



OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

**Minnesota Health
Insurance Exchange
(MNsure)**

FEBRUARY 2015

PROGRAM EVALUATION DIVISION

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OFFICE OF THE LEGISLATIVE AUDITOR

STATE OF MINNESOTA • James Nobles, Legislative Auditor

February 2015

Members of the Legislative Audit Commission:

The federal Affordable Care Act aimed to reduce the number of people without health insurance and improve the ability of consumers to compare their insurance options. Rather than relying on the federal government's online health insurance exchange for this purpose, Minnesota chose to develop its own exchange. The Legislature created an agency (MNSure) to develop the exchange, and MNSure's web-based enrollment system opened in October 2013.

In Spring 2014, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate MNSure. In our view, the establishment of Minnesota's health insurance exchange was well intended, but it was not well executed. For a variety of reasons, the online enrollment system was seriously flawed, and MNSure's customer service was inadequate. Our report focuses mainly on MNSure's first year of enrollment, and we recommend changes in the governance of both the agency and its enrollment system.

Our evaluation was conducted by Joel Alter (project manager), Ryan Moltz, and Laura Schwartz. We received full cooperation from MNSure, the Department of Human Services, and the Office of MN.IT Services.

Sincerely,

A handwritten signature in black ink that reads "Jim Nobles".

James Nobles
Legislative Auditor

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Summary

In its first year of operations, MNsure’s failures outweighed its achievements.

Key Facts

- Minnesota is 1 of 13 states that are enrolling individuals in health insurance through state-based “exchanges,” which facilitate the comparison and purchase of health insurance. (pp. 6-7)
- Minnesota’s health insurance exchange—called MNsure—shares some similarities with executive branch state agencies. But the exchange also has important differences, such as its governance by a board. (p. 9)

Key Findings

- MNsure implemented its enrollment website in 2013 with serious technical problems. It did not adequately test the site, and it made insufficient use of state government technology experts. (pp. 25, 35, 38)
- Federal law imposed an ambitious timeline on states developing exchanges. This challenge was heightened by late federal rules, delays in passing state legislation, and problems with vendor selection and performance. (pp. 26-33)
- MNsure staff withheld information from the MNsure Board and other key officials before the enrollment website was launched. (p. 53)
- MNsure reported that it met its overall enrollment target in its first open enrollment period, but the target was seriously flawed. The target contained an error that resulted in an unrealistically low estimate. (p. 69)
- Many people who bought insurance through MNsure have been satisfied with the products they purchased.

But the initial enrollment process was often lengthy, and technical problems frustrated consumers, insurers, and counties. (pp. 80, 81, 92, 95)

- About 28 percent of MNsure enrollees said they were uninsured immediately before enrolling. (p. 73)
- During its first year, MNsure failed to provide adequate customer service through its call center. Also, the roles played by consumer assisters were not sufficiently clear, so consumers were often referred back and forth among them. (pp. 106, 113-122)

Key Recommendations:

- The Legislature should amend state law to give the governor, rather than the MNsure Board, authority to appoint the MNsure chief executive officer. In addition, the Legislature should consider whether to retain the MNsure Board as a governing body or to make it purely advisory. (p. 55)
- The Legislature should amend statutes to formally create a governance structure for MNsure’s enrollment system and ensure that MNsure’s future information technology work is subject to oversight from the Office of MN.IT Services. (pp. 36, 52)
- MNsure and DHS should ensure that insurance brokers are fairly compensated for enrolling consumers through MNsure. (p. 109)
- MNsure should improve its ability to access and analyze the applicant and enrollee data it collects. (p. 62)

Report Summary

In 2010, President Obama signed into law the Affordable Care Act. Among other things, the act authorized the establishment of health insurance “exchanges” to help people compare and purchase insurance online.

Many states rely on the federal government’s exchange for this purpose, but Minnesota established its own exchange, called MNsure. In 2011, Governor Dayton directed the Department of Commerce to develop a state-based exchange. Minnesota has received \$189 million in federal grants for this purpose.

The exchange began enrolling individuals in health insurance in October 2013. Individuals who purchase commercial insurance through MNsure may qualify for tax credits that are not available to individuals who purchase insurance outside of MNsure. Also, unlike most other states, Minnesota relies on its exchange to make eligibility determinations for its publicly funded health care programs, mainly Medical Assistance and MinnesotaCare.

Multiple factors complicated the already difficult challenge of building a health insurance exchange by October 2013.

In mid-2011, the Department of Commerce solicited vendors to build an online enrollment website. The contracting process took longer than expected, and exchange officials grew dissatisfied with the lead vendor just months into the contract.

The federal government required Minnesota to establish legal authority for its exchange. However, the Minnesota Legislature did not formally create MNsure until March 2013—about six months before the exchange began enrolling people. In addition, the

federal government’s rules that indicated how exchanges should operate trickled out piecemeal, well into 2013. These delays created additional time pressures on state officials and vendors developing the online enrollment system.

MNsure sought limited technical advice from state experts and did too little testing of the system.

Experience has shown that it is difficult to implement big information technology projects on time, within budget, and with all the expected features. The development of the MNsure enrollment system was large and complicated, and state officials undertook this project with limited technical expertise.

The 2011 Legislature created the Office of MN.IT Services to oversee all executive branch information technology projects. But state officials building the health insurance exchange initially shunned this office, and the Legislature later exempted MNsure from most oversight by the Office of MN.IT Services. MNsure’s limited use of this agency may have contributed to technical problems that arose during development of the exchange. The Office of MN.IT Services became more involved in MNsure activities in 2014, but we recommend a statutory change to ensure this office’s continued role in overseeing MNsure’s technology development.

Various “red flags” in the weeks and months before October 2013 suggested that the launch of the online exchange might not go well. For example, an independent contractor’s reviews of the exchange raised serious doubts about its readiness. MNsure staff did not share this information with MNsure’s governing board.

MNsure failed to adequately test the exchange’s website before enrollment

began. The tests were limited in number and scope. The tests showed many problems, and there was little time to address them.

MNsure's technical problems escalated in late 2013 and continued well into 2014. For example, applications got stuck in the system, and MNsure could not easily make changes to individuals' insurance coverage in response to events such as births or income changes.

MNsure enrolled many people in its first year, but its overall enrollment target was flawed.

MNsure reported 371,000 health insurance enrollments during its first year. About 56,000 (15 percent) of these were in commercial insurance, and the remainder were in public health care programs.

MNsure set enrollment targets in October 2013. The overall target for the first open enrollment period (through March 2014) included an erroneous Department of Human Services projection. Specifically, the department estimated that only about 12,000 people would enroll in Medical Assistance over a six-month period. If a more realistic estimate of Medical Assistance enrollment (perhaps over 100,000) had been included in MNsure's overall target, actual enrollments for the first open enrollment period would have fallen far short of the overall target.

The online enrollment system was built without authoritative documentation of consumers' enrollment choices. As a result, it was difficult during the first year to use MNsure records to definitively determine who enrolled and in which insurance products. MNsure's enrollment system lacks good reporting capabilities, making it difficult for MNsure staff to extract data for management and decision-making purposes. We recommend that MNsure address this weakness.

A 2014 analysis by University of Minnesota researchers indicated that the number of uninsured Minnesotans fell significantly after MNsure opened for business. The impact of MNsure on this reduction is unclear; other factors, such as Minnesota's expansion of its Medical Assistance program, may have played a role in this reduction. We surveyed individuals who enrolled in commercial insurance through MNsure, and 28 percent said they were uninsured immediately prior to buying insurance through MNsure.

MNsure's technical problems frustrated consumers, although many were satisfied with the products available through MNsure.

When MNsure was in development, state officials said enrollment would be simple and user-friendly. But a majority of people we surveyed who bought commercial insurance through MNsure said it took more than four hours to do so. Most said they experienced significant technical problems. Insurers and counties also had major problems using the MNsure system to manage cases.

MNsure's technical problems caused the Department of Human Services to defer until 2015 its plans to use MNsure to reexamine the eligibility of most individuals who had been enrolled before October 2013 in the state's public health care programs. These eligibility reviews are supposed to occur annually, but some individuals in Minnesota's public programs had gone two years without them, as of late 2014.

In our survey, most people who purchased commercial insurance through MNsure told us they would choose the same product again, if given the chance. Survey respondents reported mixed views when asked whether the premiums and out-of-pocket costs of products purchased through MNsure were better than

insurance they had immediately prior to buying insurance through MNsure.

During MNsure's first year, many consumers were not notified about (1) the status of their applications for insurance or (2) their eligibility for public programs or tax credits. Thus, many did not know whether they had obtained insurance through MNsure or what they needed to do to complete their applications.

MNsure provided inadequate consumer assistance during its first year.

MNsure's customer service center did not answer calls within an acceptable amount of time. MNsure understaffed the center, did not have a plan for handling technical questions, and provided insufficient training to staff. In MNsure's first 11 months, about one-third of calls were abandoned.

MNsure also arranged for in-person enrollment assistance from networks of MNsure-certified "navigators" and insurance brokers, but there were significant problems. A majority of consumer assisters we surveyed said the training they received from MNsure was inadequate. MNsure certified a limited number of assisters before open enrollment started in October 2013. MNsure provided weak oversight of grants it gave to organizations that helped consumers.

The roles played by various types of consumer assisters were, at times, confusing and inefficient. For example, some assisters were not authorized to offer advice on insurance products—so consumers seeking advice had to be referred to other assisters who could provide this. Some insurance brokers helped consumers enroll, only to find they did not qualify to be compensated for their work.

The Legislature should reconsider MNsure's governance arrangement.

MNsure is governed by a seven-person board—the Department of Human Services Commissioner plus six members appointed by the governor. The board appoints MNsure's chief executive officer.

The Governor appointed MNsure's board members in late April 2013. By law, the board could not assume its full authority until it adopted internal policies and bylaws, which it finished in mid-August 2013. As a result, the board had little influence over exchange operations before the launch of MNsure's website. Also, MNsure staff provided board members, the Governor, and others with limited information in 2013 about the exchange's operational readiness.

