STATE OF MINNESOTA

Office of Governor Mark Dayton

130 State Capitol ♦ 75 Rev. Dr. Martin Luther King Jr. Boulevard ♦ Saint Paul, MN 55155

October 3, 2017

The Honorable Don J. Wright
Acting Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Secretary Wright and Administrator Verma:

Thank you for your September 22, 2017 letter, approving Minnesota's application for a 1332 State Innovation Waiver and providing $323 million for the state's two-year reinsurance program. This program will lower individual market premiums by about 20 percent, compared to what they would have been without it.

However, I strongly disagree with the paragraph in your letter, which indicates that MinnesotaCare, the state's Basic Health Program (BHP), is not eligible for pass-through funding under the law. For 25 years, MinnesotaCare has been a very successful, bipartisan coverage program for about 100,000 Minnesotans, who earn no more than $24,120 a year (or $49,200 for a family of four). This program today operates under federal law as a Basic Health Plan (BHP) and offers low-cost coverage through MNsure, the State Exchange.

Based on our waiver application, your revised approach to the BHP would reduce Minnesota's future funding for MinnesotaCare by about $369 million. By not allowing Minnesota to receive a full pass through of Basic Health Plan funds for MinnesotaCare, the federal government is discouraging state innovation that lowers the cost of coverage with a BHP, receiving a windfall of funds that should be going to the state, and penalizing Minnesota for providing a BHP for its residents.

This approach is also contrary to the explicit guidance from the U.S. Department of Health and Human Services and the U.S. Department of Treasury staff this spring to Minnesota legislators and my staff during the drafting of the legislation and waiver application, which assured Minnesota that our Basic Health Plan funding would be unharmed. Attached is a memorandum from my General Counsel that provides an alternative perspective and argues two main points:

1) **There is nothing in the text of the ACA, the Section 1331 Basic Health Plan (BHP) regulation, or the Section 1332 State Innovation Waiver regulations that prohibit Minnesota from receiving its full complement of BHP funding.**

2) **The Secretary has broad authority to determine the amount of Basic Health Program funding.**

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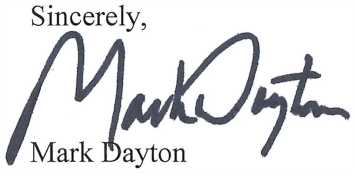
Thank you in advance for your consideration of the attached memo. I urge you to reconsider your decision and hold federal funding levels for MinnesotaCare harmless under the State Reinsurance Program, as provided under federal law, specifically under Section 1332(a)(3).

Sincerely,



Mark Dayton
Governor

cc: Members of Minnesota's Congressional Delegation

Attachment

Office of Governor
Mark Dayton

Memorandum

TO: Governor Mark Dayton and Lt. Governor Tina Smith
FROM: Kimberly Holmes
DATE: September 29, 2017
RE: Basic Health Program and 1332 State Innovation Waiver

Facts

Minnesota was recently informed that their request for a 1332 waiver was approved. This approval is coupled with a devastating $369 million cut in funding for Minnesota's Basic Health Plan (BHP). This cut would impact on the state's future ability to provide health coverage for about 100,000 Minnesotans, as well as our state's budget going forward.

The Centers for Medicaid & Medicare Services (CMS) argue that the statutory text of sections 1331 and 1332 of the Affordable Care Act (ACA) prohibits CMS from approving Minnesota's reinsurance waiver while holding harmless MinnesotaCare's federal funding.

CMS is incorrect and there is nothing in the applicable statutes that prohibits Minnesota from receiving its full BHP funding, unadjusted for the impact of reinsurance.

Argument

I. There is nothing in the text of the ACA, the Section 1331 Basic Health Plan (BHP) regulation, or the Section 1332 state innovation waiver regulation that prohibits Minnesota from receiving its full complement of BHP funding.

In 2014, CMS expressly stated in its explanation of the final rule implementing section 1331 that a state with a BHP program could apply for a 1332 waiver beyond the parameters of the BHP. This statement in the CMS final rule is fundamentally inconsistent with CMS's current reading of the statute.

