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ACA IMPLEMENTATION RESEARCH NETWORK

MINNESOTA: INDIVIDUAL STATE REPORT

State-Level Field Network Study of the Implementation of the Affordable Care Act

August 2015

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MINNESOTA: INDIVIDUAL STATE REPORT

State-Level Field Network Study of the Implementation of the Affordable Care Act

Part 1 – Setting the State Context

1.1. Decisions to Date

Under the Patient Protection and Affordable Care Act (ACA) of 2010, states have the option to expand their Medicaid health insurance program eligibility to individuals earning up to 138 percent of the federal poverty level (FPL), including low-income childless adults. States are required to either participate in a federal health insurance exchange/marketplace or set up their own state-based marketplace to allow individuals and business to compare and enroll in health insurance coverage. Minnesota is one of twenty-nine states that has elected to expand its Medicaid program; it is one of only six states that expanded its Medicaid program before the ACA expansion date of January 2014 (first doing so in March 2011 and again in February 2013);[1] and it is one of only fourteen states and the District of Columbia that has chosen to create and operate its own state-based health insurance marketplace.[2]

Prior to passage of the ACA, Minnesota had a number of programs aimed at improving access to health insurance. For example, in 2012, Minnesota was one of thirty-five states with a state-based high-risk pool to provide coverage to people deemed "uninsurable." Enrollees included those with preexisting health conditions and limited access to affordable coverage in the individual and employer-based health insurance markets and/or with incomes too high to qualify for public assistance.[3] One of the nation's largest and oldest high-risk pools, the Minnesota

Comprehensive Health Association (MCHA) was established in 1976 and in January 2013 provided coverage to 26,500 people. The passage of the ACA provided expanded coverage options for high-risk individuals and the opportunity for states to participate in a federal high-risk pool called the Pre-Existing Condition Insurance Program (PCIP). Minnesota provided coverage through both the PCIP and MCHA until the end of 2014 in order to give high-risk individuals ample time to transfer to Medicaid, MNsure (the insurance marketplace), or the private individual market.[4] Between September 2013 and May 2014, MCHA membership dropped by over 16,000 enrollees due to new eligibility for Medicaid or marketplace subsidies.[5,6]

Minnesota had also taken steps to provide coverage for low-income childless adults prior to the ACA Medicaid expansion. In 1976, the state-funded General Assistance Medical Care (GAMC) program was established to provide medical coverage to childless adults at or below 75 percent of the FPL. MinnesotaCare, another public program, was enacted in 1992 to provide basic health insurance to individuals who do not have access to affordable coverage. The program was expanded over time to cover childless adults with income at or below 250 percent of the FPL and to families with children with income up to 275 percent of the FPL.[7] The GAMC program ended on February 28, 2011, as enrollees were moved to Medicaid because of the new ACA-supported eligibility rules.[8] Some of the MinnesotaCare population also moved to Medicaid once the full ACA expansion was implemented in 2013.

Medicaid Expansion

In March 2011, Governor Mark Dayton signed Executive Order 11-01,[9] which expanded eligibility for Medical Assistance (Minnesota's Medicaid program) to low-income childless adults with income at or below 75 percent of the FPL.[10] Since Minnesota already covered these individuals under the GAMC program, this expansion simply moved enrollees from one program to another. In February 2013, Dayton signed legislation to expand Medical Assistance further, extending eligibility to childless adults at or below 138 percent of the FPL. The income limit for children ages two to eighteen was also increased from 150 percent of the FPL to 275 percent of the FPL. These changes took effect January 1, 2014.[11]

Minnesota petitioned to establish a Basic Health Program (BHP) in 2014 to provide additional coverage options. The BHP is an optional program under the ACA through which states can offer more affordable coverage to individuals who are ineligible for Medicaid and are between 139 and 200 percent of the FPL. Since Minnesota had already covered this population under the MinnesotaCare program, the state submitted a Blueprint Plan to the Centers for Medicare & Medicaid Services (CMS) to transition MinnesotaCare into a BHP. MinnesotaCare adjusted its eligibility criteria to meet the ACA standards and became an ACA-defined

BHP on January 1, 2015. As the nation's first BHP, MinnesotaCare now provides low-cost standard coverage for individuals between 139 and 200 percent FPL, using funding that would have otherwise been directed to the federal marketplace premium tax credits and cost-sharing subsidies.[12]

Health Insurance Marketplace

In August 2010, Republican Governor Tim Pawlenty issued an executive order prohibiting state agencies from applying for federal ACA grants, making Minnesota one of only two states that were not awarded a marketplace State Planning and Establishment grant from CMS in September 2010.[13] Dayton, a Democrat, was elected governor in November 2010 and promptly removed the federal grant limitations so the state could begin planning for a health insurance marketplace.

Dayton signed Executive Order 11-30 on October 31, 2011 authorizing the establishment of a state-based marketplace through the Health Insurance Exchange Advisory Task Force.[14] During the planning phases, the marketplace was originally part of the Minnesota Department of Commerce, but marketplace administration was later transferred to Minnesota Management and Budget due to concern that the Department of Commerce, which administers and regulates the health insurance industry, had a conflict of interest. There was also criticism from the public that the Department of Commerce "lacked transparency and was unwilling to answer basic questions about what the exchange would look like and how it would be funded."[15]

The marketplace was eventually established as a stand-alone quasi-governmental entity with a governing board appointed by the governor. Minnesota chose to run its own marketplace for several reasons, among them wanting to maintain itself as a national leader in health reform.[16] The autonomy of MNsure also allowed Minnesota to use federal funds to address its need for a software redesign for its public program eligibility and enrollment system.

After the state received a delayed State Planning and Establishment federal grant in February 2011, the Health Insurance Exchange Advisory Task Force dedicated its time to designing and developing the insurance marketplace. The fifteen member task force was appointed by the Minnesota Department of Commerce commissioner and included work groups composed of a broad array of stakeholders, including consumers, employers, health care providers, health insurers, experts in health care markets and public health improvement, representatives from labor, Medicaid spokespersons, and individuals with experience navigating health plan enrollment.[17]

By January 2012, the task force had released recommendations regarding adverse selection, financing, governance, and the role of navigators. Dayton used these recommendations, which were broad and were criticized by some for not including more details for the public,[18] to guide the development of Minnesota's health

insurance marketplace legislation. In November 2012, Minnesota submitted a marketplace plan to the federal government based on the task force's recommendations, and the plan was approved in December 2012. Over the next year and a half, the state selected a logo and name for its marketplace, MNsure, entered into a contract with MAXIMUS, Inc., to create the website, developed its in-person and navigator program to help consumers with the marketplace, and prepared for both open enrollment and the start of plan coverage.[19]

Between 2011 and 2012, Minnesota's health insurance marketplace was under the authority of an executive order, but Dayton intended to introduce legislation in the 2012 legislative session to pass the marketplace into law. The Republicans held a majority in the House of Representatives and Senate for the first time in thirty-eight years, however, and marketplace legislation was repeatedly blocked. Republicans were unhappy with Dayton's use of the executive order and were determined to prevent any legislation from being passed. Of the Republican opposition, Dayton said, "for reasons of ideology and politics, they want to bash our effort to establish an exchange, rather than join it."[20]

The 2013 Minnesota legislative session brought a change in power, and with a new Democratic-Farmer-Labor (DFL) majority in both the House of Representatives and Senate, marketplace legislation was introduced as HF5/SF1 in January 2013. The legislation was introduced in the House by State Representative Joe Atkins (DFL) and in the Senate by Senator Tony Lourey (DFL). The bill was pushed through the legislature and went through eighteen committees with over ninety hours of debate.[21] There were 150 amendments proposed, and the final bill that passed did not receive any Republican votes.[22] The bill became law on March 20, 2013.[23] The Senate Minority Leader, Republican David Hann, predicted the exchange would be poorly received by the public, and Republicans expressed concern regarding the budget, board authority, and data privacy. Despite opposition, Democrats argued that the marketplace would drive down health care costs. Since open enrollment was set to begin on October 1st, MNsure had six months to move forward and fully establish the marketplace and information technology (IT) system.[24]

Federal grants were instrumental in the creation and development of MNsure. Section 1311 of the ACA appropriated an unspecified amount of funding for planning and establishment grants for health insurance marketplaces,[25] and Minnesota received six federal grants to assist in the development of MNsure. Among the fourteen states operating their own state-based marketplaces, Minnesota received the fourth lowest amount of funding from the federal government.

