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Evaluating the Potential Impact of a Public Option on State Costs and Insurance Coverage in Minnesota

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Overview

As Americans continue to grapple with rising health care costs and barriers to health care access, policymakers are looking for solutions to these ongoing issues. In Minnesota, a state which has a history of innovation in expanding access to and affordability of insurance coverage for its residents, policymakers are exploring a public option as a way to address these health care access and affordability challenges.

During the 2023 legislative session, Minnesota policymakers passed legislation (SF 2995) requiring the Commissioner of the state Department of Human Services (DHS) to contract a third-party to conduct an actuarial and economic analysis of different public option models.[1] As a first step towards implementation of the Public Option, the 2023 Minnesota State Legislature directed the Minnesota Department of Commerce and the DHS to complete an actuarial and economic analysis of offering an expanded version of the state's Basic Health Program (MinnesotaCare) as a public option. The resulting report by Milliman was released in January 2024 and evaluated the budgetary impacts to the state and the number of estimated enrollees in a new public option.[2] In March 2024, state lawmakers introduced new legislation for a public option (SF 4778) that closely aligns with "Option 1" examined by Milliman, where the Public Option is offered through the same program structure as MinnesotaCare, which operates as a Basic Health Program.[3]

As the state's policymakers consider the next steps involved in creating a public option, it will be critical to review and seek out additional evidence that will help them understand the impacts of the program on their stated policy objectives, such as affordability, coverage, and access to care.

To understand the implications of the proposed MinnesotaCare buy-in ("Public Option"), economists at FTI Consulting modeled its effects on insurance coverage and costs. Specifically, we modeled the "Option 1" scenario,[4] taking into account what was prescribed in the Minnesota public option bill, and reviewed the assumptions made in the Milliman report. We found that the Public Option would result in limited coverage gains for Minnesotans and disruptions to the exchange market, while representing a significant financial undertaking for the state. Additionally, we assessed the underlying factors and assumptions that may be driving the variation in results between our findings and Milliman's projections.

Key Findings

- Provider reimbursements directly impact the Public Option premium, and while the plan may appear affordable when assuming reimbursements are set at the "floor" (Medicare rates) put forward in the legislation, in reality, the Public Option premium is likely to be much higher if the state seeks out reimbursements that are more financially sustainable for providers.
- We estimate that the Public Option will draw a significant number of enrollees from the exchange markets; meanwhile a smaller number of individuals would become newly insured.
  - Sixty percent of exchange enrollees would switch to the Public Option.
  - Further, only 10 percent (25,000) of uninsured individuals would gain coverage.
- The Public Option would cost the state more than $340 million annually. When accounting for Minnesotans obtaining their health insurance off-exchange, these figures are higher.
  - The state costs are comprised of approximately $92 million for the uninsured who enroll in the Public Option, and $251 million for people enrolled in an exchange plan that switch to the Public Option.
- The Public Option would be nearly seven times more expensive than Minnesota's current successful reinsurance program, which has reduced premiums for enrollees in the individual market by 20 percent, to cover only an additional 25,000 individuals.
- In some areas, our findings differ from Milliman's projections. We identified various factors and assumptions in the Milliman report which appear to explain these discrepancies – including assumptions around reinsurance and projections of the uninsured population.
  - Should the state of Minnesota sunset reinsurance in 2025, as assumed by Milliman, we expect that exchange enrollees could experience premium increases of 20 percent or higher, amounting to nearly $24 million in added costs for those that remain in the exchanges.

— This could have significant implications on insurance coverage and the ability of consumers to access care. It is likely that premium shocks would increase the number of uninsured in the state in the years leading up to the Public Option, thereby driving up the projection of uninsured individuals gaining coverage when the policy is implemented.