On Printed Page 14125 of the final rule establishing the BHP, CMS's response to a comment on encouraging state flexibility explicitly acknowledges that states adopting Basic Health Plans could pursue innovation waivers under Section 1332 that extended beyond the parameters of the BHP. The language reads as follows:

> A state interested in pursuing innovations that extend beyond the parameters of BHP and into other insurance affordability programs has the option, beginning in 2017, to request a waiver for state innovation as specified in section 1332 of the Affordable Care Act.[1]

This sentence issued by the agency is fundamentally incompatible with a CMS determination that BHP federal funding was inflexibly fixed on a premium tax credit and cost-sharing reduction amount. This statement authorizes BHP states to pursue state waivers and it makes it clear that the agency regulations do not contemplate a determination that those very waivers disqualified BHP states from receiving original BHP funding. Final rules are approved by the Office of General Counsel (OGC). It's conceivable that CMS' legal counsel must have approved this language prior to March 2014.

II. The Secretary has broad authority to determine the amount of Basic Health Program funding.

Section 1331(d)(3)(A)(ii) makes it clear that the Secretary has broad authority to determine the amount of Basic Health Program funding. The statutory provision states that the Secretary "shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided'.

42 C.F.R.§ 600.605(b) of the final BHP rule further clarifies the scope of the Secretary's authority in determining the payment methodology for calculating premium tax credits and cost-sharing reductions, and explicitly clarifies that the Secretary has the discretion to "consider the following factors to determine the applicable adjustments" when "determining the premium tax credit and cost-sharing reduction components" of the payment methodology.

Most importantly, 42 C.F.R.§ 600.605 (b) (8) of the BHP final rule states that the Secretary can make applicable adjustments to the determinations of the premium tax credit and cost-sharing reduction components based on "other factors affecting the development of the methodology **as determined by the Secretary**" (emphasis added). This provision of the regulation makes it clear that the Secretary has express authority to make adjustments to the underlying cost-sharing and premium tax credit amounts.

42 C.F.R.§ 600.605(b)(5) of the BHP final rule states that the Secretary can make applicable adjustments to the determinations of the premium tax credit and cost-sharing reduction

[1] https://www.federalregister.gov/documents/2014/03/12/2014-05299/basic-health-program-state-administration-of-basic-health-programs-eligibility-and-enrollment-in, Page 14125

components based on determining "reinsurance payments had the enrollee been enrolled in a qualified health plan through an Exchange." CMS' own explanation of its payment methodology for the BHP illustrates the connection between the BHP payments and the federal subsidies in the individual market:

> We proposed in the overview of the funding methodology to calculate the PTC and CSR as consistently as possible and in general alignment with the methodology used by Exchanges to calculate the advance payments of the PTC and CSR, and by the Internal Revenue Service (IRS) to calculate the allowable PTC. We proposed in this section 4 equations that compose the overall BHP funding methodology.

In fact, the statute itself also explicitly contemplates "determining . . . reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an exchange" as a relevant factor. Even if this refers to the now-defunct *federal* reinsurance program, it nonetheless illustrates the general breadth of permissible factors the Secretary can consider in determining Basic Health Program funding and how the statute intended the concept of reinsurance to guide adjustments to BHP payment calculations.

Finally, CMS asserts that section 1332 cannot be applied to BHP enrollees because the BHP statute provides that BHP enrollees are not eligible to participate in the Exchange because it provides that enrollees "...shall not be treated as a qualified individual under section 1312 eligible for enrollment in a qualified health plan offered through an Exchange..." Section 1331 (e)(2) of the ACA. The "shall not be treated as" language clarifies that BHP enrollees are in fact are eligible to enroll through the Exchange, but are not also eligible for the subsidies that would otherwise incur if they were enrolled in a qualified health plan.

III. Conclusion

The Secretary has clear and broad discretion and authority to adjust BHP payments in the manner requested by Minnesota. There would be no need for the statute and regulations to explicitly provide the Secretary the authority to consider a wide variety of "relevant factors," outlined above, in determining the payment methodology of cost-sharing reductions and premium tax credits for Basic Health Program funding if the law was intended not to be flexible.