After two years of open enrollment, the federal government has invested more than $189 million in the development of MNsure, which is the only state-based marketplace that combines eligibility determination for qualified health plans (QHPs),

Medicaid, and the state BHP.[26] Many states either assess or determine Medicaid eligibility within their marketplace, but then transfer the account to the Medicaid state agency. Minnesota is one of twelve states that have an integrated system for both Medicaid and QHPs and it is the only state that also includes a BHP.[27]

1.2. Goal Alignment

Minnesota has responded affirmatively to the goals of federal reform in its implementation of the ACA. Minnesota has a history of public health insurance programs and was progressive in its provision of Medicaid access for low-income individuals prior to federal reform. The state committed to federal health care reform by implementing the early Medicaid expansion under the ACA, first expanding coverage eligibility to childless adults at or below 75 percent of the FPL in 2010 and then expanding coverage to childless adults up to 138 percent of the FPL in 2013.[28] Minnesota also developed its own state-based marketplace.

Part 2 – Implementation Tasks

2.1 Marketplace Priorities

Several issues continue to be at the forefront of MNsure: governance, improving IT system functionality, and maximizing enrollment.

MNsure was established as a quasi-governmental organization with a CEO and governor-appointed board. The first chief executive officer (CEO) of MNsure, April Todd-Malmov, resigned in December 2013 after a troubled rollout due to marketplace functionality issues.[29] Former Department of Human Services Assistant Commissioner Scott Leitz became MNsure CEO after Todd-Malmov's departure. In May 2015, Leitz announced his resignation to assume a position at a health think tank. Allison O'Toole, deputy director for External Affairs at MNsure, was subsequently appointed by the governing board as interim CEO.[30] The governance of the marketplace continues to be debated: Proposed bills in the 2015 legislative session ranged from making MNsure a state agency (SF 139) to becoming a federally facilitated marketplace under HealthCare.gov (HF 1664).[31]

As indicated above, MNsure experienced significant technical difficulties during the first year of open enrollment. The website was primarily built by the main contractor, MAXIMUS, Inc., with the assistance of several subcontractors. The 2015 evaluation report from the Minnesota's Office of the Legislative Auditor[32] cited widespread dissatisfaction among consumers regarding the quality of the MNsure software and system.

After the launch of MNsure in fall 2013, the website had serious functionality issues in processing applications effectively and determining eligibility. To address these issues, MNsure hired Deloitte Consulting LLP after the first enrollment period in 2014 to improve the MNsure IT system. There continues to be ongoing

updates and refinements related in part to MNsure's unique enrollment system, which combines both private and public insurance. The 2015 enrollment period featured a stronger IT system, but many Minnesota counties are still struggling with determining eligibility for coverage.[33] The IT system remains a top priority moving forward.

MNsure's mission is to ensure that all Minnesotans have the security of health insurance.[34] It has enrolled over 360,000 people in health insurance coverage over two enrollment periods from 2013-15.[35] About a third are enrolled in private qualified health plan coverage; the rest are enrolled in Medicaid or MinnesotaCare (Table 1). A report released by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota found a 40.6 percent decline in the uninsured in Minnesota from September 30, 2013 to May 1, 2014. Most of this drop was due to the large growth in Medicaid coverage, which was obtained through MNsure.[36] Enrollment has been supported by brokers, navigators, and certified application counselors. As MNsure moves forward, it is a continuing priority to develop adequate incentives for these consumer assisters and improve the contact center user experience to further facilitate enrollment.

Table 1. Number of Minnesotans Enrolled in Health Coverage Through MNsure

	2013-14	*2014-15*
Qualified Health Plans	48,626	61,109
MinnesotaCare*	37,985	31,070
Medical Assistance (Medicaid)	99,531	90,839
Total	186,144	183,018

Source: MNsure, as of March 2015.

* MinnesotaCare is a publicly subsidized health care program for the uninsured with incomes less than 200 percent of the FPL who do not qualify for other types of insurance.

2.2 Leadership – Who Governs?

MNsure was originally located within the Department of Commerce and then Minnesota Management & Budget. It is now a stand-alone, quasi-governmental organization. Nonetheless, the Department of Human Services, which is charged with administering Minnesota's public health insurance programs, is involved in MNsure operations by ensuring that enrollment in public programs is streamlined within the MNsure online system. In addition, the commissioner of the Department of Human Services sits on the governing board. The departments of Commerce and Health are also involved with MNsure through state health insurer regulation.

MNsure and its CEO report to the governing board. The MNsure board consists of the MNsure CEO and seven board members, one of which is the commissioner of Human Services. The board was first appointed on April 30, 2013. While board members are appointed by the governor, the CEO is appointed by the board. The board serves staggered four-year terms that are limited to two terms of service. Minnesota is the only state that requires both the House and Senate to approve marketplace board member appointments.[37] The board members each represent a required interest and are listed below:

- Thompson Aderinkomi, founder and CEO of RetraceHealth, representing individual consumers eligible for individual market coverage;
- Phil Norrgard, director of Human Services for Fond du Lac Band of Lake Superior Chippewa, representing individual consumers eligible for public health care coverage;
- Brian Beutner, independent business advisor, representing small employers;
- Peter Benner, independent consultant, representing health administration, health care finance, health plan purchasing, and health care delivery systems;
- Kathryn Duevel, MD, representing public health, health disparities, public health care programs, and the uninsured;
- Tom Forsythe, vice president of Global Communications at General Mills, representing health policy issues related to the small group and individual markets;[38] and
- Lucinda Jesson, commissioner of the Minnesota Department of Human Services.

The board's main marketplace responsibilities include hiring staff, establishing the budget, seeking funding, contracting, and exercising "all powers reasonably necessary to implement and administer the requirements of the ACA and the state MNsure law."[39]

The MNsure board has established the Health Industry Advisory Committee and the Consumer and Small Employer Advisory Committee to provide guidance, advice, and recommendations to the board. These board-appointed committees meet at least every quarter and consist of insurance representatives, health care providers, the health care industry, consumers, and other stakeholders. Both committees can provide advice and recommendations to the board at any time or at the request of the board. The committees create their own agendas and research tasks as they see fit. It is the responsibility of the board to confer with the committees when appropriate, and the committees guide MNsure in achieving long-term goals and outcomes for the health industry, consumers, and small employers.[40]

2.3 Staffing

According to MNsure's Level Two Establishment federal grant application,[41] the marketplace employs ninety-nine full-time equivalent (FTE) staff within the areas of senior management, support operations, legal/appeals, financial management, policy and plan management, individual eligibility and enrollment, Small Business Health Options Program (SHOP), customer service, navigators/brokers, communications, and the call center. The call center and communications department require the most staffing. The marketplace also employs 80.27 FTEs through interagency agreements with Information Technology for Minnesota Government (MN.IT) at the Department of Human Services, MN.IT at MNsure, MN.IT Central, the Department of Commerce, and the Department of Health. MNsure staff is not subject to state staffing regulations because of the organization's unique governance. Key marketplace staff are located in a downtown St. Paul office.