Background

The state of Minnesota has long led the way in prioritizing access to health care for its residents, with an uninsured rate of 4.5 percent in 2022, which is significantly lower than the national uninsured rate of 7.7 percent.[5,6] Two programs – MinnesotaCare and the Minnesota Premium Security Plan – have been important drivers of Minnesota's achievements in health coverage. MinnesotaCare was created in 1992 by Republican Governor Arne Carlson, predating the Affordable Care Act (ACA) by decades.[7] MinnesotaCare was established to provide coverage for low-income residents who do not qualify for Medicaid but otherwise do not have access to affordable health insurance.[8] The program currently covers people whose incomes are below 200 percent of the federal poverty level (FPL),[9] with over 96,500 Minnesotans enrolled in the program as of April 2024.[10]

In 2015, MinnesotaCare was converted into a Basic Health Program under the ACA, which allowed the program to receive substantial federal funding.[11] As a Basic Health Program, MinnesotaCare receives 95 percent of the amount of the federal funding that the state would have otherwise received in marketplace subsidies for the Basic Health Program population.[12] In addition to federal funding, MinnesotaCare is financed with enrollee premiums and state funding from Minnesota's Health Care Access Fund, which receives most of its state revenue from a tax on providers.[13] Premiums for MinnesotaCare enrollees typically range from $0 to $80 per person per month; however, due to the enhanced advanced premium tax credits (APTC) enacted by the American Rescue Plan Act of 2021 (ARPA) and extended by the Inflation Reduction Act of 2022 (IRA), enrollees will pay no more than $28 per person per month in premiums through 2025.[14,15]

To bring increased stability to the individual market risk pool, reduce premiums, and increase the number of Minnesotans with insurance coverage, in 2017, Minnesota also established a state-run reinsurance program called the Minnesota Premium Security Plan (MPSP), effective beginning in 2018.[16] In 2016 and 2017, prior to the implementation of this reinsurance program, Minnesotans were experiencing premium hikes that amounted to around 30 percent annually, and the size of the individual market was contracting by 20 to over 35 percent each year.[17] The MPSP partially reimburses insurers for high-cost claims, which reduces premiums for consumers purchasing coverage in the individual market by financially protecting insurers from high-cost claims of between $50,000 to $250,000.[18] Through an ACA Section 1332 State Innovation Waiver, Minnesota receives federal pass-through funding to partially finance the MPSP.[19] The MPSP has been a remarkably successful program, lowering premiums for Minnesotans purchasing insurance in the individual market by around 20 percent.[20]

The Public Option, as introduced by Senate Bill 4778, would expand MinnesotaCare to people above 200 percent of the FPL cap, allowing Minnesotans to buy into the program, with premiums on a sliding scale according to income.[21] Importantly, the legislation specifies that the Public Option would reimburse providers at rates equal to or greater than Medicare rates, which are significantly lower than rates paid by private insurers.[22,23] In conjunction with the bill, the state of Minnesota has indicated that it will apply for a new Section 1332 waiver, which, if approved, would enable the state to get federal pass-through funding for Public Option premium subsidies for those individuals who would have receive subsidized coverage on MNsure.[24]

While FTI Consulting's analysis is based on the March 2024 Senate Bill (SF 4778), state lawmakers are considering other avenues to the legislation, including the Senate Health and Human Services (HHS) omnibus budget bill (SF 4699).[25] If the legislature passes this bill, the Public Option would go into effect on January 1, 2028, pending federal approval.[26] However, since our analysis models the previous version of the legislation, we assume a start date of January 1, 2027. Notably, the key findings from this report and the items it raises for policymakers' consideration would largely remain unchanged if we had modeled a 2028 start date.

MinnesotaCare Public Option – Fast Facts

FTI Consulting's analysis models the Public Option based on the following key provisions, as introduced in Senate Bill 4778.

- **Effective Date:** January 1, 2027.
- **Platform:** The Public Option will be offered off-exchange by the state, as an extension of MinnesotaCare.
- **Eligibility:** Individuals with household income above 200 percent FPL.
- **Federal Waiver:** Minnesota will request a Section 1332 waiver for federal funding to establish a public option.
- **Provider Reimbursement:** Reimbursed at rates equal to or greater than the Medicare payment rate for the same service, or for a similar service if the specific service is not reimbursed under Medicare.*
- **Premiums:** Determined on sliding scale by enrollee income.
- **Actuarial Value**: 94 percent (except for enrollees above 400 percent FPL).