In our view, an agency with MNsure's impact and visibility should be directly accountable to the governor. There is some precedent for an agency having both a governor-appointed administrator and board (for example, the Minnesota Pollution Control Agency), but the Legislature should consider what future role it wants the MNsure Board to play.

The Legislature should create in law a governance structure for MNsure's enrollment system; the current multi-agency structure is entirely informal. MNsure's online system is used for enrollments in both commercial insurance and public health care programs. The Department of Human Services, which administers the public programs, wants more explicit authority to participate in decisions about this system.

Introduction

The Affordable Care Act of 2010 significantly changed the federal government's involvement with health care insurance. First, it mandated that most people have coverage through a public program or a private health insurance policy. In addition, the law authorized government-created, online health insurance "exchanges" (or "marketplaces") to help individuals and businesses compare and purchase health insurance. Each state had the option of creating its own exchange, relying on the federal government's exchange, or sharing exchange responsibilities with the federal government. Minnesota chose to develop its own online exchange, known as MNsure. Consumers could begin enrolling in public or private health insurance through MNsure on October 1, 2013, with coverage starting January 1, 2014, or later.

While many people have successfully enrolled in insurance through MNsure, many others have encountered problems. In April 2014, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate the development and implementation of MNsure. We asked the following questions:

- **To what extent has Minnesota's state-based health insurance exchange helped consumers make informed choices?**
- **What are the characteristics of MNsure enrollees? Has the exchange reduced the number of Minnesotans who lack insurance?**
- **Was the exchange adequately planned and implemented? Has MNsure provided sufficient outreach, marketing, and applicant assistance? What has contributed to MNsure's technical and operational problems?**
- **Has MNsure's governing board exercised sufficient oversight of the exchange's operations?**

To address these questions, we solicited input through interviews and written information requests from MNsure staff and board members; staff from the Office of MN.IT Services (which provides information technology services to state agencies) and the Minnesota departments of Human Services, Health, and Management and Budget; representatives of key MNsure stakeholders, such as counties and health plans; and federal human services officials. We requested to interview the person who served as director of Minnesota's exchange from 2011 until her resignation in December 2013; she did not respond directly to our requests.¹

¹ We invited the former MNsure executive director to speak with us, and a second time we sent her a subpoena, but she did not respond either time. Her attorney contacted us on several occasions, but his conditions for an interview with the former director were not acceptable. Primarily, her attorney said the former director would only cooperate if the Office of the Legislative Auditor paid all expenses she incurred by cooperating, including her attorney's fees.

We analyzed a variety of documents, including statutes, contracts, planning documents, federal grant applications, marketing materials, board minutes, and many others. We considered the results of three prior reports by our office: two financial audits and a special review.² We examined and critiqued the MNsure enrollment website, but we did not contract with technical experts to assess its functionality; the website's technical issues have received extensive scrutiny from MNsure, the Office of MN.IT Services, and various contractors. We also reviewed key decisions and developments leading to the enrollment system's implementation, plus post-implementation reports that evaluated the system's adequacy. We did not independently test the software components of MNsure's enrollment system or their security.

We administered several questionnaires. We surveyed representative random samples of three types of MNsure-certified consumer assisters: navigators, certified application counselors, and insurance brokers.³ We also surveyed a representative random sample of nonelderly adult heads of household who enrolled through MNsure in commercial insurance from October 2013 through June 2014.⁴

We obtained data on all individuals who enrolled through MNsure as of June 30, 2014. Among other things, we used these data to analyze the characteristics of enrollees, such as where they lived and the types of insurance they enrolled in through MNsure. We also obtained data about the operation of MNsure's customer service center, as well as data on grants made by MNsure.

We reviewed the MNsure enrollment website, using a test version of the site. We were told that this version generally reflected the content and appearance that users experienced during the first open enrollment period. However, because there had been some changes to improve the functionality of the website after it opened October 1, 2013, and because the test version did not directly interact

² Office of the Legislative Auditor, *Minnesota Health Insurance Exchange: MNsure; Internal Controls and Compliance Audit, July 2011 through December 2013* (St. Paul, October 28, 2014), <http://www.auditor.leg.state.mn.us/fad/pdf/fad1421.pdf>; *Department of Human Services: Oversight of MNsure Eligibility Determinations for Public Health Care Programs, October 2013 through April 2014* (St. Paul, November 12, 2014), <http://www.auditor.leg.state.mn.us/fad/pdf/fad1422.pdf>; and *MNsure: An Unauthorized Disclosure of Private Data; Special Review* (St. Paul, November 7, 2013), <http://www.auditor.leg.state.mn.us/fad/pdf/fad1327.pdf>.

³ Not counting members of our samples whose contact information was incorrect, we sent survey invitations by e-mail to 313 navigators, 292 certified application counselors, and 547 brokers. We received responses from 222 navigators (71 percent), 167 certified application counselors (57 percent), and 295 brokers (54 percent). The survey results reported in this evaluation only include those of respondents who said they did, in fact, work with MNsure applicants during the first open enrollment period. The samples of respondents were large enough that we can be 95 percent confident that the true percentage of the population who would have selected a particular response to a survey question was within 5.4 to 7.5 percentage points of the survey respondents' answers, depending on the survey question and the group surveyed.

⁴ Not counting members of our sample whose contact information was incorrect, we sent survey invitations by U.S. mail to 975 MNsure enrollees. We received responses from 281 enrollees (29 percent). The sample of respondents was large enough that we can be 95 percent confident that the true percentage of the population who would have selected a particular response to a survey question was within about 6 percentage points of the survey respondents' answers.

with federal databases, our use of the test version did not fully mirror the experiences of actual users.

In addition, we examined existing literature regarding the design and development of health exchanges under the Affordable Care Act. For other states that operate exchanges with governing boards, we examined provisions in state laws regarding those boards.

Our evaluation focused largely on development and implementation of Minnesota's health insurance exchange up to Fall 2014. This represented the period through MNsure's first year of enrollment. We did not evaluate in depth MNsure operations during the second open enrollment period (which started November 15, 2014), and we did not independently assess the functionality of MNsure's enrollment system during that period. However, our report offers comments about MNsure activities and operations as of late 2014 or early 2015 in a few areas we were able to examine.

Our review occurred too soon to fully assess some aspects of Minnesota's health insurance exchange. For example, many of MNsure's initial enrollment targets were for 2016. We examined enrollments through 2014 and available evidence about changes in Minnesota's number of uninsured individuals, but additional research—over longer periods—will be necessary. Likewise, the achievement of some statutory goals for MNsure, such as improvements in health insurance affordability, quality, and competition, are not apparent from a single year's experience.

We focused primarily on MNsure's efforts to enroll individuals and families rather than businesses. MNsure has provided opportunities for small businesses (with 2 to 50 full-time-equivalent employees) to sign up for insurance, but relatively few did so during MNsure's first year.

Our report briefly describes the ongoing exchange-related activities of the departments of Commerce and Health, but we did not evaluate these activities. For example, the Department of Commerce approves rates for insurers that offer products through MNsure.

We have included a glossary of key terms at the end of this report (Appendix A), as well as a timeline of selected events in MNsure's history (Appendix B). These may be of particular interest to general readers.

Chapter 1: Background

According to a recent analysis, 366,000 Minnesotans—or 7 percent of Minnesota’s total population—were uninsured in 2013.¹ The 2010 Affordable Care Act, among other goals, aimed to reduce the number of uninsured people nationally. The act authorized states to establish health insurance “exchanges” to enroll people in insurance and improve their ability to compare insurance products. This chapter briefly reviews the portions of the federal law relevant to health insurance exchanges, and it provides an overview of Minnesota’s health insurance exchange.

KEY FINDINGS IN THIS CHAPTER

- **Minnesota’s state health insurance exchange (MNSure) has some important differences from other executive branch state agencies.**
 - **In contrast to practices in many other states, Minnesota’s exchange provides a single website at which individuals’ eligibility for tax credits and public health care programs can be determined.**
-

FEDERAL HEALTH CARE REFORM

In March 2010, President Obama signed into law a set of federal health care reforms often called the Affordable Care Act (ACA).² The law was intended to make health insurance accessible to more Americans, while decreasing health care’s cost and improving its quality.

Starting in 2014, the law requires most people to obtain health insurance or pay a financial penalty. To comply with the requirement, individuals may obtain insurance through an employer or a public program (such as Medicaid or Medicare), or purchase individual or family insurance. The box on the next page shows the types of insurance Minnesotans had as of May 2014; most had insurance through employer-sponsored or other types of group insurance. Federal law exempts some people from the insurance mandate, such as those with very low incomes and those for whom the cost of insurance premiums would exceed 8 percent of household income.

The ACA also authorized an expansion of the federal Medicaid program, which insures low-income people at little or no expense to them. Previously, the

¹ Henry J. Kaiser Family Foundation, “Health Insurance Coverage of the Total Population,” <http://kff.org/other/state-indicator/total-population/#>, accessed November 22, 2014. Minnesota’s percentage of uninsured people was the third lowest among states.

² Patient Protection and Affordable Care Act, Public Law 111-148, 124 Stat. 119 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, 124 Stat. 1029 (March 30, 2010).

program covered specific categories of low-income people, but there were gaps in the coverage. For example, Medicaid covered many low-income adults with dependent children; it often did not cover low-income adults without dependent children. Under the ACA, states have the option to expand their Medicaid programs to cover nearly all nonelderly adults at or below 138 percent of the federal poverty level.³ As of the end of 2014, 27 states (including Minnesota) and the District of Columbia had decided to implement the expansion.⁴ The federal government pays states for 100 percent of their Medicaid expansion costs from 2014 through 2016. In 2017, the federal contribution begins to decline gradually, stabilizing at 90 percent of the expansion costs by 2020.

Minnesotans' Sources of Health Insurance, May 2014

Type	Percentage Covered
Group insurance	56%
Medicare	16
Other public programs	17
Individually purchased (Includes 5.0% who purchased directly from insurers and 0.8% who purchased through Minnesota's health insurance exchange)	6
Other	<1
TOTAL:	95%
No health insurance	5%

SOURCE: 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, University of Minnesota, June 2014).