MNsure has also contracted with several outside organizations to provide additional services — specifically, IT infrastructure. The main vendors include Deloitte, MAXIMUS, EngagePoint, Connecture, and Identity Access Management. Contracts have also been issued for work in the areas of the contact center, evaluation, advertising, processing, and quality.[42]

2.4 Outreach and Consumer Education

In March 2012, the Outreach, Communications, and Marketing Work Group was created by the state to advise the Health Insurance Advisory Task Force on MNsure communications and best practices to effectively engage consumers.

The work group consisted of various stakeholders and prioritized three main target groups of enrollees: Medicaid members, small employers, and individuals. Several outreach channels were identified by the group to reach the target audience for the marketplace. An extensive market research project by SalterMitchell was conducted to inform the workgroup and consisted of key informant interviews, focus groups, and statewide surveys.[43] The recommendations from the work group informed the MNsure marketing plan, which focused on community outreach through both grassroots and professional organizations. The plan also included paid advertising, a robust educational component of the website, and active engagement of navigators. The work group disbanded in 2013, and MNsure has moved forward to implement its recommendations, such as leveraging partnerships and customizing communications to different populations. Efforts are led by MNsure's Marketing and Communications director.[44]

As a result of the work group recommendations, the MNsure Navigator/Agent/Broker program operates the Outreach and Infrastructure Grant Program, which awards grants to community organizations in the state to assist in enrolling hard-to-reach populations. Between 2013 and 2014, $4.7 million was given to

forty-one organizations.[45] Each grantee had an enrollment goal, which some exceeded. The Hmong American Partnership was among the most successful grantees, enrolling approximately 2,200 people through MNsure. Thirty grantees failed to meet their goals, a result that has prompted conversation regarding grant oversight.[46] In all, the outreach grants were responsible for 70 percent of navigator enrollment.[47] The grants also supported general outreach efforts such as informational videos, community presentations, and door-to-door canvassing. The state continues to fund and promote these efforts, and in September 2014 an additional $4.6 million in grants were awarded to twenty-eight recipients for a grant period that ran until June 30, 2015. Examples of recent grant recipients include Health Access MN, Inc., Minnesota AIDS Project, and Somali Health Solutions.[48]

Other outreach efforts included a request for proposals by the state for a Public Awareness Marketing/Outreach Campaign to increase awareness of MNsure and to promote enrollment.[49] In September 2013, MNsure launched its $8.6 million multipronged marketing and education campaign featuring local folk hero Paul Bunyan. In addition, the state was divided into Targeted Area Networks, and each area featured on-site liaisons to provide outreach and educational information about MNsure as well as to coordinate enrollment.[50] The 2015 advertising and outreach campaign featured the slogan "95% of Minnesotans Now Have Health Insurance, 100% Need It." This message was featured on television, radio, online, and around the community.[51] In addition, MNsure has focused outreach through "theme weeks" when particular populations, such as young invincibles, were targeted. MNsure's mobile campaign had more than 800 subscribers in January 2015.[52]

2.5 Navigational Assistance

Under the ACA, all marketplaces are required to establish a navigator program that provides impartial information and support. Under the direction of the Navigator/Agent/Broker director, MNsure provides support to navigators, certified application counselors, and brokers in assisting consumers with enrolling in coverage through MNsure as well as in conducting the outreach and education efforts mentioned in section 2.4. These consumer assisters must complete online training programs and be certified.

In Minnesota, the navigator program was an extension of the existing Minnesota Community Application Agent program (MNCAA). MNCAA was established in 2008 to engage community organizations in enrolling individuals in public health care programs. In 2012, 140 organizations were participating in the program and received a $25 incentive payment for each individual enrolled. From 2008-12, the MNCAA program facilitated over 50,000 applicants to public health care programs.

The program's success was in part due to the MNCAA Resource Center, which was a state-staffed resource through

which organizations could access current case information on their clients. The MNCAA program also proved the value of using existing community organizations to aid in health coverage enrollment, which became a key feature of the MNsure Navigator Program.[53] Current MNsure navigators include many of the MNCAA community organizations as well as other organizations and counties, and they provide MNsure application assistance for both private and public coverage. Navigators are required to complete twenty hours of training and are paid $70 per commercial and MinnesotaCare enrollee and $25 per Medical Assistance enrollee. In 2015, Minnesota had 182 navigator organizations that included 986 individual navigators.[54]

Certified Application Counselors undertake similar tasks as navigators, but they are usually employed by hospitals and clinics and provide assistance in addition to their primary job responsibilities. Brokers from insurance agencies are only required to complete two hours of training and are paid through the insurers. They are more focused on commercial plan sales. Only navigators and brokers are listed in the online assister directory.

In September 2013, MNsure opened a contact center to answer questions from consumers about the marketplace and their health insurance coverage.[55] The contact center is not contracted out, but is instead operated in-house by MNsure. During the first enrollment period, the center had difficulty with wait times, which averaged almost an hour during December 2013. The 2014-15 enrollment period brought a determined effort to improve the center experience. During the week of December 14, 2014, the center received 35,598 calls while maintaining an average wait time of less than ten minutes.

In addition to the contact center, MNsure contracted with six health insurance agencies and navigator organizations to establish walk-in enrollment centers. MNsure also established a helpline solely for brokers, named Broker One Stop. Additionally, in November 2014, MNsure launched a new online calculator to assist consumers in determining if they could qualify for federal subsidies or public programs.[56]

2.6 Interagency and Intergovernmental Relations

2.6(a) Interagency Relations. As required by Minnesota law, MNsure must maintain strong partnerships with state agencies to ensure interoperability. Specifically, the MNsure board is responsible for maintaining agreements with the Office of Enterprise Technology and the commissioners of Human Services, Health, and Commerce. Once agreements are made, the board must submit an annual report to the chairs and ranking minority members of the committees in the Senate and House of Representatives who preside over these agencies.[57]

As stated earlier, MNsure has a close relationship with the Department of Human Services because of the integrated QHP and public health program enrollment system. The Department of

Human Services administers three public programs in Minnesota: Medical Assistance, the Children's Health Insurance Program (CHIP), and MinnesotaCare, which provides coverage to individuals not eligible for Medical Assistance and now operates as a Basic Health Program as defined by the ACA. The Department of Human Services worked closely with MNsure to develop MNsure's IT system and started accepting applications for public programs through the new system on October 1, 2013. The system is designed to determine eligibility by validating reported income, Social Security numbers, citizenship or immigration status, and Medicare enrollment. The Office of Enterprise Technology is responsible for assisting with IT service coordination across all of the health care programs, including MNsure. To facilitate such an advanced IT system, the state legislature created an agency to oversee IT in the executive branch called the Office of MN.IT Services. Although its input was limited throughout the marketplace building process due to vendor contracts, it is an essential stakeholder as MNsure works to improve its IT infrastructure.