*For the purposes of this analysis, economists at FTI Consulting modeled provider reimbursements at 100% of Medicare rates or the "floor" set by the legislation. This demonstrates the maximum effects in terms of enrollment. Higher provider reimbursements would yield smaller enrollment and higher premiums.

Results

Premiums, Provider Reimbursements, and Subsidies

Premiums and Provider Reimbursements

Like MinnesotaCare, the Public Option is intended to provide an affordable coverage option for consumers. To do this, the legislation indicates that the state will use certain levers at its disposal to create an attractive and lower-priced plan option. According to the legislation, the Public Option will have a high actuarial value of 94 percent due to its broad coverage and expanded benefits not normally covered by qualified health plans (QHPs) in today's exchange market. Typically, the higher the actuarial value, the higher the premium. However, according to the legislation, the Public Option will reimburse providers "at payment rates equal to or greater than the Medicare payment rate for service, or for a similar service if the specific service is not reimbursed under Medicare." If reimbursements were at or near the "floor" (100% Medicare), then this would effectively drive down gross premiums, creating a much cheaper plan option relative to commercial plans with the same actuarial value, drawing in consumers.[27]

For the purposes of this analysis, Economists at FTI Consulting assume provider reimbursements at the "floor" proposed in the legislation, 100 percent of Medicare rates. This is to showcase the maximum possible enrollment effect of the Public Option plan and allow for direct comparisons to previous estimates. However, stakeholders should consider that the legislation does not specify any mechanism that would ensure providers accept reimbursements that are significantly below market rates—many exchange plans reimburse providers over twice as much, at approximately 207 percent of Medicare rates.[28]

If the Public Option were to reimburse providers above Medicare rates, and closer to current market rates, this would likely result in increased premiums and/or increased state funding for premium subsidies and lower Public Option enrollment. To better understand reimbursements' impact on premiums, economists at FTI Consulting projected the Public Option premium at different reimbursement levels by applying the same scaling adjustment Milliman used to modify the premium from one based on Medicaid reimbursement levels to one based on Medicare reimbursement levels.[29] As seen in Table 1, below, as provider reimbursements come closer to commercial rates, the public option premiums also rise significantly.

Further, while the Public Option's financial impact on providers is not the focus of this analysis, below-market provider reimbursement would likely impact providers' financial viability, which could, in turn, threaten access to care (for additional information, see Discussion section). Provider reimbursement rates are a key assumption in both our model and Milliman's, and it will be an important factor as policymakers make decisions about what constitutes a sustainable payment rate for providers and evaluate the costs of the Public Option for the state.

Table 1: Projected Public Option Premiums at Various Provider Reimbursement Levels

PO Enrollment Source	Milliman PO Premium Estimate (100% Medicare)	Projected PO Premiums (150% Medicare)	Projected PO Premiums (200% Medicare)
MNSure	$883	$1,167	$1,472
Off-Exchange	$917	$1,103	$1,391
Uninsured	$553	$741	$935

Notes: Milliman estimates taken from Table 11 of Milliman's Report. Adjustment made using the methodology Milliman employed to adjust premiums from reimbursement level of 83% of Medicare to 100% of Medicare. Changing premiums will also have the effect of changing the enrollment base and costs which will also affect premiums. Those effects are not represented in this table due to lack of individual cost data. In Milliman's Report, however, this effect seemed to further increase premiums, likely due to adverse selection, as can be seen by comparing the premiums in Table 8 to the premiums in Table 11, the latter of which are higher than the straight calculation would imply.