The U.S. Congressional Budget Office estimated that the ACA would reduce the number of nonelderly people without health insurance—by 12 million in 2014, 19 million in 2015, and 25 million in 2016.⁵ Most of the increase in insurance coverage was projected to occur as a result of enrollments in insurance exchanges established by the ACA, discussed below.⁶

A health insurance exchange is a marketplace established under the Affordable Care Act to facilitate the comparison and purchase of health insurance.

According to the federal government, exchanges (sometimes called “marketplaces”) are:

³ As an example of 138 percent of the federal poverty level, this threshold for a family of four in 2014 was \$32,913. The ACA said the federal government could withhold all of a state's Medicaid funds if the state did not expand the Medicaid program; however, the Supreme Court said this was unconstitutionally coercive. See *National Federation of Independent Business et al. vs. Sebelius, Secretary of Health and Human Services*, 567 U.S. ____ (2012), 132 S.Ct 2566.

⁴ In January 2011, Governor Dayton issued an executive order that, starting by March 1, 2011, expanded Medicaid to adults without dependent children who had incomes up to 75 percent of federal poverty guidelines. In 2013, the Legislature further expanded Minnesota's Medicaid program to cover additional populations.

⁵ U.S. Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (Washington, DC, April 2014), 3-4.

⁶ For 2016, the Congressional Budget Office estimated that 24 million additional people will be covered by insurance obtained through insurance exchanges, and an additional 12 million through Medicaid and the Children's Health Insurance Program. These increases will be partially offset by reductions in employment-based coverage and other coverage.

A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The [exchange] also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the [exchange], and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The [exchange] encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance.⁷

Thirteen states (including Minnesota) and the District of Columbia are enrolling individuals in health insurance coverage for 2015 through their own exchanges, while most other states are relying entirely on the federal exchange.

Each state had the option to (1) develop its own exchange, (2) enter into a state-federal partnership exchange, or (3) rely on the federal government's exchange. Exhibit 1.1 shows the types of exchanges that are currently used by each state to enroll individuals. Two states (Oregon and Nevada) that operated their own

Exhibit 1.1: Types of State Health Insurance Exchanges for Individuals, 2015

Type of Exchange	States
State-Based Exchange (14)	California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington
State-Federal Partnership (5)	Arkansas, Delaware, Illinois, Iowa, New Hampshire
Federal Exchange (32)	Alabama, Alaska, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, ^a New Jersey, New Mexico, ^a North Carolina, North Dakota, Ohio, Oklahoma, Oregon, ^a Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, Wyoming

^a These states are considered to have state-based exchanges, but they are relying on the federal government's online exchange for 2015 enrollments.

SOURCES: National Conference of State Legislatures, http://www.ncsl.org/Portals/1/Documents/Health/Health_Insurance_Exchanges_State_Profiles.pdf, accessed January 4, 2015; Henry J. Kaiser Family Foundation, State Health Insurance Marketplace Types, 2015, <http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/>, accessed January 2, 2015.

⁷ Definition of "Health Insurance Marketplace," <https://www.healthcare.gov/glossary/health-insurance-marketplace-glossary>, accessed December 29, 2014.

exchanges in 2014 are now enrolling individuals using the federal exchange, and one state (Idaho) that had a federal-state partnership in 2014 is using a state-based exchange in 2015.

MINNESOTA'S HEALTH INSURANCE EXCHANGE

In a 2011 executive order, Governor Mark Dayton directed the Commissioner of Commerce, in consultation with a legislatively created health care reform task force, to “[d]esign and develop a Minnesota health insurance exchange to ensure access to affordable, high-quality health coverage that maximizes consumer choice and minimizes adverse selection.”⁸ Pursuant to that direction, the executive branch obtained federal grants and did considerable planning for building the exchange. In December 2012, when the federal government authorized Minnesota to establish a state-based exchange, it required Minnesota to develop “sufficient legal authority...to operate the exchange.”⁹ We discuss the development process for Minnesota’s exchange further in Chapter 2.

Statutory Authority

In 2013, the Legislature authorized in law the state’s health exchange, which was named MNsure.¹⁰ Exhibit 1.2 shows the purposes of MNsure specified in state law. For example, the law says MNsure should “simplify the comparison, choice, enrollment, and purchase” of health insurance.¹¹

MNsure is governed by a seven-member board: six members appointed by the governor, and the Commissioner of Human Services (or the commissioner’s designee). The board is authorized by statute to:

- employ staff and delegate responsibilities to them;
- establish the MNsure budget;
- seek revenues to fund MNsure operations;
- contract for the receipt and provision of goods and services;
- enter into information-sharing agreements with entities while ensuring adequate protection of the information shared; and
- “exercise all powers reasonably necessary to implement and administer the requirements of” the ACA and the state MNsure law.¹²

⁸ Governor Mark Dayton, Executive Order 11-30, “Establishing a Vision for Health Care Reform in Minnesota,” October 31, 2011. The term “adverse selection” refers to the greater likelihood of unhealthy individuals than healthier individuals to purchase health insurance.

⁹ Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services, letter to Governor Mark Dayton, December 20, 2012.

¹⁰ *Laws of Minnesota* 2013, chapter 9.

¹¹ *Minnesota Statutes* 2014, 62V.03, subd. 1.

¹² *Minnesota Statutes* 2014, 62V.05, subd. 1(b)(6).

Exhibit 1.2: Statutory Purposes of MNsure

- (1) Promote informed consumer choice, innovation, competition, quality, value, market participation, affordability, suitable and meaningful choices, health improvement, care management, reduction of health disparities, and portability of health plans;
- (2) Facilitate and simplify the comparison, choice, enrollment, and purchase of health plans for individuals purchasing in the individual market through MNsure and for employees and employers purchasing in the small group market through MNsure;
- (3) Assist small employers with access to small business health insurance tax credits and to assist individuals with access to public health care programs, premium assistance tax credits and cost-sharing reductions, and certificates of exemption from individual responsibility requirements;
- (4) Facilitate the integration and transition of individuals between public health care programs and health plans in the individual or group market and develop processes that, to the maximum extent possible, provide for continuous coverage; and
- (5) Establish and modify as necessary a name and brand for MNsure based on market studies that show maximum effectiveness in attracting the uninsured and motivating them to take action.

SOURCE: *Minnesota Statutes* 2014, 62V.03, subd. 1.

MNsure shares some similarities with executive branch state agencies, but it also has important differences.

MNsure is subject to a number of state requirements that apply to other state agencies. MNsure must comply with the Government Data Practices Act, and it must employ individuals in accordance with the state's personnel management law and the Public Employee Labor Relations Act. MNsure Board members are subject to state laws regarding conflicts of interest, and board members and employees are subject to laws that govern receipt of gifts. Also, the MNsure Board is subject to state laws requiring that it conduct meetings that are open to the public, with some exceptions.¹³

Exhibit 1.3 shows key differences between laws that apply to MNsure and those that apply to other state agencies. The governance of MNsure by a board is one important difference. In contrast to MNsure, nearly all state agencies that have far-reaching policy and administrative responsibilities are headed by a governor-appointed commissioner.¹⁴ State law has established 17 "departments of the

¹³ MNsure is subject to the state open meeting law, but the following types of MNsure meetings may be closed: (1) meetings regarding compensation negotiations with the director or managerial staff; (2) meetings regarding contract negotiation strategy; and (3) meetings regarding not-public data or trade secret information.

¹⁴ The Legislature has also created agencies that have more limited functions. For example, some state agencies license and regulate individuals in certain occupations, and these agencies are generally governed by boards. In some instances, the Legislature has created corporations (such as Enterprise Minnesota, Inc., and Minnesota Business Finance, Inc.) that follow laws established for nonprofit corporations or business corporations.

state,” each headed by a commissioner.¹⁵ Two agencies that are not “departments of the state”—the Pollution Control Agency and the Housing Finance Agency—are the only cabinet-level agencies serving statewide missions that are governed by boards. Those agencies, unlike MNsure, also have governor-appointed commissioners.

Exhibit 1.3: Key Differences between MNsure and Other State Agencies

- **Governance:** Most state “departments” do not have governing boards, although many state regulatory entities (such as occupational licensing boards) have them. Also, only one other state agency (the Board of Campaign Finance and Public Disclosure) has its board members approved by both the Minnesota House and Senate. In addition, until 2016, the compensation of MNsure board members is more generous than compensation for members of most other state-created boards.
- **Rules:** MNsure is authorized to indefinitely use an expedited process for adopting rules; usually statutes grant this authority to agencies only in selected cases.
- **Exemptions from certain laws:** MNsure is exempt from many laws pertaining to state procurement, Office of MN.IT Services oversight of IT projects, and various Department of Administration requirements.
- **Conflict of interest:** Certain elements of MNsure’s conflict of interest provisions are more restrictive than those that apply to most state boards. For example, a spouse of a board member may not be a health carrier executive. Also, board members are prohibited not only from being employed by a health insurer or provider but also from representing them.
- **Employee classification:** State law specifies that all of MNsure’s managerial staff are in the unclassified service.

SOURCES: *Minnesota Statutes* 2014, 62V, and Minnesota House of Representatives research staff.

The Legislature exempted MNsure from some laws that apply to most other agencies. As discussed further in Chapter 2, MNsure’s information technology projects are not subject to the full range of oversight by the state’s information technology agency (the Office of MN.IT Services) that applies to other agencies’ projects. Also, MNsure is authorized to follow an expedited rulemaking process and is exempt from many of the state’s purchasing laws.¹⁶

Governing Board

We assessed how MNsure’s governing board compares with exchange boards in other states. Specifically, we reviewed statutes and documents from the nine states that, starting in 2013, operated exchanges governed by a board.¹⁷

¹⁵ The “departments of the state” are established in *Minnesota Statutes* 2014, 15.01.