The Department of Commerce is responsible for regulating health plan requirements for plans offered through MNsure. Additionally, along with the Department of Health, the Department of Commerce must be consulted on general MNsure operations. Both departments must approve premium rates for any company that wishes to sell on the marketplace and also must enforce any market rules for the plans.[58]

2.6(b) Intergovernmental Relations. MNsure has relied on support from both the federal and local governments. The Center for Consumer Information and Insurance Oversight (CCIIO) has awarded $189 million in federal grants to MNsure. These dollars have been essential in developing MNsure's IT infrastructure and maintaining a robust staff for the Minnesota marketplace. Table 2 below summarizes the federal grants awarded to the state.

Table 2. Federal Grants Awarded to Minnesota

February 2011	$1 million	Exchange Planning Grant for research and planning[58]
August 2011	$4.2 million	Level One Establishment Grant for work plan and budget[59]
February 2012	$26 million	Level One Establishment Grant for exchange design and development[60]
September 2012	$42.5 million	Level One Establishment Grant for exchange development[61]
January 2013	$39.3 million	Level One Establishment Grant for exchange development[62]
October 2013	$41 million	Level Two Establishment Grant for operations, IT, quality rating, consumer satisfaction surveys[63]
December 2014	$34 million	22 percent increase to existing grants for IT development and consumer assistance[64]

Local county offices have been instrumental in enrollment outreach and have been the main actors in fostering the relationship between Medicaid and MNsure. County officials have applauded MNsure on a smooth enrollment process, which has led to high Medicaid enrollment. Yet counties have had concerns about system functionality and transferring public program renewals to the MNsure IT system. County workers have expressed dissatisfaction in the usability of the MNsure system, citing difficulties in updating enrollee information.[59] To address these concerns, MNsure has made an active effort to engage counties in developing priority goals and a work plan. Coordination is a high priority given the significant county role in eligibility determination and enrollment.[60]

2.6(c) Federal Coordination. As MNsure worked to build the marketplace in a short period of time, it struggled to keep up with the late release of federal rules.[61] In addition, MNsure, along with other state-based marketplaces, did not have full direction on how to coordinate with the federal government's Data Services Hub, since the hub was not approved to operate until September 2013. The Data Services Hub was essential in marketplace development for verifying enrollment information, but MNsure was not able to connect with the federal data hub until the first day of enrollment, October 1, 2013. This disjointed implementation contributed to some state officials viewing the marketplace development as an overly rushed process, with the state moving too quickly to begin enrollment in October 2013, as encouraged by the federal government.[62]

2.7 QHP Availability and Program Articulation

2.7(a) Qualified Health Plans (QHPs). The Minnesota Departments of Health and Commerce certify private health plans available via MNsure (i.e., QHPs) and released guidelines for this certification in October 2012.[63] In general, the guidance requires QHPs to meet federal certification standards and existing state standards related to network adequacy and essential community providers.[64]

All QHPs offer the same set of core benefits:

- Preventive services at no cost (examples: blood pressure and diabetes screenings; mammograms and colonoscopies; vaccinations and flu shots)
- Maternity and newborn care
- Mental health and substance abuse services
- Emergency services
- Prescription drugs
- Hospitalization

Per the ACA, all plans offered through MNsure include certain consumer protections, including no lifetime limits on coverage, no annual dollar limits, a cap on out-of-pocket costs, and a prohibition on discrimination based on preexisting conditions or gender.[65]

On September 6, 2013, MNsure announced that it would have five insurers participating in its marketplace — Medica, HealthPartners, Blue Cross Blue Shield, PreferredOne, and UCare. For the first open enrollment period (OEP), these insurers offered 141 QHPs to individuals, and three of the insurers also offered plans in the SHOP marketplace for small firms.[66]

During the first enrollment period, the plans purchased were spread fairly evenly between platinum, gold, silver, and bronze levels, with bronze plans having the highest enrollment and gold plans having the smallest. Forty-one percent of these QHP enrollees received an advanced premium tax credit and 13 percent received a cost-sharing reduction.[67] Based on data from MNsure enrollees from October 1, 2013, to June 30, 2014, PreferredOne had the largest market share among insurers during the first year, claiming 59.9 percent of enrollees. The company's success was in part due to offering the lowest cost plans available at all metal levels.[68]

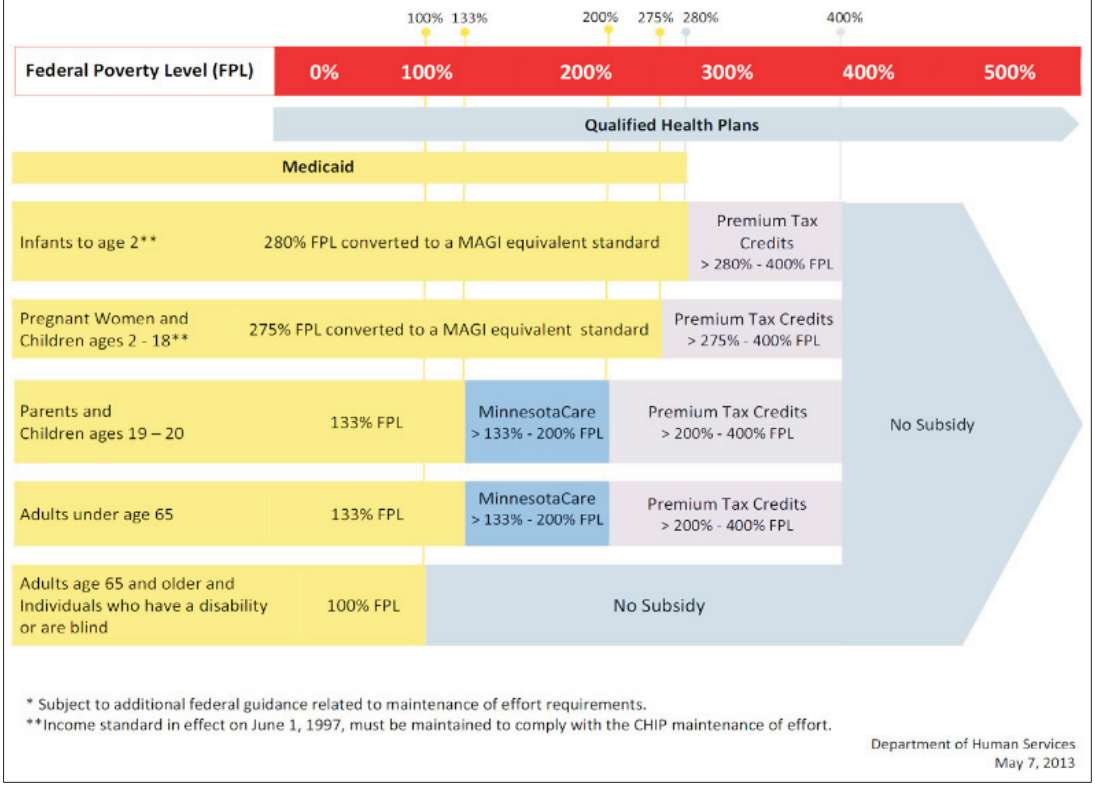
In September 2014, PreferredOne announced that it would not offer plans via MNsure for the second open enrollment period. Blue Plus, an affiliate of Blue Cross Blue Shield, entered the marketplace during this time, but the total number of plans offered to individuals for 2015 was lower than in 2014 (84 vs. 141).[69] In 2015, a similar proportion of enrollees qualified for the advanced premium tax credits and cost-sharing subsidies, with 45.7 percent of households receiving the tax credit and 12.7 percent receiving a cost-sharing reduction. Preliminary data from the 2014-15 enrollment period show that Blue Cross Blue Shield has become the primary insurer on MNsure, claiming 42.8 percent of the plans sold.[70]

2.7(b) Clearinghouse or Active Purchase Marketplace. MNsure serves as a "clearinghouse" marketplace, and a statute passed in 2014 allows all insurance products meeting federal requirements to be offered on the marketplace. This policy has continued into 2015, but the MNsure board may choose to evaluate plans based on other criteria in the future.[71]

2.7(c) Program Articulation. MNsure was built to provide eligibility determination and to enroll individuals in both commercial and public coverage programs. MNsure operates under a "No Wrong Door" model, meaning individuals are evaluated for all public and private coverage options when they apply to MNsure. Figure 1 provides the continuum for different levels of coverage in Minnesota.