Premium Subsidies

Premium subsidies are another way that the government will help to reduce the price of the Public Option for consumers. Consumers' net premiums for the Public Option will vary by income level as consumers from various FPLs will have access to subsidies from either the state, federal government (indirectly through pass-through if a 1332 waiver is approved), or both, to defray the costs of their health insurance choice.[30] Due to the increased subsidies required by the Public Option bill, our projected net Public Option premium is often lower than exchange premiums, which will drive enrollment, as we will discuss in the next section.[31] Notably, any changes to these subsidies at the state or federal level could impact the overall affordability of the Public Option since the *gross* Public Option premiums are generally higher. Moreover, the state may also need to increase its subsidies – raising the state's overall costs for the program – to maintain the affordability of the public option under a scenario where provider reimbursements are closer to commercial rates and *gross* premiums are even higher.

Impacts on Health Insurance Coverage

Minnesota ranks among the top states in rates of insurance coverage in the nation, with an uninsured rate of 4.5 percent in 2022.[32] Just ten years ago, the state's uninsured rate was 9.4 percent, demonstrating the significant strides Minnesota has made in increasing access to health coverage.[33] FTI Consulting's economists found that the implementation of the Public Option would result in 78,000 new enrollees in MinnesotaCare who have either switched from a current exchange plan or newly enrolled in any insurance plan, reducing the uninsured rate by less than half of a percentage point. The largest group of Public Option enrollees would be in the 200-250 percent FPL bracket, followed closely by the 250-300 percent bracket (for additional enrollment information, see Table 2 below).

Since many of the enrollees in the Public Option would be switching from commercial plans rather than becoming newly insured, the gains in the state's insured rate would be limited. We estimate that if the Public Option were enacted, 10 percent of the uninsured population would gain coverage, reducing Minnesota's uninsured rate to 4 percent, whereas 60 percent of the exchange population would switch to the Public Option. Considering these incremental improvements to health coverage, it remains important for policymakers to understand the coverage improvements that the Public Option would yield relative to the program's impacts in other areas, especially considering the new program would be a significant financial undertaking for the state.

The Public Option would draw 60% of exchange enrollees out of the marketplace.

Effects on State Costs

The Public Option would be a costly undertaking for Minnesota, especially considering the limited coverage gains it would create. Our analysis found that the Public Option would cost the state more than $340 million annually, representing approximately $92 million for the uninsured who enroll in the Public Option, and $250 million for people enrolled in an exchange plan that switch to the Public Option.

The Public Option would cost the state of Minnesota more than $340 million annually.

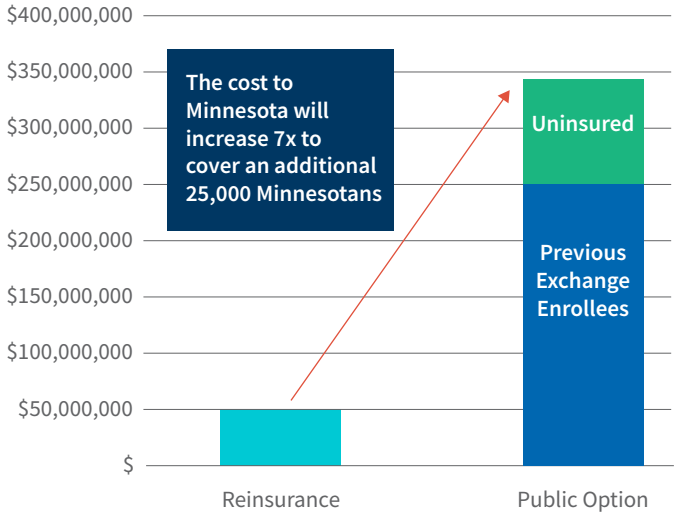
MPSP – a successful program which has reduced premiums for enrollees in the individual market by 20 percent[34] – costs the state around $50 million annually, which is nearly one seventh as expensive as Minnesota's share of costs for the Public Option.[35]

Table 2: Enrollment in Minnesota Public Option by FPL

FPL Bracket	Switch to PO	Newly Insured by PO	Total PO	Share of Switchers	Share of Newly Insured	Share of Total Enrollment
Total	53,600	24,800	78,400			
200%-250%	20,000	8,100	28,100	37%	33%	36%
250%-300%	14,100	8,500	22,600	26%	34%	29%
300%-400%	15,100	5,800	20,900	28%	23%	27%
400%+	4,400	2,400	6,800	8%	10%	9%

Source: Authors' calculations using data from CMS, ACS.