¹⁶ Agencies may use an expedited rulemaking process only when authorized to do so by state law. This process is shorter than the regular rulemaking process. For example, the expedited process—unlike the regular process—provides no opportunity for a public hearing on the proposed rule, unless such a hearing is specifically required by law.

¹⁷ Besides Minnesota, these states were California, Colorado, Connecticut, Hawaii, Maryland, Massachusetts, Oregon, and Washington.

Minnesota's exchange board—with seven voting members—was one of the smaller boards. Only California's (with 5 voting members) was smaller; Hawaii's board (with 15 voting members) was the largest.

All members of the MNsure Board were appointed by the Governor.

In Minnesota, the governor (subject to legislative confirmation) controls the make-up of the exchange board. Governor Dayton made the initial six board appointments in April 2013; in accordance with the law, the Department of Human Services Commissioner served as the seventh member. The six appointed members have staggered terms, which limits the number of members a governor can appoint in the future at a given time.¹⁸ During the 2013-2014 open enrollment period, four other states (Hawaii, Maryland, Oregon, and Washington) had exchange boards in which the governor had authority to appoint each member whose service on that state's board was not specifically designated by statute.

In three states (California, Colorado, and Connecticut), statutes require the appointment of a portion of the exchange board's members by legislative leaders or legislative committees. For example, of California's five exchange board members, one must be appointed by the Senate Committee on Rules, and one must be appointed by the Assembly speaker.

Three states (Colorado, Connecticut, and Washington) had statutory provisions that authorized members of both political parties to play a part in governing board appointments; Minnesota did not. For example, all of Washington's nine board members were appointed by the governor, but that state's statutes required the governor to select two members nominated by the Senate majority caucus, two nominated by the Senate minority caucus, two nominated by the House majority caucus, and two nominated by the House minority caucus.

Minnesota was the only state that required both the House and Senate to approve exchange board members. This requirement for confirmation by both houses is unusual among Minnesota agencies, too. The Board of Campaign Finance and Public Disclosure is the only other Minnesota entity that requires separate confirmation by both the House and Senate.¹⁹

Unlike some states, Minnesota prohibits people employed by or representing the health insurance industry from being appointed to the exchange board.

An appointed member of the MNsure Board may not—during the board term or within one year prior to appointment—be an employee of a health care insurer,

¹⁸ The terms of the initial appointees to the MNsure Board differ, which allow for staggered appointments subsequently. For future appointments, board members will serve four-year terms, which is the most common length of terms in states with exchange boards.

¹⁹ *Minnesota Statutes* 2014, 10A.02, subd. 1. Members of the Board of Campaign Finance and Public Disclosure must be confirmed by 60 percent of House and Senate members, while MNsure Board members must be confirmed by a simple majority. For other Minnesota agencies with officials subject to confirmation, the Senate is typically responsible for these approvals.

an insurance agency, or a health care provider.²⁰ Of the nine states that had exchange boards starting in 2013, two others (California and Connecticut) prohibited employees or representatives of these professions from appointment to their exchange boards. Three other states prohibited certain industry professionals from being appointed to their exchange boards, but these states' provisions were less restrictive than Minnesota's.²¹

The other three states with governing boards did not ban representatives of any professions from serving on their boards. Rather, they limited the number of industry-affiliated people who could serve on the exchange board (Oregon and Colorado) or simply required them to abide by conflict of interest requirements (Hawaii).

Minnesota law requires appointed members of the MNsure Board to represent certain groups or to have certain types of expertise, as shown in Exhibit 1.4.

Exhibit 1.4: Statutory Requirements for Composition of the MNsure Board

- One member representing the interests of individual consumers eligible for individual market coverage;
- One member representing individual consumers eligible for public health care program coverage;
- One member representing small employers;
- One member with demonstrated expertise, leadership, and innovation in health administration, health care finance, health plan purchasing, and health care delivery systems;
- One member with demonstrated expertise, leadership, and innovation in public health, health disparities, public health care programs, and the uninsured;
- One member with demonstrated expertise, leadership, and innovation in health policy issues related to the small group and individual markets; and
- The Commissioner of the Department of Human Services or a designee.

SOURCE: *Minnesota Statutes* 2014, 62V.04, subd. 2.

Organization

Minnesota's health insurance exchange has had three different locations within the executive branch of state government during its short history. When planning for the exchange started in January 2011, the exchange was part of the Minnesota Department of Commerce. In September 2012, the Governor announced that he

²⁰ *Minnesota Statutes* 2014, 62V.04, subd. 4. The law also prohibits lobbyists, navigators (defined later in this chapter), and spouses of health insurer executives from serving on the board.

²¹ Maryland did not prohibit health insurance providers from being appointed, and Massachusetts did not prohibit providers or insurance agents from being appointed. Washington prohibited appointment of anyone whose board membership could benefit their financial interests or those of the entities they represent.

would be moving the exchange to the Department of Management and Budget. According to the Governor,

This move will address the concern that certain core functions of the Exchange—providing health insurance options to individuals and small employers—are potentially in conflict with the Department of Commerce’s role in regulating insurance companies and the sale of health insurance products. Additionally, [the Department of Management and Budget] has the capacity and experience with financial oversight and human resources required for the next phase of designing and developing the Exchange.²²

Exchange employees transferred to the Department of Management and Budget in December 2012, following the execution of an interagency agreement.

When the Governor signed legislation in March 2013 that created MNsure, MNsure became a stand-alone state agency. MNsure’s governing board did not assume its statutory authority and responsibilities until August 2013, when it had approved a set of policies and bylaws for the organization. Until that time, the board’s duties were performed by the Commissioner of the Department of Management and Budget.

Since exchange planning began in January 2011, MNsure has had two administrative directors. April Todd-Malmlov served as executive director until her resignation in December 2013. She was replaced by Scott Leitz, whose title was changed to chief executive officer.

Types of Coverage Offered Through MNsure

MNsure’s online enrollment system has three primary functions: (1) determining consumers’ eligibility for public health insurance programs, such as Medicaid; (2) serving as a marketplace that facilitates the comparison and purchase of certain commercial health insurance products; and (3) determining consumers’ eligibility for federal tax credits and cost-sharing reductions to lower the premiums and out-of-pocket expenses associated with commercial plans.²³

The MNsure enrollment system makes eligibility determinations for both commercial insurance and public health care programs, which distinguishes it from the exchanges used in a majority of states.

For many insurance seekers, Minnesota’s exchange provides a one-stop shopping experience. Applicants who do not qualify for a public insurance program can learn through the exchange whether they qualify for federal tax credits when they purchase commercial insurance. Also, if a household contains some members who qualify for a public program and others who do not, MNsure’s enrollment system can assess eligibility for public programs or public subsidies for all household members.

²² Governor Mark Dayton, letter to Senator David Senjem, Senator Thomas Bakk, Representative Kurt Zellers, and Representative Paul Thissen, September 18, 2012.

²³ MNsure also sells health insurance for employees of small businesses and stand-alone dental insurance. These types of insurance are not discussed in this report.

Nationally, all of the health insurance exchanges implemented under the ACA are expected to determine whether an individual purchasing commercial insurance is eligible for federal tax credits and cost-sharing reductions. However, most states have separate processes—involving agencies outside of the exchange—that determine whether individuals qualify for public programs such as Medicaid. Specifically, in 27 states, the exchange makes only a preliminary assessment of whether an individual qualifies for a public program; the individual is then transferred to a human services agency for a final determination. In contrast, Minnesota’s enrollment system determines eligibility for public programs, in addition to determining eligibility for federal tax credits and subsidies.

Commercial Insurance Through “Qualified Health Plans”

Insurers may apply to MNsure to have their commercial insurance products sold through the state exchange. Federal law requires that products sold through exchanges be certified as “qualified health plans.”²⁴

Among the certification requirements, qualified health plans must offer a comprehensive set of services. These are commonly referred to as “essential health benefits.”²⁵ Plans must offer services in at least the ten benefit categories shown at the right. All qualified health plans must offer benefits similar to those offered by a “benchmark plan.” In Minnesota, the “small group” insurance plan (that is, an insurance product sold to businesses with 2 to 50 full-time employees) with the largest enrollment statewide provides the benchmark for evaluating the benefits in other plans.

Types of “Essential Health Benefits”

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services

Qualified health plans are classified by “metal levels”: bronze, silver, gold, or platinum. Assigning metal levels to qualified health plans is intended to help consumers compare plans offering similar coverage. These metal levels reflect the percentage of total essential health benefit costs the plan is expected to cover, based on actuarial assessments. For example, a bronze plan would cover 60 percent of the expected value of the essential health benefits; at the other extreme, a platinum plan would cover 90 percent.²⁶ Chapter 4 discusses the percentage of people who bought various types of qualified health plans through MNsure.

²⁴ Also, with certain exceptions, health plans that are sold in the small group and individual markets outside of MNsure must meet “market rules” specified in *Minnesota Statutes* 2014, chapter 62K.

²⁵ Certain insurance products that already existed at the time the ACA was signed into law are not required to cover the essential health benefits mandated by the ACA.

²⁶ Health insurers may also sell plans that offer “catastrophic” coverage, which may have an actuarial value below 60 percent. Catastrophic plans meet the same requirements as other qualified health plans, but they do not cover any benefits other than three primary care visits per year until a high deductible is reached. Catastrophic plans are only available to individuals who are (1) under the age of 30 or (2) deemed by MNsure to have a “hardship exemption” from the ACA’s individual mandate to purchase health insurance because the available coverage is unaffordable.

Insurers who want to sell products through MNsure must offer qualified health plans in all of the metal levels and insurance markets in which they offer coverage outside of MNsure.²⁷ Also, premiums must be the same for the same plans sold inside and outside of MNsure.

Minnesota law required the MNsure Board to allow all insurance products meeting federal certification requirements to be offered through MNsure in 2014.²⁸ In subsequent years, the board may limit which products are sold through MNsure.²⁹ During each of MNsure's first two years of operations, five insurers offered products through the exchange to individuals.³⁰ There was a small increase in the total number of qualified health plans offered to individuals and families through MNsure in the second year of open enrollment (84) compared with the first (78).