Although the modified adjusted gross income (MAGI)-based Medicaid eligibility system is integrated within MNsure, there have been technical difficulties in conducting redetermination of Medicaid eligibility. As mentioned earlier, local counties have expressed their dissatisfaction in the usability of the integrated system, citing difficulties in changing records to reflect enrollee "life changes," such as marriage, income, etc. Minnesota was one of thirty-four states that delayed their review of enrollee renewals in 2014. The state is currently processing renewals to determine

Figure 1. Minnesota Coverage Continuum in 2014*



Source: Minnesota Department of Human Services[79]

whether individuals are enrolled in the appropriate health insurance program.

2.7 (d) States That Did Not Expand Medicaid. N/A — Minnesota has moved forward with the expansion of Medicaid.

2.7 (e) Government and Markets. Prior to the ACA, 55.2 percent of Minnesotans had employer-sponsored health insurance, and public insurance enrollment had increased from 25.1 percent in 2004 to 31.1 percent in 2013.[73] Before the ACA, Minnesota also imposed rate bands for the individual and small group markets, which limited insurers to a certain range of premiums. In 2011, Minnesota was one of fifteen states that prohibited rating based on gender.[74]

Minnesota is a unique market for private insurance in that no single health insurer dominates the market and all health maintenance organizations (HMOs) are required to be nonprofit entities. HMOs are also required to participate in Medicaid, fostering more collaboration between private and public coverage. Under the ACA, a premium tax on MNsure private plans in part finances the marketplace.[75]

The departure of PreferredOne from MNsure during the second enrollment period was newsworthy.[76] PreferredOne is said to have exited because of the little profit gained from such a significant administrative investment. PreferredOne offered the lowest premium in the 2013-14 enrollment period, in part due to the Commerce Department request to consider lowering its initially proposed rates. The company embraced the low-cost strategy, but

was not able to maintain low premiums. As a result, individuals who chose to say with a PreferredOne plan outside of MNsure in 2015 experienced a 63 percent average premium increase. A recent Brookings paper found that, in Minnesota, average monthly costs for insurers on the individual market increased dramatically while premiums were only slightly increased, demonstrating the difficulty in managing risk for the individual market.[77]

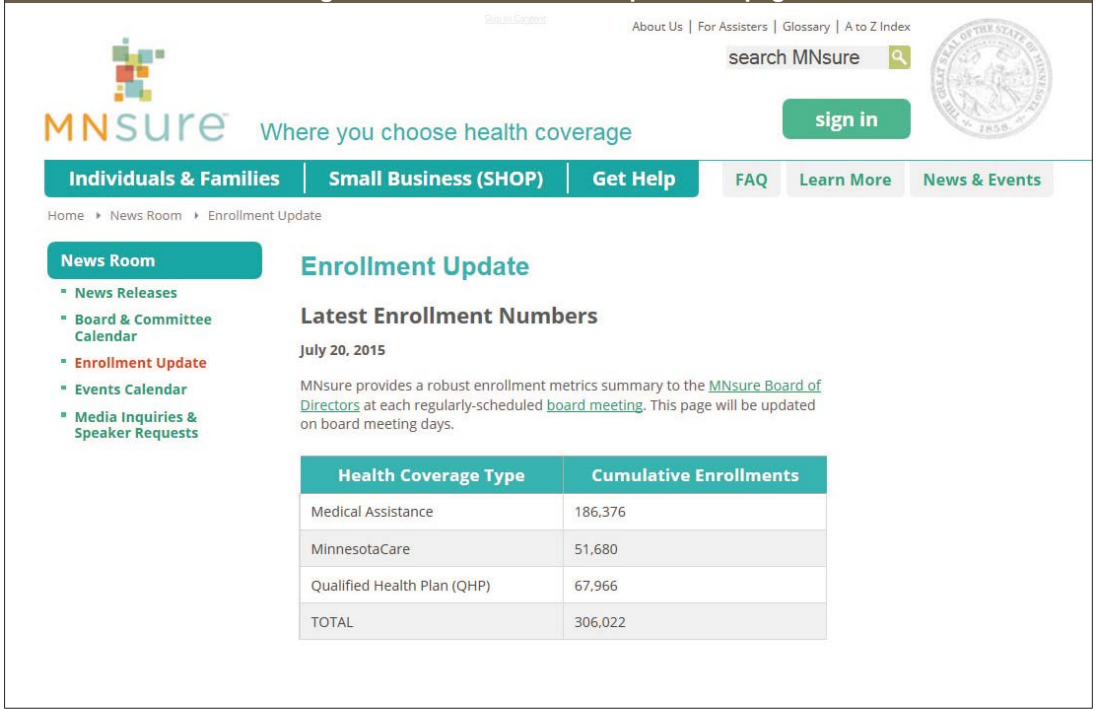
2.8 Data Systems and Reporting

The MNsure IT system is integrated with Medicaid eligibility, a step taken to achieve data streamlining in Minnesota. Like many new IT systems, the MNsure enrollment system experienced technical problems throughout implementation and initial use. The problems were mainly to do with determining eligibility of customers and processing redetermination updates within the coverage periods. MNsure has taken several steps to rectify these issues and has contracted with different groups such as Optum and Deloitte to provide feedback on technological functionality. Moving forward from these assessments, MNsure continues to work on improving the IT system, especially with regard to its usability for counties and other stakeholders.[78]

To monitor marketplace progress, MNsure produces enrollment summaries for the board of directors and publishes the reports on the website. These reports break down the enrollment numbers in Medical Assistance, MinnesotaCare, and QHPs.[79] The screenshot in Figure 2 shows these numbers as of July 2015.

The Minnesota Department of Health (MDH), along with the State Health Access Data Assistance Center (SHADAC) conducts

Figure 2. MNsure Enrollment Update Webpage



a biannual statewide survey, the Minnesota Health Access Survey (MNHA), which will be an important tool for evaluating variations in insurance coverage after MNsure's implementation. The last survey was conducted between August 2013 and November 2013, immediately before the first MNsure open enrollment period, so the survey in 2015 will be able to assess changes in insurance coverage since that time and the role of MNsure in these changes.