Figure 1: Federal vs. State Costs for Minnesota Public Option



Sources: Authors' calculations using data from CMS, ACS; Minnesota Commerce Department

Discussion

Milliman Analysis

Since Milliman's January 2024 report is currently the only public report that has examined the potential impact of the Minnesota Public Option, we find it important to discuss the differences in our methodology and results.[36] In order to understand the differences in our results versus those in the Milliman report that project different costs and take-up of the program, it is essential to consider the various factors and assumptions that appear to be driving these discrepancies.

Reinsurance

Milliman's results rely on the premise (according to input they received from the state) that Minnesota's reinsurance program is approved through 2027 but ceases to operate due to a lack of funding after 2025.[37] Milliman assumed, as a result of this, that all exchange premiums would immediately increase by 25 percent.[38] This large rate shock could create an affordability "cliff" for consumers, causing more individuals to become uninsured in 2026, the year before the Public Option is slated to begin.

Our approach, on the other hand, assumes that the reinsurance program will continue without change as we did not have a reason to believe the state would terminate the existing program, which has for years made private exchange coverage significantly more affordable. However, given that Milliman's report is based on this assumption, we also modeled the impact of sunsetting reinsurance in 2025 to allow for some comparison. By changing this assumption, we project that relative to our initial findings above, ("Results"), an additional 12,500 individuals would enroll in the Public Option (6,500 previously uninsured, 6,000 switching from the exchanges). Meanwhile, federal pass-through would increase significantly by $56 million, whereas costs to Minnesota will be slightly lower, down by $14 million.[39] Table 3 below summarizes these differences.

Ultimately, the state's decision to terminate reinsurance before the Public Option is implemented would create massive premium rate shocks, amounting to nearly $24 million annually in added costs shouldered by exchange enrollees, impacting the affordability of their healthcare coverage. This could have significant implications for insurance coverage rates and the ability of consumers to access care in the period before the Public Option is implemented. In exchange for this significant disruption, the state would have only about 6,000 uninsured individuals enroll in the Public Option, and it would be drawing additional consumers away from the private market by raising the cost of the previous coverage option they had chosen.

Table 3: Impact of Reinsurance Decisions on Public Option Enrollment and Costs in 2027

	Reinsurance Continues	Reinsurance Sunsets in 2025
Total PO Enrollment	53,600	66,100
Federal Pass-Through Funding	$80M	$136M
MN State Costs	$343M	$329M

Source: Authors' calculations using data from CMS, ACS.

Individual Market Instability

Milliman's model of removing the current reinsurance program estimates that premiums will jump 25 percent after the program ceases to operate.[40] As such, if reinsurance were terminated, then enrollees who remain on the exchange would likely experience significant premium hikes, potentially as a result of the diminished risk pool. In fact, Milliman's report projects that approximately 72 percent of exchange enrollees would switch to the Public Option.[41] With enrollment reduced to such an extent, many existing plans would likely shut down, and payers could potentially leave the state altogether. According to Milliman only 30,800 Minnesotans would remain on the exchange,[42] making it the fifth smallest exchange in the United States.[43]

Uninsured Baseline

Milliman's report projects that there will be 310,000 uninsured Minnesotans in 2027, representing a baseline uninsurance rate of 5.4 percent – much higher than Minnesota's 2022 uninsurance rate of 4.5 percent.[44] Milliman's projected uninsured rate would be the highest in Minnesota since 2015. Based on Minnesota's recent uninsured rates, along with projections of Minnesota's population, our analysis projects that there would be less than 290,000 uninsured Minnesotans in 2027. Importantly, some of these 290,000 individuals (or 310,000 per Milliman's analysis) would not be affected by the new Public Option offering, since everyone below 200 percent of the FPL is already eligible.