People purchasing commercial insurance through an ACA exchange (such as MNsure) may qualify for tax credits or other subsidies that are not available to people buying insurance outside of the exchange.

The Affordable Care Act authorized the federal government to provide subsidies to make commercial health insurance purchased through exchanges more affordable. As shown in Exhibit 1.5, households with annual incomes between 201 percent and 400 percent of the federal poverty level may be eligible for an “advanced premium tax credit.”³¹ In such cases, the U.S. Treasury Department sends monthly payments to the individual's health plan to cover all or part of the person's monthly insurance premium. Alternatively, an individual may receive the tax credit when filing federal income taxes. A person who buys the same insurance product outside of an exchange is not eligible to receive a tax credit.

People with incomes between 201 and 250 percent of the federal poverty level may also qualify for “cost-sharing reductions” authorized by the Affordable Care Act. With a cost-sharing reduction, a person's health insurance product has

²⁷ As used here, “insurance markets” refers to the “individual market” and “small group market.” The individual market is insurance not associated with a group health plan. Employers with 50 or fewer employees may obtain employee coverage through small group market health plans.

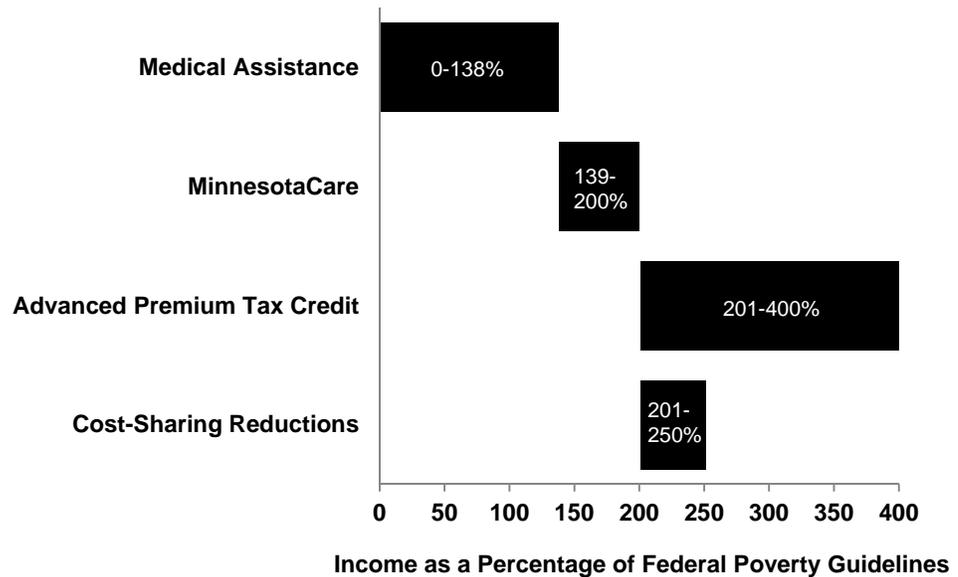
²⁸ *Minnesota Statutes* 2014, 62V.05, subd. 5(f).

²⁹ *Minnesota Statutes* 2014, 62V.05, subd. 5(e). The MNsure Board decided to allow all insurance products meeting federal certification requirements to be offered through MNsure in 2015. State law requires the board to adopt policies and procedures that will govern its selection of products to be offered through the exchange.

³⁰ The most noteworthy change from the first to second year was that the insurer (PreferredOne) that had the most enrollees in qualified health plans during the first year's open enrollment chose not to participate in MNsure during the second year. Four insurers that offered products through MNsure in 2014 (Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica, and UCare) continued to do so in 2015, and one additional insurer (BluePlus) also did so.

³¹ Besides income requirements, there are other criteria to qualify for an advanced premium tax credit through MNsure. Notably, one must not be eligible for public health care programs; must not have access to employer-sponsored insurance that is affordable and covers at least 60 percent of the employee's medical costs within the benefit categories covered by the employer; must file income taxes jointly, if married; must be a U.S. citizen or qualified noncitizen; and must be a Minnesota resident.

Exhibit 1.5: Nonelderly Adults' Income Eligibility for Minnesota's Public Health Care Programs and Federal Subsidies



NOTES: The income criteria are based on household “modified adjusted gross income.” For coverage year 2015, 138 percent of the federal poverty level for a family of four is \$32,913; 200 percent is \$47,700; and 400 percent is \$95,400.

SOURCE: Minnesota House Research Department, *Eligibility for Subsidized Health Coverage in Minnesota: 2013 Session Changes* (St. Paul, October 2013).

lower out-of-pocket health care expenses—copayments, deductibles, and coinsurance—than it would otherwise have.³²

Individuals enroll in qualified health plans during “open enrollment” periods. The first open enrollment period for Minnesota’s health insurance exchange ran from October 1, 2013, through March 31, 2014. Enrollments during this period provided coverage during calendar year 2014. For calendar year 2015, the open enrollment period lasted from November 15, 2014, through February 15, 2015. Outside of open enrollment periods, individuals may enroll in qualified health plans through an exchange only if they have qualifying life events, such as marriage, divorce, birth or adoption of a child, or a job loss, or they are members of a federally recognized American Indian tribe.

³² Cost-sharing reductions are available to people who purchase a “silver plan”—that is, one that would cover 70 percent of the expected value of the essential health benefits. The subsidy effectively increases the silver plan’s expected coverage of health care costs from 70 to 73 percent. Also, people who qualify for cost-sharing reductions have lower out-of-pocket maximum costs than other people.

Public Health Care Programs

The Minnesota Department of Human Services (DHS) administers three public health care programs. **Medical Assistance (MA)** is Minnesota's version of the federal Medicaid program. In any given month, MA provides health insurance to about one million Minnesotans. The **Children's Health Insurance Program (CHIP)** is a federal program that provides coverage to uninsured children under age two and uninsured pregnant women. It is by far the smallest of Minnesota's public health care programs.³³ The Minnesota Legislature created **MinnesotaCare** in 1992 to offer low-cost coverage to people not eligible for MA; as discussed below, it is now Minnesota's version of a "Basic Health Program," as defined by the ACA.³⁴ As of October 2014, MinnesotaCare had about 76,000 enrollees. These public health insurance programs are supported by a combination of federal and state funding.

Since October 2013, most Minnesotans seeking to enroll in state public health care programs have been required to apply through MNsure.

Federal and state legislation changed the way eligibility is calculated for Minnesota's public health care programs, starting January 1, 2014. Specifically, the Affordable Care Act changed the method used to determine whether certain individuals are eligible for Medicaid and CHIP, and the Minnesota Legislature enacted similar changes for MinnesotaCare.³⁵ For people who qualify for these programs based on income, the ACA and Minnesota law require the use of an income measure ("modified adjusted gross income") that is also used for federal tax purposes.³⁶ Earlier, Exhibit 1.5 showed the income guidelines for persons in these programs who are required to enroll through MNsure. As of January 2014, for individuals who are parents or adults under age 65 without Medicare, assets are no longer considered when determining eligibility for Minnesota's public health care programs.

The Affordable Care Act gave states the option of implementing a "Basic Health Program," starting in 2015.³⁷ Under this option, states receive federal assistance to provide subsidized coverage for individuals with modified adjusted gross incomes between 139 and 200 percent of the federal poverty level.³⁸ A Basic

³³ Only 213 people enrolled in CHIP through MNsure during MNsure's first seven months.

³⁴ *Laws of Minnesota* 1992, chapter 549, art. 4. MinnesotaCare was originally called Health Right.

³⁵ Minnesota Department of Human Services, *Bulletin: Legislative Changes to Medical Assistance and MinnesotaCare Effective January 1, 2014* (St. Paul, December 11, 2013).

³⁶ "Modified adjusted gross income" is a household's adjusted gross income (AGI) plus any tax-exempt Social Security, interest, or foreign income. For some people covered by Medical Assistance—such as the elderly and people with disabilities—eligibility is not based on modified gross income, so they are not required to enroll through MNsure.

³⁷ The 2013 Legislature made changes in MinnesotaCare eligibility, covered services, and service delivery that would allow it to qualify as a Basic Health Program. Many of these changes took effect in January 2014.

³⁸ For states implementing a Basic Health Program, the federal government pays 95 percent of the premium tax credit and cost-sharing reductions for which the individuals would have qualified if they had enrolled through a health insurance exchange in a qualified health plan.

Health Program allows individuals to keep health insurance if their incomes rise above the maximum for Medicaid eligibility (138 percent of the federal poverty level). In Minnesota, the MinnesotaCare program functions as the state's Basic Health Program. Most MinnesotaCare recipients pay a sliding-scale premium, ranging from \$4 to \$50 monthly. As of early 2015, Minnesota was the only state with a Basic Health Program.³⁹

DHS is accountable for ensuring that individuals' eligibility for each of the state's three public health care programs is determined correctly.⁴⁰ DHS worked closely with other state officials on the development of the MNsure information technology system that enrolls and determines the eligibility of applicants for public programs. DHS's goal has been to use the MNsure system to validate applicant-provided information, including income, Social Security number, citizenship or immigration status, and Medicare enrollment.⁴¹

MNsure's online system started processing new applications for the state's public health care programs on October 1, 2013. Individuals who were already enrolled in these programs on that date were supposed to have their eligibility reviewed annually through MNsure, but many of these reviews were postponed (see discussion in Chapter 2).

Roles of Other State Agencies

Besides MNsure and DHS, two state agencies—the Minnesota departments of Commerce and Health—play important roles in Minnesota's health insurance exchange.

Insurance companies that wish to sell products in Minnesota (through or outside MNsure) must annually submit proposed premium rates to the Department of Commerce. If the department concludes that a proposed rate is justified, it approves the rate. In the case of proposed rates for "health maintenance organizations," the Department of Commerce makes recommendations on the rates to the Department of Health, which has final authority to approve these rates.⁴²

Minnesota law also establishes "market rules" that apply to individual and small group health insurance products that are offered, sold, issued, or renewed in

³⁹ Minnesota law clarifies that a person who meets MinnesotaCare eligibility requirements is not eligible to enroll in a qualified health plan offered through MNsure. See *Minnesota Statutes* 2014, 256L.04, subd. 1c.