To gain more insight on insurance coverage in 2014, SHADAC and the Minnesota Department of Health conducted the Minnesota Health Insurance Transitions Study (MN-HITS), which recontacted individuals from the 2013 MNHA who reported having privately purchased insurance or being uninsured. The follow-up survey found that 50 percent of the previously uninsured had gained insurance since MNsure had opened. Of those people, 53 percent enrolled in public programs and 44 percent enrolled in individual coverage via MNsure.[80]

The Minnesota Department of Health also conducted an extension of the Urban Institute's national Health Reform Monitoring Survey (HRMS).[81] The HRMS-MN consisted of a larger sample of Minnesota residents in order to estimate uninsured rates for nonelderly adults in Minnesota in September 2014. Nearly 500 Minnesotans participated in this survey, which found that the uninsured rate for adults aged eighteen to sixty-four was 6.7 percent. The survey also found that Minnesotans who had health insurance in 2014 were satisfied with their coverage. The findings from HRMS-MN contribute to evidence that Minnesota has one of the lowest post-ACA uninsurance rates in the country.[82]

In another attempt to measure health insurance coverage in 2014, MNsure enlisted SHADAC to conduct a study to evaluate the level of insurance coverage in Minnesota. SHADAC measured the number of individuals insured before the first open enrollment period and one month before it ended. The study estimated that the state's uninsured population fell by 40.6 percent.[83]

Finally, MNsure has worked with other data providers to evaluate its performance. The state Office of the Legislative Auditor released a comprehensive evaluation of MNsure in February 2015, which provided a great deal of information for this report.[84] The Improve Group, contracted by MNsure, also released an evaluation report of the MNsure navigator program in January 2015. The report highlighted the success of the navigator program in decreasing Minnesota's rate of uninsurance and the shortcomings in navigator compensation, resources, and training.[85]

In the future, MNsure has plans to conduct an enrollee satisfaction survey in order to comply with federal reporting requirements.[86]

Part 3 – Supplement on Small Business Marketplaces

3.1 Organization of Small Business Marketplaces

Small employers with up to fifty employees are able to buy health insurance coverage through MNsure's SHOP marketplace, which opened in fall 2013. The SHOP marketplace is integrated into the main MNsure website and offers a small business shopping tool that lists the plans available in each county and the rates by coverage effective date, age, and tobacco use. MNsure's SHOP offers employers a choice of coverage options and the ability to qualify for a tax credit to lower their costs. Through MNsure, employers are able to review and select plans from multiple carriers (versus having to go directly to each individual carrier) and can aggregate billing.[87] Employers must contribute at least 50 percent of the premium, and at least 75 percent of eligible employees must participate in order for a firm to purchase coverage through SHOP.

Education about SHOP marketplace enrollment is integrated into the mandatory assister training. SHOP marketplace enrollment grew from 726 enrollees during the 2013-14 OEP[88] to 1,405 enrollees in the 2014-15 OEP.[89]

Part 4 – Summary Analysis

4.1 Policy Implications

By the end of the second enrollment period in 2015, MNsure reported that more than 300,000 individuals had enrolled in health insurance coverage through the marketplace since its launch. Eighty percent of this new coverage is due to growth in public program enrollment, with the remaining coverage due to QHP enrollment. Between September 30, 2013, and May 1, 2014, the number of uninsured Minnesotans fell by 180,500 — a reduction of 40.6 percent. Minnesotans saved $30 million on their insurance premiums through tax credits in 2014.[90]

While the increase in health insurance coverage was driven particularly by an increase in the number of Minnesotans enrolled in public health insurance programs, enrollment in private health insurance plans has also increased. As MNsure moves forward, it is important to maintain a strong private QHP market, as those premiums significantly contribute to the marketplace's revenues. MNsure has repeatedly scaled down its private enrollment projections, most recently by 15 percent in March 2015. The new three-year budget plan now estimates a total of 130,000 people will enroll in private plans by 2017. Low enrollment in private plans could have significant funding impacts for MNsure in the future.[91]

Although the number of uninsured has fallen since the implementation of MNsure, the Minnesota Office of the Legislative Auditor's evaluation report[92] reflects a lack of confidence in MNsure's technological capacity and ability to meet the various

needs of eligibility determination. There is sentiment that subpar communication and transparency between MNsure, the governing board, and the state legislature has been detrimental to the advancement of the marketplace and that Minnesota attempted too much in such a short amount of time. Critics are looking for more oversight in spending, increased efficiency, and improvements in the consumer experience as the marketplace moves forward.

4.2 Possible Management Changes and Their Policy Consequences

After two open enrollment periods, the state of Minnesota is eager to make legislative changes to improve the administration of the website and the marketplace. Current debate revolves around the governance of the marketplace. Some believe that moving MNsure under state government would allow for more oversight and accountability, and they prefer the stricter hiring guidelines that would take effect. The Minnesota Office of the Legislative Auditor also calls for state law to adopt an information technology governance structure to streamline IT-related decisions related to the marketplace.[93] There was no consensus reached on MNsure governance changes during the 2015 legislative session. Instead, $500,000 was appropriated to establish a task force to address the future of MNsure and other health reform initiatives. The task force will consist of twenty-nine experts appointed by the state who are required to submit a report to the legislature by January 2016.[94]

Critics of MNsure have also illuminated the issue of enrollment outreach grant oversight. For the 2013-14 grant period, thirty grantees failed to meet their target numbers but still received their entire funding. Grantee information was also self-reported, which calls into question the reliability of the numbers. To address this concern, MNsure hired three additional staff to oversee current grant operations.[95]

One of the biggest challenges MNsure will face is its financial stability. As federal grant funding is set to expire in 2015, the marketplace must evaluate the level of premium taxes necessary to sustain marketplace operations. QHP enrollment is key to maintaining viability, and MNsure will continue to develop different ways to add value to the consumer experience. The marketplace is currently requesting proposals to develop consumer decision support tools for the website to enhance "shopping" for a plan.[96] In addition, MNsure will also be recommending — although not requiring — that insurers develop more innovative insurance plans that can be highlighted on the website. The board hopes that these new products will attract more customers.[97]

Endnotes

1 "Medicaid Expansion: Coverage for more Minnesotans starting in 2011," Health Reform Minnesota, n.d., http://mn.gov/health-reform/topics/health-insurance/medicaid-expansion/index.jsp.

2 "State Decisions in Health Insurance Marketplaces and the Medicaid Expansion, 2014," Henry J. Kaiser Family Foundation, updated December 11, 2013, http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/#note-2.

3 Lynn A. Blewett, Elizabeth Lukanen, Kathleen T. Call, and Heather Dahlen, "Survey of High-Risk Pool Enrollees Suggests That Targeted Transition Education and Outreach Should Begin Soon," *Health Affairs* 32, 9 (2013): 1568-75.

4 "Coverage of Uninsurable Pre-Existing Conditions: State and Federal High-Risk Pools," National Conference of State Legislators, updated June 2014, http://www.ncsl.org/research/health/high-risk-pools-for-health-coverage.aspx

5 Elizabeth Lukanen, Heather Dahlen, Lynn A. Blewett, and Kathleen T. Call, *Minnesota Comprehensive Health Association Enrollee Survey: Assessing the Results* (Minneapolis: State Health Access Data Assistance Center, May 2013), http://www.shadac.org/files/shadac/publications/MCHAEnrolleeSurveyFindings_May2013.pdf.

6 Julie Sonier, Elizabeth Lukanen, and Lynn Blewett, *Early Impacts of the Affordable Care Act on Health Insurance Coverage in Minnesota* (Minneapolis: State Health Access Data Assistance Center, June 2014), http://www.shadac.org/files/shadac/publications/ACA%20Impacts%20Report_0.pdf.

7 Randall Chun, "MinnesotaCare," Research Department, Minnesota House of Representatives, updated November 2014, http://www.house.leg.state.mn.us/hrd/pubs/mncare.pdf.

8 "General Assistance Medical Care," Minnesota Department of Human Services, updated September 1, 2011, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=120597.