While both FTI Consulting and Milliman's analyses had to rely on assumptions, it is important to consider the factors that are creating differences in the results of our analysis and Milliman's, since Minnesota policymakers and other stakeholders may use both our findings and the Milliman report as a resource when attempting to make informed decisions about the Public Option. Additionally, since both analyses rely heavily on assumptions when performing calculations, small variations in assumptions can result in significantly different findings.

Minnesota Premiums

The proposed legislation used a contribution schedule by income slightly different from what Milliman modeled. FTI Consulting's analysis used the schedule as written in the legislation.

Unanswered Questions

Given the legislative efforts to establish the Public Option are still underway, and the legislation may change, some unanswered questions remain regarding the specifics of how the Public Option would be implemented. While these fall outside the scope of this analysis, it is imperative for policymakers to consider these prior to implementation.

Impacts on Providers

As introduced in Senate Bill 4778, provider reimbursement could be as low as Medicare payment rates, which are much lower than commercial rates.[45] In fact, a 2021 report from the Minnesota Community Measurement shows that commercial plans pay 207 percent of what Medicare pays.[46] Assuming reimbursements are set at or near the "floor" in the legislation, providers may find it challenging to maintain a balanced payer mix and preserve sustainable practices and operations if many of their patients switch from private coverage to the Public Option. While this analysis did not assess the financial consequences for providers, FTI Consulting's previous report on the Minnesota Public Option found that the Public Option could significantly disrupt providers' payer mix and cause financial distress for Minnesota's hospitals, especially those in rural areas.[47] Ultimately, providers' financial challenges could impact patients, who may find accessing the care they need more challenging as providers may need to make changes to their service offerings to remain viable. The legislation, as it stands, does not provide any language regarding what would constitute a reasonable or sustainable payment rate for providers. It simply sets a baseline at 100 percent of Medicare, which is likely unrealistic as a starting point. Policymakers will need to determine how to meet the needs of both providers and patients to offer and enable sufficient access to care.

Impacts to Exchange Market

Our analysis suggests that at least 54,000 exchange enrollees would switch to the Public Option, or nearly 60 percent of all Public Option enrollees.[48] The large number of enrollees switching from private exchange coverage to the Public Option would substantially reduce the exchange market, potentially destabilizing the exchange market altogether by altering the risk pool and potentially driving increases in premiums. A previous FTI Consulting analysis on the impact of a national Public Option on market stability and consumer choice found that, as a result of diminished exchange enrollment, a national Public Option would result in private insurers exiting the marketplaces, leaving remaining enrollees with limited health care options.[49] In the case of Minnesota, this could mean that exchange enrollees may have fewer plans to choose from, and those who prefer their current private plan may not have access to it in the future.

Conclusion

While the Public Option may be attractive to policymakers seeking to increase access to affordable health care coverage, our analysis finds that the proposed Public Option will be an expensive undertaking for the state of Minnesota that is unlikely to result in correspondingly significant coverage gains. The results of our analysis suggest that a Public Option in Minnesota could require significant resources from the state, without significantly contributing to increasing health care coverage. Further, if provider reimbursements are closer to commercial rates – which is likely more realistic – this would drive up premiums and lower overall Public Option enrollment, and the program would remain an expensive undertaking to the state Given the high costs to the state, combined with the small improvements to the state's uninsured rate and potentially significant disruptions to the individual market, provider finances, and access to care, Minnesota's policymakers must carefully consider the consequences of creating a Public Option, especially as it compares to other mechanisms – like reinsurance – that have been proven to increase access to affordable health care coverage for Minnesotans.

This report was commissioned by the Partnership for America's Health Care Future Action.

Appendix

Notes on Methodology

Public Option Premiums

As FTI Consulting did not have claims data with which to produce estimates of premiums for the Public Option, the premium determined and used in the Milliman analysis was used for this study.