⁴⁰ DHS has not delegated responsibility for public program eligibility determinations to MNsure. However, DHS uses a shared information technology system—the MNsure enrollment system—to determine eligibility for public programs. For people enrolling in commercial insurance, this system also determines eligibility for tax credits and cost-sharing reductions.

⁴¹ For the public programs that enroll individuals through MNsure, *Minnesota Statutes* 2014, 62V.05, subd. 7(a)(2), requires MNsure to have an agreement with DHS that outlines services and cost responsibilities for eligibility and enrollment activities.

⁴² A health maintenance organization is a type of insurer defined in *Minnesota Statutes* 2014, 62D.02, subd. 4. It provides or arranges for health services on the basis of a fixed, prepaid sum, without regard to the amount of services provided to a given enrollee.

Minnesota through or outside of MNsure.⁴³ The departments of Commerce and Health share responsibility for enforcing these requirements. For example, the Department of Commerce requires insurers to justify the “metal levels” (actuarial values) of their products. It also enforces laws governing the marketing practices of insurers. The Department of Health, among other duties, reviews the adequacy of insurers’ networks of health care providers, and enforces statutory requirements for insurers to have quality assurance and improvement programs.

Budget

Exhibit 1.6 shows MNsure’s adopted budget for calendar year 2014 and its draft budgets for fiscal years 2015 through 2017. MNsure recently changed from a calendar year budget to a state fiscal year budget (from July to June). The exhibit reflects the budget revisions MNsure proposed after it received an additional \$34 million in federal revenues in December 2014. Below, we further discuss MNsure’s revenues and expenditures.

Revenues

To plan and build health insurance exchanges, states have relied largely on federal funds. Initially, states could apply for \$1 million “planning grants”; 49 states (including Minnesota) and the District of Columbia received such a grant. These grants helped states research and plan how their exchanges would operate. Later, states could apply for larger “establishment grants” to continue planning for their exchanges; 37 states (including Minnesota) and the District of Columbia received such grants. Most states that received establishment grants eventually decided not to operate their own exchanges. Other states advanced further in their planning and established governance structures for state-based exchanges; they were eligible to receive additional (“Level 2”) establishment grants. Fourteen states (including Minnesota) and the District of Columbia received Level 2 establishment grants.

Minnesota has received \$189 million in federal grants to plan and establish its health insurance exchange, but these grants will be a diminishing revenue source for MNsure.

Chapter 2 provides details on the timing and amount of individual federal grants Minnesota has received. The total amount Minnesota received (through October 2014) was the fourth lowest among the 14 states (plus the District of Columbia) that opened state-based exchanges in 2013.⁴⁴ Also, Minnesota’s total federal grants for its exchange per capita (\$28.60) was among the lowest for states that built their own exchanges.⁴⁵

⁴³ *Minnesota Statutes* 2014, chapter 62K.

⁴⁴ As of October 2014, total federal grants awarded for state-based exchanges ranged from \$90.8 million (Nevada) to \$1.07 billion (California); the median among states that opened exchanges in 2013 was \$178.9 million.

⁴⁵ As of October 2014, total federal grants per capita ranged from \$26.02 (New York) to \$275.51 (Vermont); the median among states that opened exchanges in 2013 was \$38.16.

Exhibit 1.6: MNsure 2014 Budget and Draft Budgets for Fiscal Years 2015 to 2017

Revenues (in thousands)	Calendar Year 2014	July 2014-June 2015	July 2015-June 2016	July 2016-June 2017
Federal Grants	\$ 94,162	\$ 60,668	\$ 28,278	\$ 0
Premium Withhold	2,194	5,314	10,647	16,003
Department of Human Services	36,535	52,507	56,103	28,713
Carry Forward	0	537	405	400
Total	\$132,891	\$119,026	\$95,434	\$45,116

Expenditures (in thousands)	Calendar Year 2014	July 2014-June 2015	July 2015-June 2016	July 2016-June 2017
Administrative	\$ 10,744	\$ 13,337	\$ 8,437	\$ 8,437
Regulatory (Departments of Health and Commerce)	3,794	1,805	650	650
Communications	8,510	5,714	3,887	3,887
Customer Service ^a	29,279	24,608	20,585	16,745
Technology System	68,692	73,157	61,475	14,134
Total	\$121,019	\$118,621	\$95,034	\$43,853

NOTES: The MNsure Board adopted a fiscal year 2015 budget in October 2014, but MNsure received \$34 million in additional federal grant money in December 2014. In January 2015, the board considered the revised fiscal year 2015 budget and the fiscal year 2016 and 2017 budgets shown here. As of early February 2015, the board had not taken action on the proposed financial plan covering these three years.

^a Customer service includes the MNsure contact center, the assister programs, eligibility and enrollment services, the small business options program, and plan management and reporting.

SOURCE: Office of the Legislative Auditor, summary of information from MNsure, October 2014 and January 2015.

The ACA required states running their own exchanges to be financially self-sustaining by 2015. However, the federal government has authorized some states (including Minnesota) to continue using unspent federal grants beyond 2014. As shown in Exhibit 1.6, MNsure estimated that revenues from federal grants would decline from \$94.1 million in 2014 to \$28.3 million in fiscal year 2016, with no federal grant revenues in fiscal year 2017.

MNsure is authorized in state statute to retain or collect a portion of the premiums for products sold through MNsure.⁴⁶ Initially, MNsure was authorized by statute to collect up to 1.5 percent of premiums for individual and small group market health plans and dental plans. For calendar years 2015 and beyond, the statutes authorize MNsure to collect up to 3.5 percent of health plan premiums. Exhibit 1.6 shows that revenues from the premiums sold through MNsure were projected to increase from \$2.2 million in 2014 to \$10.6 million in fiscal year 2016 and \$16.0 million in fiscal year 2017. This increase reflects that (1) a larger portion of the premium will be withheld in the years following 2014 and (2) MNsure projects growth in the number of enrollees whose premium revenues will be withheld.

⁴⁶ *Minnesota Statutes* 2014, 62V.05, subd. 2(a) through (c).

Starting in fiscal year 2016, the largest revenue source for MNsure is expected to be DHS payments to MNsure. These payments help to pay for MNsure's assistance in enrolling individuals in public programs. As shown in Exhibit 1.6, DHS payments are projected to account for over half of MNsure's revenues in fiscal years 2016 and 2017.

Spending

In the period leading up to the launch of MNsure's online enrollment system, MNsure spent most of its money on technology. For example, in fiscal year 2013, information technology contracts, software support, and software licenses accounted for 75 percent of MNsure's spending.⁴⁷

MNsure anticipates spending reductions in all areas of its budget through fiscal year 2017.

As shown earlier in Exhibit 1.6, technology-related spending is expected to remain a significant share of MNsure's total spending in the future, but the dollar amount of these expenditures is declining. MNsure budgeted \$68.7 million for its technology system in 2014; it anticipates technology spending of \$14.1 million in fiscal year 2017. Likewise, as shown in Exhibit 1.6, MNsure is in the midst of declining spending for customer service, communications, administrative services, and regulatory services (provided by the departments of Health and Commerce).

Consumer Assisters

As required by federal rules, MNsure uses various "consumer assisters" to help individuals enroll through MNsure. Exhibit 1.7 provides an overview of the different types of assisters and the compensation they receive for enrolling someone through MNsure. Chapter 6 discusses MNsure's assister program in more detail. Assisters must obtain certification from MNsure before helping individuals enroll in health insurance through MNsure. All three types of assisters are required to complete specialized training before they can become certified by MNsure.

Navigators receive state payments for helping consumers enroll through MNsure, while brokers receive compensation from insurers for enrolling consumers through MNsure. Certified application counselors can, as a part of their jobs, help individuals enroll in MNsure, but they do not receive compensation from the state or insurers for doing so.

⁴⁷ Office of the Legislative Auditor, *Minnesota Health Insurance Exchange: MNsure, Internal Controls and Compliance Audit, July 2011 through December 2013* (St. Paul, October 28, 2014), 6. This analysis did not include \$33 million in MNsure spending funded from DHS revenues, all of which MNsure spent for information technology "systems development."

Exhibit 1.7: Types of MNsure-Certified Consumer Assistants and State Compensation per Enrollee, 2014

Type of Assister	Typical Employer	Compensation per Enrollment
Navigator ^a	Community organization	MNsure paid \$70 per qualified health plan enrollment. DHS paid \$70 per MinnesotaCare enrollment and \$25 per Medical Assistance enrollment.
Certified Application Counselor (CAC)	Hospital	None.
Insurance Broker ^b	Insurance agency	A MNsure-certified broker appointed by an insurer to sell insurance on behalf of that insurer was paid by the insurer for enrollments in the insurer's products sold through MNsure. ^c

^a In this table and throughout our report, we use the term “navigators” to refer to (1) individuals who help enroll people in public programs and are not eligible to be paid from federal grants; and (2) individuals (sometimes called “in-person assistants”) who help enroll people in qualified health plans and are eligible to be paid from federal grants. This is consistent with how the term has been used by MNsure.

^b In this report, we use the term “broker” to refer to an insurance “agent” or “producer” licensed under *Minnesota Statutes* 2014, chapter 60K.

^c According to the Henry J. Kaiser Family Foundation, in 2010 brokers in Minnesota earned an average of \$97 per enrollment or renewal, or 3.9 percent of premiums in the individual market.

SOURCE: Office of the Legislative Auditor.

Oversight

The 2013 Legislature created the MNsure Legislative Oversight Committee to monitor MNsure. According to statute, the committee “shall review the operations of MNsure at least annually and shall recommend necessary changes in policy, implementation, and statutes to the board and to the legislature.”⁴⁸ The committee consists of five Senators and five House members, with three members appointed by each body’s majority leadership and two members appointed by each body’s minority leader. Between MNsure’s creation in state law in March 2013 and the end of 2014, this committee met eight times.

