of the market) through MNsure
- MNsure would administer the credits by sending monthly checks to insurers

8

Health Insurance Reforms

OneCare Buy-In/ MNCare Buy-In – Public Option (HF11 – Schultz – DFL – Duluth)

Sets up state-run plans that competes with private sector individual market carriers

- Requires DHS to design MNCare to compete with private health plans for those over 200% FPG
- Competes with private market health plans, but excludes those on Medicare, medial assistance (Minnesota's version of Medicaid), or MinnesotaCare
- Effective for plan year 2025 or upon federal approval, whichever is later
- This year's proposal sets up a sliding premiums effective 2025
- Old monthly max premium was $80 new following the ARPA rules is $28/mo
- Sets up transitional subsidies for 2023 and 2024 for individual & small group markets for those enrolled in a gold plan
- Concerns that this plan would shift costs onto private plans due to reduced reimbursement rates to hospitals & clinics - Uses Medicare rates (commercial rates are 187% of Medicare rates on average)

9

Health Insurance Reforms

OneCare Buy-In/ MNCare Buy-In – Public Option

Sets up state-run plans that competes with private sector individual market carriers

- Individual Market Impact – private plans cannot compete with Medicare or Medicaid rates
- Group Market Impact – small groups not required to offer coverage may use the plan instead of group coverage due to Medicare rate
- Small employer transitional health care credit equal up to 50% of the employer's qualified health care expenses.
- Includes dental, vision & mental health
- Requires commissioner of DHS to create a small group plan that can receive employer contributions
- Capitalized with $145 million in taxpayer money
- Sold Exclusively through Mnsure
- Exempt from MNsure premium withhold (pays undefined in-lieu of payment)
- Requires a federal waiver

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10

Health Insurance Reforms

OneCare Buy-In/ MNCare Buy-In – Public Option

Differences between MNCare Buy-In and OneCare:

- OneCare sets up a state-run insurer to offer QHPs
- OneCare kicks in when Health Commissioner determines there is a "Market Failure" when any county does not have "affordable or comprehensive" products available, they may offer Gold and Silver plans too
- MNCare is built on the MinnesotaCare product chassis
- OneCare claimed to be fully paid by enrollee premiums
- MNCare Buy-In proposes a sliding premium scale

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11

Approaches to Health Insurance Reforms

Minnesota Health Plan – Single Payer SF1643 Marty (DFL – Roseville)

Including dental, vision and hearing, mental health, chemical dependency treatment, prescription drugs, medical equipment and supplies, long-term care, and home care

- shall not pay for drugs requiring a prescription if the pharmaceutical companies directly market those drugs to consumers in Minnesota
- No cost-sharing. No deductible, co-payment, coinsurance, or other cost-sharing shall be imposed with respect to covered benefits
- No balance billing
- Private health insurance may not be sold in Minnesota for services provided by the Minnesota Health Plan
- Paid for by premiums and business health tax
- HF2499 heard Monday requiring a study by DHS of the MN Health Plan

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12

Continued Health Insurance Reforms

MNsure
- SF604 Koran (R-North Branch) Transition From MNsure to a Federal Marketplace
- Governor's Supplemental Budget gives a General Fund appropriation for loss of funds from the Reinsurance Plan extension
- $18.8 million in funding to upgrade the IT system
- Distributed an additional $73 million in tax credits through ARPA

13

Continued Health Insurance Reforms

Reference Based Pricing Plans
HF2195 Gruenhagen (R- Glencoe)/ SF2111 Draheim (R- Madison Lake)
- Allows policies with a max. reimbursement rate expressed as a percentage of Medicare reimbursements (ex. 150% of Medicare)
- Plans with reimbursement rates of 120% or more of Medicare are exempt from geographic & network adequacy requirements
- Providers who participate agree that reimbursement is payment in full

14

Continued Health Insurance Reforms

Returning to Underwriting Model - SF804 Koran (R – North Branch)/HF816 Gruenhagen (R– Glencoe)
- modifies requirements for health insurance underwriting, renewability, and benefits
- Creates mid-size group rate bands +-25%
- creates the Minnesota health risk pool program
- allows the creation of unified personal health premium accounts creates the Minnesota health contribution program
- eliminates certain health plan market rules
- requests waivers

15

Price Transparency

HF2311 Elkins (DFL- Bloomington)/ SF2110 Draheim (R-Madison Lake)