Take-up

Take-up was determined using elasticities for uninsured and already insured enrollees in exchange plans. Estimates of elasticities were taken from CBO Analysis.[50] Premiums were adjusted for their actuarial value as part of take-up estimation.

Population Growth

Minnesota population was assumed to grow at a rate of 0.2 percent per year.

Premium Growth

ACA plan premiums were assumed to grow 4.5 percent annually. This was derived based on analysis of growth in average premiums between 2021 and 2024.

Primary Data Sources

- American Community Survey Data - IPUMS USA, University of Minnesota, www.ipums.org
- Center for Medicare and Medicaid Services
- Kaiser Family Foundation

ENDNOTES

[1] "SF 2995," Minnesota Legislature (last accessed April 23, 2024), https://www.revisor.mn.gov/bills/text.php?number=SF2995&version=latest&session=ls93&session_year=2023&session_number=0.

[2] Busch, Fritz, Peter Fielek, Michael C. Cook, and Alisa Gordon, "State of Minnesota Department of Human Services Public Option Study," Milliman (January 30, 2024), https://mn.gov/commerce-stat/insurance/industry/policy-data-reports/2024_public_option_report.pdf.

[3] "SF 4778," Minnesota Legislature (last accessed April 23, 2024), https://www.revisor.mn.gov/bills/text.php?number=SF4778&version=0&session=ls93&session_year=2024&session_number=0.

[4] Most similar to option 1C illustrated in the Milliman report.

[5] "New HHS Report Shows National Uninsured Rate Reached All-Time Low in 2023 After Record-Breaking ACA Enrollment Period," U.S. Department of Health and Human Services (August 3, 2023), https://www.hhs.gov/about/news/2023/08/03/new-hhs-report-shows-national-uninsured-rate-reached-all-time-low-2023-after-record-breaking-aca-enrollment-period.html.

[6] American Community Survey, United States Census Bureau (2022), https://data.census.gov/profile/Minnesota?g=040XX00US27

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[10] "Managed care enrollment figures," Minnesota Department of Human Services (last accessed April 15, 2024), https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_141529.

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[12] Ibid.

[13] "MinnesotaCare Basics," Minnesota Department of Human Services (last accessed May 13, 2024), https://mn.gov/dhs/medicaid-matters/medicaid-minnesotacare-basics/minnesotacare-basics/.

[14] Norris, Louise, "Affordable Care Act's Basic Health Program," HealthInsurance.org (May 3, 2023), https://www.healthinsurance.org/obamacare/affordable-care-acts-basic-health-program/.

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[16] "Section 1332 State Innovation Waiver," Minnesota Commerce Department (last accessed April 23, 2024), https://mn.gov/commerce/insurance/industry/reinsurance.jsp.

[17] "Section 4: Individual and Small Group Health Insurance Markets - Chart Summaries," Minnesota Department of Health (last accessed April 23, 2024), https://www.health.state.mn.us/data/economics/chartbook/summaries/section4summaries.html.

[18] "Minnesota Premium Security Plan & Section 1332 State Innovation Waiver," Minnesota Commerce Department (last accessed April 23, 2024), https://mn.gov/commerce-stat/pdfs/1332-waiver.pdf.

[19] Ibid.

[20] "Section 1332 State Innovation Waiver," Minnesota Commerce Department (last accessed April 23, 2024), https://mn.gov/commerce/insurance/industry/reinsurance.jsp.

[21] "SF 4778," Minnesota Legislature (last accessed April 23, 2024), https://www.revisor.mn.gov/bills/text.php?number=SF4778&version=0&session=ls93&session_year=2024&session_number=0.

[22] Ibid.

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[26] Ibid.

[27] "SF 4778," Minnesota Legislature (last accessed April 23, 2024), https://www.revisor.mn.gov/bills/text.php?number=SF4778&version=0&session=ls93&session_year=2024&session_number=0.

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[29] Busch, Fritz, Peter Fielek, Michael C. Cook, and Alisa Gordon, "State of Minnesota Department of Human Services Public Option Study," Milliman (January 30, 2024), Page 52, https://mn.gov/commerce-stat/insurance/industry/policy-data-reports/2024_public_option_report.pdf.