State law also requires the Office of the Legislative Auditor (OLA) to review MNsure. The law says OLA “shall audit the books, accounts, and affairs of MNsure once each year or less frequently as the legislative auditor’s funds and personnel permit.”⁴⁹ Since 2013, OLA has issued a financial audit of MNsure’s expenditures of federal funds, a financial audit of MNsure eligibility

⁴⁸ *Minnesota Statutes* 2014, 62V.11, subd. 1(b).

⁴⁹ *Minnesota Statutes* 2014, 62V.03, subd. 2.

determinations for public health care programs, and a special review of a MNsure data security breach, in addition to this evaluation.⁵⁰

CONTEXT FOR MINNESOTA'S EXCHANGE

Minnesota's health insurance exchange is a complicated information technology project. The enrollment website must link to the Federal Data Services Hub, which provides access to information such as citizenship status, immigration status, and tax records. The exchange is supposed to offer multiple access points—or “portals”—for consumers, insurers, county staff, MNsure finance staff, and persons assisting consumers with the enrollment process, thus allowing these groups to see various information from the online application. Because consumers are asked to provide private information, such as income and Social Security numbers, it is critical for the website to be secure. Furthermore, the website's software needs to perform complex calculations to determine individuals' eligibility for tax credits and publicly funded health care programs.

To understand the development of MNsure, it is useful to consider several points of context related to information technology projects.

Many organizations struggle to successfully complete large information technology projects.

One international firm that researches information technology—the Standish Group—has examined public and private projects and concluded that large projects are particularly risky. It found that only 10 percent of information technology projects with more than \$10 million in labor costs succeeded—that is, were delivered on time, within budget, and with the required features and functions.⁵¹ In contrast, it reported that 76 percent of small projects (under \$1 million in labor costs) succeeded.

Similar findings were reported in a review of 5,400 information technology projects by another firm, McKinsey & Company. This analysis showed that, on average, large projects (defined as those with initial price tags over \$15 million) ran 45 percent over budget and 7 percent over schedule, while delivering 56 percent less value than predicted.⁵²

⁵⁰ Office of the Legislative Auditor, *Minnesota Health Insurance Exchange: MNsure; Internal Controls and Compliance Audit, July 2011 through December 2013* (St. Paul, October 28, 2014), <http://www.auditor.leg.state.mn.us/fad/pdf/fad1421.pdf>; *Department of Human Services: Oversight of MNsure Eligibility Determinations for Public Health Care Programs, October 2013 through April 2014* (St. Paul, November 12, 2014), <http://www.auditor.leg.state.mn.us/fad/pdf/fad1422.pdf>; and *MNsure: An Unauthorized Disclosure of Private Data; Special Review* (St. Paul, November 7, 2013), <http://www.auditor.leg.state.mn.us/fad/pdf/fad1327.pdf>.

⁵¹ The Standish Group, *Chaos Manifesto 2013: Think Big, Act Small* (Boston, 2013), 1 and 4. The Standish Group recommended that organizations find ways to break large projects into a series of smaller ones.

⁵² Michael Bloch, Sven Blumberg, and Jurgen Laartz, *Delivering Large-Scale IT Projects On Time, On Budget, and On Value*, http://www.mckinsey.com/insights/business_technology

The Minnesota Department of Human Services (DHS) failed at a previous attempt to develop a large automated system to determine eligibility for the state's health care programs.

In 2003, DHS entered into a contract with a vendor to develop a system called “HealthMatch.” This automated system was supposed to determine applicant eligibility for nearly all of Minnesota’s publicly funded health care programs. But DHS and its vendor underestimated the project’s complexity, resulting in implementation delays.⁵³ DHS terminated its contract with the vendor in 2008. The system was never implemented, and DHS continued to rely on manual enrollment processes and decades-old information technology systems. When Minnesota later decided to build a health insurance exchange that would include automated methods for determining eligibility for publicly funded health care, state officials wanted to avoid the problems that HealthMatch encountered.

As Minnesota began developing its health insurance exchange, state government consolidated its information technology operations.

The 2011 Legislature passed a law that brought all of the executive branch’s information technology resources into one department under the direction of a chief information officer.⁵⁴ Previously, information technology staff were employed by a variety of state agencies. Under the new law, these staff were employed by the Office of Enterprise Technology (later renamed to the Office of MN.IT Services). The law required a transfer of authority, duties, staff, and assets to the consolidated office by October 1, 2011. Among the responsibilities of the office was oversight of state agency information technology projects, “to ensure their successful completion and avoid the fate of projects such as HealthMatch.”⁵⁵ Despite this, the Office of MN.IT Services played a limited role in the development of the MNsure enrollment system, as discussed in Chapter 2.

/delivering_large-scale_it_projects_on_time_on_budget_and_on_value, accessed October 1, 2014.

⁵³ Office of the Legislative Auditor, *Follow-up Review: MinnesotaCare Eligibility Determination* (St. Paul, April 2007), 12.

⁵⁴ *Laws of Minnesota* 2011, First Special Session, chapter 10, article 4.

⁵⁵ Office of Enterprise Technology, *Consolidation of Information Technology Systems and Services: Legislative Report* (St. Paul, January 19, 2012), 6.

Chapter 2: Exchange Development and Implementation

Minnesota opted to develop its own health insurance exchange under the federal Affordable Care Act, rather than rely on the federal exchange. This chapter examines planning and implementation of the exchange's automated enrollment process. Later in the report, we discuss the role the MNSure Board played in this process (Chapter 3) and the development of other MNSure operations, such as the consumer assister programs, customer service activities, and marketing (Chapter 6). Appendix B provides a timeline of key events in MNSure's development and implementation.

KEY FINDINGS IN THIS CHAPTER

- **Minnesota's efforts to meet an ambitious federal deadline were hindered by late federal rules, delays in passing state legislation, and problems with vendor selection and performance.**
- **Serious technical deficiencies plagued MNSure's enrollment system throughout its first year of operations.**
- **MNSure did too little testing of the technology it developed, and it did not make sufficient use of state government's information technology experts.**
- **Because of technical problems with MNSure's online enrollment system, many Medical Assistance recipients did not receive timely reviews of their eligibility.**

Minnesota's health insurance exchange has been one of the largest—and most troubled—information technology projects in the history of Minnesota state government. This chapter discusses many factors that contributed to the exchange's difficulties. Lack of effort was not among them.

Minnesota's health insurance exchange encountered numerous problems despite hard work by many staff.

Staff from MNSure, the Office of MN.IT Services, the Department of Human Services, and vendors worked diligently to develop the exchange.¹ We heard accounts (and saw evidence) of staff working long days and nights to build and

¹ Many others—such as insurers, counties, community organizations, and the state departments of Health and Commerce—also devoted considerable time to the exchange's planning and implementation.

implement the exchange. One exchange official described working 22-hour days after the MNsure enrollment system started—doing her regular job for part of that time, and addressing consumer problems during the remainder. Staff and vendors sometimes held daily conference calls in the middle of the night. After problems with the exchange’s functionality came to light, staff and vendors worked hard to identify possible solutions.

TIMELINESS ISSUES

When the Affordable Care Act (ACA) was signed into law in March 2010, it required state-based health insurance exchanges to be operational by January 1, 2014.² Subsequent federal guidance said that exchanges would need to be ready to begin operations October 1, 2013, for the purpose of accommodating an open enrollment period that would start on that date.³ This section examines issues that have affected the timeliness of Minnesota’s development of its exchange.

Passage of State Legislation

Exhibit 2.1 shows significant events leading to the passage of a 2013 state law that authorized Minnesota’s exchange. In 2006, Massachusetts was the first state to pass legislation to create a health insurance exchange. Just one year later, Minnesota Governor Tim Pawlenty advocated development of an exchange in his State of the State speech. The Governor said an exchange would “allow uninsured individuals access to health insurance that will lower premium costs by roughly 30 percent.”⁴ The 2007 Legislature subsequently funded a study, issued in 2008, that discussed how a health insurance exchange would function.⁵

The ACA passed in 2010, but it took three more years for Minnesota to pass legislation creating a state exchange.

In 2010, after the ACA passed, the federal government made grants available for states wishing to explore the creation of an exchange. However, later that year, Governor Pawlenty issued an executive order that prohibited state agencies from applying for discretionary grants related to the ACA, unless approved by the governor or required by law.⁶ Consequently, Minnesota was one of only two states that was not awarded a federal planning grant in September 2010.

² Patient Protection and Affordable Care Act, Public Law 111-148, sec. 1321(c)(1).

³ 76 *Fed. Reg.* 136 (2011), Proposed Rules, 41870.

⁴ Governor Tim Pawlenty, *State of the State Address: A Better Minnesota*, January 17, 2007.

⁵ *Laws of Minnesota* 2007, chapter 147, art. 19, sec. 3, subd. 6.

⁶ Governor Tim Pawlenty, Executive Order 10-12, “Directing State Departments and Agencies Regarding Discretionary Participation in the Federal Health Care Law,” August 31, 2010.

Exhibit 2.1: Key Actions Related to Creation of a Health Insurance Exchange in Minnesota

Date	Action
January 2007	Governor Pawlenty advocated creation of a health insurance exchange in his State of the State speech.
May 2007	The Legislature mandated a study (issued in 2008 by the Department of Health) to examine how an exchange would function.
March 2010	President Obama signed the federal Affordable Care Act (ACA) into law.
May 2010	The Legislature established a health care reform task force in response to the ACA. ^a
August 2010	Through executive order, Governor Pawlenty prohibited state agencies from applying for federal planning grants related to the ACA.
January 2011	Governor Dayton rescinded Governor Pawlenty's August 2010 order. Minnesota applied for (and subsequently received) a federal planning grant to explore the possibility of establishing an exchange.
October 2011	Through executive order, Governor Dayton directed the Commerce Commissioner to develop a health insurance exchange, and he restarted the health care reform task force that met in 2010.
March 2013	The Legislature passed and Governor Dayton signed legislation that created MNsure in state statutes.