- "Medicare percent" means the percentage of the Medicare allowable payment rate
- health care provider accepts as payment in full for health care services provided by that provider
- Requires provider disclosure to ease consumer shopping
- Does not set prices, just requires prices be expressed in a percent of Medicare

Surprise Billing Elements:

- The provider must have the patient sign a notice indicating the patient understands whether the care is covered, and whether it is in or out of network
- All providers that use sub-contractors (specialists and subspecialists) must require all those subcontractors to agree to the same Medicare-Percent as the contracting provider
- Providers must disclose their Medicare-Percent in writing, and patients will be asked to sign this disclosure statement prior to receiving care. This replaces the current open-ended promise to pay contract common to providers today.

16

Long-Term Care Changes

- HF1983 – Gruenhagen (R- Glencoe)Life Policies to Convert to LTC Insurance
- SF463 – Draheim (R- Madison Lake) Expands LTC insurance tax credit
- SFXXXX/HFXXXX – Yet to be introduced bill from Dept. of Commerce will allow approval of Term Life Products that can convert to LTC insurance. Dubbed "LifeStage"
  - Joint project between DHS and Commerce to help solve the LTC budget problem with a private sector solution
  - Includes actuarial input
  - Targeted at middle income people in the Group Market

17

Long-Term Care Changes

HF1664 Schultz (DFL-Duluth) –

- Establishes a Washington State style LTC insurance program
- establishes the long-term services and supports trust fund and long-term services and supports trust program
- establishes long-term services and supports taxes, the revenues for which are deposited into the long-term services and supports trust fund.
- Employer & Employee tax rates not yet specified
- No opt-out provisions or provisions for those with existing private sector LTCi policies

18

Employer Mandates

Paid Family & Medical Leave (HF1200 Richardson, DFL-Mendota Heights)

- Takes the place of Short-term Disability – no exemption for small employers
- If enacted, Minnesota would be the only state in the nation with such expansive and expensive mandates in terms of eligibility, qualifying events, benefits and employer obligation. Due to cost and complexity, only nine other states and Washington, D.C. –have enacted versions of paid leave mandates.
- The tax will be .65% up to the FICA wage max of $142,800, which will raise about $850 million/year
- Creating a statewide mandate on **ALL** employers to provide 12 weeks of paid parental and family leave **AND** 12 weeks of paid medical leave would mean an employee could miss 24 weeks of work - 44 percent of workdays in a year.
- Business groups concerns about cost of finding temporary replacements
- Concerns about the IT lift for large projects like MNLARS or MNsure

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19

Employer Mandates

Paid Family & Medical Leave (HF1200 Richardson, DFL-Mendota Heights)

- Appropriates $1.7 billion for up-front funding to avoid prior issue of imposing a tax, but getting no benefits until 12 months later
- Employers required to continue to pay for employer portion of health insurance
- Returning employees have right to same seniority and benefits
- Private plans are an option, but if have shorter duration must have same or better wage replacement and pay an oversight fee
- Annual premiums start 1/1/2023

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20

State Sponsored Retirement Plan for Private Sector

HF1258 Becker-Finn (DFL - / SF976 Pappas (DFL – St. Paul)
Minnesota Secure Choice Retirement Plan

- "Eligible employee" means a person who is employed by an eligible employer and who, for the immediately preceding calendar year, worked 500 or more hours of service for the eligible employer
- Eligible Employers include for-profit and non-profits that does not sponsor or contribute to a retirement savings plan for its employees or, in the case of a sole proprietorship, for the sole proprietor
- If an eligible employer does not execute a participation agreement to become a participating employer in the Secure Choice multiple employer retirement plan under section 187.04, the eligible employer shall enroll eligible employees in the Secure Choice individual retirement account plan
- The attorney general may impose, after due process, monthly or quarterly penalties against any eligible employer that fails to comply with this section

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21

Mandated Benefits

- Acupuncture
- lymphedema compression treatment
- requires coverage for treatments related to ectodermal dysplasias
- requires no-cost diagnostic services and testing following a mammogram
- prohibits coverage for gender dysphoria care from having to meet a higher medical necessity definition
- requires coverage for lymphedema compression treatment items
- requires health plans to cover contraceptives, contraceptive services, sterilization, and related medical services, patient education

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22

Q&A

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23