[30] "SF 4778," Minnesota Legislature (last accessed April 23, 2024), https://www.revisor.mn.gov/bills/text.php?number=SF4778&version=0&session=ls93&session_year=2024&session_number=0.

[31] FTI assumes that ARPA subsidies expire in 2025 and are not renewed.

[32] American Community Survey, United States Census Bureau (2022), https://data.census.gov/profile/Minnesota?g=040XX00US27

[33] "Health Insurance," Minnesota Department of Health | Minnesota Public Health Data Access (last updated October 13, 2022), https://data.web.health.state.mn.us/insurance_basic.

[34] "Section 1332 State Innovation Waiver," Minnesota Commerce Department (last accessed April 23, 2024), https://mn.gov/commerce/insurance/industry/reinsurance.jsp.

[35] "Section 1332 of the Patient Protection and Affordable Care Act (PPACA) State Innovation Waivers – Reinsurance Waiver Annual Report," Minnesota Commerce Department (last accessed April 23, 2024), https://mn.gov/commerce-stat/pdfs/DRAFT_DA22R_MN-Reinsurance-Annual-Reporting-Template-2022.pdf.

[36] Busch, Fritz, Peter Fielek, Michael C. Cook, and Alisa Gordon, "State of Minnesota Department of Human Services Public Option Study," Milliman (January 30, 2024), https://mn.gov/commerce-stat/insurance/industry/policy-data-reports/2024_public_option_report.pdf.

[37] Ibid.

[38] Ibid.

[39] This is less than the federal pass-through increase because more people are getting Minnesota subsidies because Public Option enrollment increased among both the uninsured and exchange enrollees switching coverage.

[40] Busch, Fritz, Peter Fielek, Michael C. Cook, and Alisa Gordon. "State of Minnesota Department of Human Services Public Option Study," Milliman (January 30, 2024), https://mn.gov/commerce-stat/insurance/industry/policy-data-reports/2024_public_option_report.pdf.

[41] Ibid.

[42] Ibid.

[43] "Marketplace Enrollment, 2014-2024," KFF (2024), https://www.kff.org/affordable-care-act/state-indicator/marketplace-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Number%20of%20Individuals%20Who%20Selected%20a%20Marketplace%20Plan%22,%22-sort%22:%22asc%22%7D

[44] Author's calculation from American Community Survey (ACS) microdata.

[45] "SF 4778," Minnesota Legislature (last accessed April 23, 2024), https://www.revisor.mn.gov/bills/text.php?number=SF4778&version=0&session=ls93&session_year=2024&session_number=0.

[46] "Health Care Cost & Utilization in 2020," Minnesota Community Measurement (November 2021), https://mncmsecure.org/website/Reports/Community%20Reports/Health%20Care%20Cost%20&%20Utilization%20Report/2021%20Cost%20and%20Utilization%20Report.pdf.

[47] Jeremy Nighohossian, "Evaluating the Potential Impact of a Public Option on Minnesota's Hospitals and Patients," FTI Consulting (May 2023), https://www.fticonsulting.com/insights/reports/evaluating-potential-impact-public-option-minnesotas-hospitals-patients.

[48] The estimate of the number of exchange enrollees (54,000) excludes Minnesotans who purchase plans off-exchange and also exchange enrollees that had no income information available through CMS data source. Accounting for both of these additional sources of enrollment would increase the number of Minnesotans who switch to the Public Option and the total costs to Minnesota.

[49] Jeremy Nighohossian, "An Updated Assessment of a Public Option's Impact on Market Stability and Consumer Choice," FTI Consulting (June 2023), https://www.fticonsulting.com/insights/reports/public-options-impact-market-stability-consumer-choice.

[50] "How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans," Congressional Budget Office (January 2019), https://www.cbo.gov/system/files?file=2019-01/54915-New_Rules_for_AHPs_STPs.pdf.

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