9 State of Minnesota Executive Department, "Executive Order 11-01, Directing Early Enrollment in Medical Assistance," January 5, 2011, http://mn.gov/governor/multimedia/pdf/Executive-Order-11-01.pdf.

10 "Medicaid Expansion: Coverage for more Minnesotans starting in 2011,"

11 Randall Chun, *Medical Assistance* (St. Paul: Research Department, Minnesota House of Representatives, updated November 2014), http://www.house.leg.state.mn.us/hrd/pubs/medastib.pdf.

12 "Basic Health Program," Medicaid.gov, n.d., http://www.medicaid.gov/basic-health-program/basic-health-program.html.

13 "2012 Progress Report: States Are Implementing Health Reform, whitehouse.gov, January 19, 2012, https://www.whitehouse.gov/sites/default/files/01-18-12_exchange_report.pdf.

14 State of Minnesota Executive Department, "Executive Order 11-30, Establishing a Vision for Health Care Reform in Minnesota," October 31, 2011, http://mn.gov/governor/images/EO-11-30.pdf.

15 James Nord, "Minnesota's health-insurance-exchange planners change agencies," *MinnPost.com*, September 19, 2012, https://www.minnpost.com/politics-policy/2012/09/minnesota%E2%80%99s-health-insurance-exchange-planners-change-agencies.

16 "1.3 Million Minnesotans to Benefit from New Health Insurance Marketplace," MNsure.org, March 20, 2013. https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-56625

17 "Commerce Commissioner Creates Health Insurance Exchange Advisory Task Force," MNsure.org, September 6, 2011. https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-53895.

18 James Nord, "Minnesota moving ahead with health insurance exchange," *MinnPost*, June 28, 2012, https://www.minnpost.com/politics-policy/2012/06/minnesota-moving-ahead-health-insurance-exchange.

19 "MNsure—About Us,"MNsure.org, n.d., https://www.mnsure.org/about-us/.

20 Robert Pear, "In Fight Over Obama Health Law, a Front in Minnesota." *New York Times*, April 30, 2012, http://www.nytimes.com/2012/05/01/health/policy/in-fight-over-obama-health-law-a-front-in-minnesota.html?_r=0.

21 "Legislation," MNsure.org, n.d., https://www.mnsure.org/about-us/legislation/.

22 Elizabeth Stawicki, "Dayton signs health exchange law, creating 'MNSURE,'" *MPR News*, March 20, 2013, http://www.mprnews.org/story/2013/03/20/politics/dayton-signs-health-exchange-bill.

23 "State Marketplace Profiles: Minnesota," Henry J. Kaiser Family Foundation, updated November 12, 2013, http://kff.org/health-reform/state-profile/state-exchange-profiles-minnesota/.

24 Jennifer Brooks, "Minnesota health insurance exchange becomes law," *Star Tribune,* March 24, 2013, http://www.startribune.com/march-21-minnesota-health-insurance-exchange-becomes-law/199278341/.

25 Annie L. Mach and C. Stephen Redhead, *Federal Funding for Health Insurance Exchanges* (Washington, DC: Congressional Research Service, October 29, 2014), http://fas.org/sgp/crs/misc/R43066.pdf.

26 "CCIIO Awards MNsure Additional $34 Million as part of Federal Grant Adjustment," MNsure.org, January 7, 2015, https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-152322.

27 Tricia Brooks, et al, "Modern Era Medicaid: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP as of January 2015," Henry J. Kaiser Family Foundation. January 20, 2015, http://kff.org/health-reform/report/modern-era-medicaid-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-as-of-january-2015/

28 "State expands health coverage for 35,000 Minnesotans," News Release, Office of Governor Mark Dayton and Lt. Governor Tina Smith, February 19, 2013, http://mn.gov/governor/newsroom/pressreleasedetail.jsp?id=102-55000.

29 James Nord, "MNsure shakeup: Executive Director Todd-Malmlov out, as problems and political pressure persist," *MinnPost*, December 17, 2013, https://www.minnpost.com/political-agenda/2013/12/mnsure-shakeup-executive-director-todd-malmlov-out-problems-and-political-p.

30 Katharine Grayson and Jim Hammerand, "MNsure CEO Scott Leitz resigning; interim replacement named," *Minneapolis/St. Paul Business Journal*, May 4, 2015, http://www.bizjournals.com/twincities/news/2015/05/04/mnsure-ceo-scott-leitz-resigning.html,

31 Christopher Snowbeck, "At Capitol, MNsure remedies are all over the map," *Star Tribune*, March 14, 2015, http://www.startribune.com/at-capitol-mnsure-remedies-are-all-over-the-map/296261641/?c=y&page=all&prepage=1.

32 *Minnesota Insurance Exchange (MNsure) Evaluation Report* (St. Paul: Office of the Legislative Auditor, State of Minnesota, February 2015), http://www.auditor.leg.state.mn.us/ped/2015/mnsure.htm.

33 Ibid.

34 "About MNsure."

35 "Enrollment Update," MNsure.org, As of March 12, 2015, https://www.mnsure.org/news-room/enrollment-update/.

36 Lukanen, Dahlen, Blewett, and Call, *Minnesota Comprehensive Health Association Enrollee Survey: Assessing the Results*

37 "Governor Dayton Appoints Seven-Member Board to Oversee MNsure," News Release, Office of Governor Mark Dayton, April 30, 2013, https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-58943.

38 "MNsure Leadership," MNsure.org, n.d., https://www.mnsure.org/about-us/staff/index.jsp.

39 *Minnesota Insurance Exchange (MNsure) Evaluation Report*.

40 "Health Industry Advisory Committee," MNsure.org, accessed November 19, 2014, https://www.mnsure.org/about-us/health-industry/.

41 "State of Minnesota Level Two Funding Application. Minnesota Budget Narrative," August 2013, https://www.mnsure.org/images/Grant-Budget-Nar-2013-08.pdf

42 "Awarded Contracts," MNsure.org, n.d., https://www.mnsure.org/about-us/rfp-contract/contracts.jsp.

43 *Minnesota Exchange Communications: Full Market Research Findings* (Tallahassee: SalterMitchell, August 10, 2012), https://www.mnsure.org/images/Report-PublicEducationOutreachResearch2012-08.pdf.

44 Sue Abderholden and Mary Sienko, *Report to the Health Insurance Exchange Advisory Task Force* (St. Paul: Outreach, Communications and Marketing Work Group, December 2012), https://www.mnsure.org/images/ATF-OutreachRpt-2012-12-11.pdf.

45 "Update: Second Round of Grants Announced," MNsure.org, September 15, 2013, https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-83668.

46 *Minnesota Insurance Exchange (MNsure) Evaluation Report*, 112.

47 Ibid.

48 "MNsure Announces Outreach and Enrollment Grant Recipients," News Release, MNsure.org, September 2, 2014, https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-140142.

49 "Request for Proposals (RFP), Minnesota Management and Budget: Health Insurance Exchange Public Awareness Marketing/Outreach Campaign," MNsure.org, February 25, 2013, https://www.mnsure.org/images/RFP-MarketingCampaign.pdf.

50 "MNsure Public Awareness and Engagement Overview," MNsure Board of Directors Meeting, July 24, 2013, https://www.mnsure.org/images/Bd-2013-07-24-PublicAwarenessOverview.pdf.

51 "MNsure Launches 2015 Advertising and Outreach Campaigns: "95% of Minnesotans Now Have Health Insurance, 100% Need It," News Release, MNsure.org, November 10, 2014, https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-147833.

52 "MNsure Packs Next 30 Days with Targeted Outreach, Updated Marketing," News Release, MNsure.org, January 16, 2015, https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-153026.

53 Kristin Dybdal, Lynn A. Blewett, Jessie Kemmick Pintor, and Kelli Johnson, "Putting Out the Welcome Mat—Targeting Outreach Efforts Under the Affordable Care Act: Evidence from the Minnesota Community Application Agent Program," *Journal of Public Health Management & Practice* 21, 1 (2015): 51-8.

54 *Evaluation Report of the MNsure Navigator Program* (St. Paul: The Improve Group, January 2015), https://www.mnsure.org/images/MNsure-navigator-program-evaluation-1-2015.pdf

55 "Consumer Contact Center Opens," News Release, MNsure.org, September 3, 2013, https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-81487.

56 Associated Press, "MNsure reports few open-enrollment problems, 500 new enrollees," *Pioneer Press*, November 17, 2014, http://www.twincities.com/localnews/ci_26954461/mnsure-signs-up-more-than-500.

57 Minnesota Statue 62V.05 Subd.7, https://www.revisor.mn.gov/statutes/?id=62V&format=pdf

58 *Minnesota Insurance Exchange (MNsure) Evaluation Report*, 18.

59 Annie L. Mach and C. Stephen Redhead, *Federal Funding for Health Insurance Exchanges*.

60 "State Marketplace Profiles: Minnesota."

61 Ibid.

62 April Todd-Malmlov, *MNsure Overview* (St. Paul: MNsure.org, April 4, 2013), https://www.mnsure.org/images/PRES-2013-04-04%20Fond%20du%20Lac.pdf.

63 "CCIIO Awards MNsure Additional $34 Million as part of Federal Grant Adjustment."

64 "State Marketplace Profiles: Minnesota."

65 "CCIIO Awards MNsure Additional $34 Million as part of Federal Grant Adjustment."

66 *Minnesota Insurance Exchange (MNsure) Evaluation Report,* 98.

67 MNsure Board of Directors Meeting, April 15, 2015, https://www.mnsure.org/about-us/directors/videos-board.jsp.

68 *Minnesota Insurance Exchange (MNsure) Evaluation Report,* 32.

69 Ibid, 33.

70 "Minnesota Health Insurance Exchange Plan Certification Guidance," MN.gov, October 9, 2012, http://mn.gov/commerce/insurance/images/HIX-CA-QHP-CertificationRequirements10-11-12.pdf.

71 Ibid.

72 "Plans & Networks," MNsure.org, n.d., https://www.mnsure.org/individual-family/networks/index.jsp.

73 "State Marketplace Profiles: Minnesota."

74 *Minnesota Health Insurance Exchange (MNsure) Evaluation Report,* 67.

75 "PreferredOne Emerges as Lowest-Cost Carrier for Individual and Family Healthcare Insurance as MNsure Open Enrollment Date Approaches," PreferredOne Newsroom, September 26, 2013, https://www.preferredone.com/about-us/newsroom/preferredone-lowest-cost.aspx.

76 Doug Belden and Tom Webb, "MNsure loses its biggest, lowest-cost insurer," *Pioneer Press*, September 17, 2014, http://www.twincities.com/politics/ci_26544179/mnsures-largest-insurer-drop-out-exchange.

77 *MNsure Metrics Dashboard*, Prepared for the MNsure Board of Directors Meeting, March 12, 2015, https://www.mnsure.org/images/bd-2015-03-12-dashboard.pdf.

78 *Minnesota Health Insurance Exchange (MNsure) Evaluation Report*, 57.

79 James Golden, "Minnesota Health Care Programs and MNsure," PowerPoint Presentation, June 26, 2013, https://www.mnsure.org/images/Bd-2013-06-26-Golden-DHS-and-MNsure.pdf.

80 *Health Insurance Coverage in Minnesota; Results from the 2013 Minnesota Health Access Survey. Fact Sheet* (St. Paul: Minnesota Department of Health, Health Economics Program, Update May 2014), http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2013primary.pdf

81 "Health Insurance Market Reforms: Rate Restrictions," Henry J. Kaiser Family Foundation, June 2012, https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8328.pdf.

82 Christopher Snowbeck, "MNsure enrollments up, but getting data to insurers troublesome," *Star Tribune*, December 18, 2014. http://www.startribune.com/lifestyle/health/286112781.html.

83 Christopher Snowbeck, "State sought lower MNsure rates from PreferredOne," *Star Tribune*, October 23, 2014, http://www.startribune.com/business/280128612.html?page=all&prepage=1&c=y#continue.

84 Amanda Kowalski, "The Early Impact of the Affordable Care Act," *Brookings Papers on Economic Activity*, Fall 2014, http://www.brookings.edu/about/projects/bpea/papers/2014/early-impact-affordable-care-act-state-by-state.

85 *Minnesota Insurance Exchange (MNsure) Evaluation Report.*

86 "Enrollment Update," MNsure.org, As of March 12, 2015.

87 *Minnesota Insurance Exchange (MNsure) Evaluation Report*, 72.

88 "Health Reform Monitoring Survey," Urban Institute, n.d., http://hrms.urban.org/.

89 "Assessing the Affordable Care Act in Minnesota: More Adults in Minnesota Have Health Insurance – Challenges Persist with Satisfaction and Understanding of Coverage," *Health Economics Program Issue Brief,* Urban Institute, December 2014, http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/HRMSIssueBrief2014.pdf.

90 Sonier, Lukanen, and Blewett, *Early Impacts of the Affordable Care Act on Health Insurance Coverage in Minnesota*

91 *Minnesota Insurance Exchange (MNsure) Evaluation Report.*

92 *Evaluation Report of the MNsure Navigator Program.*

92 "Draft Discussion Guide, MNsure Board of Directors, Monitoring and Evaluation Framework," November 13, 2013, https://www.mnsure.org/images/Bd-2013-11-13-Monitoring-EvaluationFrameworkDraft.pdf.

94 "FAQ for Small Business," MNsure.org, n.d.,https://www.mnsure.org/faq/small-business-faq.jsp.

95 *Minnesota Insurance Exchange (MNsure) Evaluation Report*, 69.

96 *Evaluation Report of the MNsure Navigator Program.*

97 Mnsure.org. "159,000 Minnesotans Enroll Through MNsure During the 2015 Open Enrollment Period," News Release, MNsure.org, February 18, 2015, https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-156688.

98 Christopher Snowbeck, "MNsure cuts two-year enrollment projection by 15 percent," *Star Tribune.* March 12, 2015, http://www.startribune.com/lifestyle/health/296098981.html.

99 *Minnesota Insurance Exchange (MNsure) Evaluation Report.*

100 *Minnesota Insurance Exchange (MNsure) Evaluation Report,* 52.

101 Christopher Snowbeck, "New task force takes up potential MNsure changes," *Star Tribune*, May 18, 2015, http://www.startribune.com/mnsure-proposals-move-to-task-force/304191891/.

102 Tony Kennedy, "After a rocky year, MNsure overhauls consumer outreach grants," *Star Tribune*, October 2, 2014, http://www.startribune.com/lifestyle/health/277967901.html.

103 "Request for Proposals: Consumer Decision Support Tools for the MNsure Website," MNsure.org, n.d., https://www.mnsure.org/images/RFP-2015-26-04-plan-comparison-tool.pdf.

104 "MNsure Board of Directors Meeting Minutes," April 15, 2015, https://www.mnsure.org/images/bd-draft-minutes-2015-04-15.pdf.