^a The task force met once in 2010 and made no recommendations.

SOURCE: Office of the Legislative Auditor.

Shortly after taking office in 2011, Governor Mark Dayton rescinded Governor Pawlenty's order.⁷ Minnesota subsequently received a \$1 million federal planning grant in February 2011. Later in 2011, Governor Dayton issued an executive order that directed his Commerce Commissioner to develop an exchange.⁸ The Governor also directed his Commerce Commissioner to convene a task force to provide advice on health care reforms, including the creation of a health insurance exchange. Legislators from both parties were among those invited to serve on the task force, but only Democrats did so. During 2011 and 2012, several bills were introduced in the Legislature that would have created a health insurance exchange. Only one received a hearing (in 2012), and none passed. At the state and national levels, there were strong philosophical disagreements (often along party lines) about the merits of the ACA.

In addition, many states halted exchange planning or postponed efforts to get legislation for exchanges while the U.S. Supreme Court reviewed the federal law's constitutionality. In June 2012, the court upheld Congress' authority to enact most provisions of the ACA.⁹

⁷ Governor Mark Dayton, Executive Order 11-02, "Removing Ban on Requests for Federal Assistance; Rescinding Executive Order 10-12," January 5, 2011.

⁸ Governor Mark Dayton, Executive Order 11-30, "Establishing a Vision for Health Care Reform in Minnesota," October 31, 2011.

⁹ National Federation of Independent Business et al. vs. Sebelius, Secretary of Health and Human Services, 567 U.S. ____ (2012), 132 S.Ct 2566.

Minnesota executive branch officials did a considerable amount of planning for an exchange before MNsure was statutorily created in 2013.

After receiving the initial federal planning grant in February 2011, Minnesota applied for and received four federal exchange “establishment grants”—totaling \$113 million—before the Legislature created MNsure in law. Exhibit 2.2 shows the history of federal grants for Minnesota’s exchange. The largest areas of expenditure from these grants were for information technology contracts and software support and licenses.¹⁰

Minnesota also submitted a “blueprint” for its exchange to the federal government in November 2012. This blueprint was based partly on input from the state’s Health Insurance Exchange Advisory Task Force and its technical work groups, which met dozens of times. The blueprint outlined how Minnesota’s exchange would comply with federal requirements. The federal government approved Minnesota’s blueprint in December 2012, contingent on several conditions.¹¹

Exhibit 2.2: Federal Grants Awarded to Minnesota to Plan and Establish a Health Insurance Exchange

Type of Exchange Grant	Award Date	Award Amount ^a
Planning	February 25, 2011	\$ 1,000,000
Establishment, Level 1, #1	August 12, 2011	4,168,071
Establishment, Level 1, #2	February 22, 2012	26,148,929
Establishment, Level 1, #3	September 27, 2012	42,525,892
Establishment, Level 1, #4	January 17, 2013	39,326,115
Establishment, Level 2, #1	October 23, 2013	41,851,458
Additions to prior grants	December 22, 2014	<u>34,343,062</u>
Total		<u>\$189,363,527</u>

NOTE: States received “planning” grants to assess whether to establish a state-based exchange. States received “Level 1 Establishment” grants for activities associated with the state’s exchange model. States received “Level 2 Establishment” grants if they had committed to establishing a state-based exchange and had completed certain steps, such as getting legal authority for the exchange.

^a Does not include federal money provided separately to the Department of Human Services for modernization of systems to determine eligibility in publicly funded health care programs.

SOURCE: U.S. Department of Health and Human Services, notices of awards.

¹⁰ Between July 1, 2011, and December 31, 2013, 26 percent of exchange expenditures were for information technology contracts, and 32 percent were for software support and services. See Office of the Legislative Auditor, *Minnesota Health Insurance Exchange (MNsure), Internal Controls and Compliance Audit* (St. Paul, October 28, 2014), 6.

¹¹ The federal government required that Minnesota (1) demonstrate the ability to perform activities outlined in the blueprint, (2) comply with regulations and progress milestones, and (3) demonstrate by March 31, 2013, legal authority (beyond existing authority) for the exchange to operate.

Contracting for the Exchange's Technology

As shown in Exhibit 2.3, the Department of Commerce issued a request for proposals in June 2011 for development of software and hardware related to what it called the exchange's "technical infrastructure."¹² Respondents were asked to "propose prototypes...for implementation of a fully functioning exchange and/or component modules."¹³ Exchange staff intended to evaluate the prototypes and pick the best vendors to separately develop each component of the exchange. Choosing a vendor to build each component was known as a "best of breed" approach.

Exhibit 2.3: Key Steps Related to Health Insurance Exchange Contracts for Technical Infrastructure

Date	Action
June 2011	Department of Commerce issued request for proposals seeking vendors to bid on development of prototypes of various pieces of the health insurance exchange technology.
November 2011	Department of Commerce selected several vendors to develop prototypes.
February 2012	Department of Commerce informed three vendors they had been selected to develop different parts of the exchange.
May 2012	State officials changed the contracting strategy. They decided to seek a contract with one primary vendor, rather than the previous plan of multiple vendors.
July 2012	After trying to contract with Deloitte Consulting as the primary vendor, exchange officials selected a different primary vendor (Maximus, Incorporated).
February 2013	Exchange officials began the process of making contract changes to downgrade Maximus' role and enhance the role of state staff and a subcontractor (EngagePoint, Incorporated).
May 2013	Contract amendments initiated in February 2013 took effect.

SOURCE: Office of the Legislative Auditor.

Exchange officials had problems (1) selecting vendors to develop the exchange's technical components and (2) getting the performance they expected from the lead vendor.

After reviewing the prototypes, the Department of Commerce informed three companies in early 2012 that they had been selected to build parts of the exchange.¹⁴ But two months later, the department suspended the "best of breed" approach and decided instead to seek a contract with a single primary vendor.

¹² Minnesota Department of Commerce, *Request for Proposals: Health Benefit Exchange Technical Infrastructure Prototypes*, published in *State Register* on June 20, 2011, p. 1998.

¹³ *Ibid.* The department selected certain respondents to receive stipends to develop the prototypes.

¹⁴ Maximus, Incorporated, was selected to develop four modules of the exchange, while IBM-Curam Software was selected for two modules, and Deloitte Consulting was selected for one. The letters, dated February 27, 2012, said the department would begin negotiations with each company for purposes of entering into contracts.

The department negotiated with Deloitte Consulting to be the primary vendor but could not reach agreement, partly because it considered Deloitte’s price to be too high. The department turned its attention to a different vendor, and in July 2012 it entered into a contract with Maximus, Incorporated. Maximus subcontracted with various vendors to help develop parts of the exchange (see Exhibit 2.4). A Maximus official told us the selection of subcontractors was an “arranged marriage” by state officials; in other words, Maximus did not have full latitude to pick its subcontractors.

Exhibit 2.4: Subcontractors Responsible for Technical Components of Minnesota’s Exchange

Component of the Exchange	Subcontractor
Individual eligibility and exemption	IBM-Curam
Individual enrollment	Connecture
Small employer eligibility and enrollment	Connecture
Health plan display and navigator/broker certification	Connecture
Provider display	Connecture
Fund aggregation and payment	EngagePoint
Account administration	EngagePoint
Mobile application or accessibility	No contract

NOTES: These are the eight “modules” for which state officials sought prototypes in a July 2011 request for proposals. Ultimately, state officials chose not to pursue development of a mobile application and did not enter into a contract for one. Responsibility for integrating the various components was initially the responsibility of the general contractor (Maximus); following a May 2013 contract amendment, it was the responsibility of EngagePoint.

SOURCE: Office of the Legislative Auditor, based on a review of MNsure documents.

Overall, this contracting process took somewhat longer than expected. This mostly reflected (1) the Department of Commerce’s decision to change from an approach that sought multiple vendors (the “best of breed”) to one that relied on a single primary vendor, and (2) the time it took to reach agreement with Maximus following the aborted efforts to contract with Deloitte.

During the first six months of the Maximus contract, state officials working on the exchange developed doubts about Maximus’ ability to deliver. For example, state officials did not believe Maximus produced a satisfactory project plan, and they thought that Maximus’ progress on project details was too slow. Some vendor and state staff told us that Maximus focused on identifying system requirements from scratch, despite the fact that subcontractors had been selected largely on the basis of the “off-the-shelf” software they could provide to the exchange.¹⁵ Thus, there was concern that Maximus was not spending scarce time

¹⁵ “Off-the shelf” products are generally presumed to be ready for use with limited tailoring. Such products are an alternative to developing fully customized products from scratch.

efficiently.¹⁶ Also, exchange officials began working with subcontractors without going through the exchange's general contractor (Maximus), and Maximus officials believed this undermined their authority.

In May 2013, exchange staff amended the Maximus contract to revise the vendor's duties. The amendment enhanced the state's role in overseeing the project, reduced Maximus' responsibilities, and revised duties of the subcontractors.¹⁷ According to the Commissioner of the Department of Human Services, this decision was necessary to ensure that the state could implement the business functions that needed to be in place October 1, 2013. The Commissioner said: "Maximus was not in a position, the state thought in early 2013, to make sure we met those goals.... [W]hen people learned that the prime contractor was not in a position to execute, roles were shifted."¹⁸

About seven months after the contract amendment, MNsure staff told the MNsure Board that the amendment "was not related to dissatisfaction with Maximus' work."¹⁹ This was not true; state dissatisfaction with Maximus was clearly a factor in this decision.

The inability of the exchange's prime contractor to "execute" was a setback in a project with a tight timeline. Some state officials suggested to us that Maximus may have lacked the expertise to oversee a project of this sort. Others suggested that state officials failed to provide sufficient direction to Maximus—noting, for example, that a project governance structure was not in place when Maximus started its work. Regardless, progress on the technical components of the exchange was slower than expected between July 2012 and Spring 2013.

Federal Guidance

The Department of Commerce's Health Insurance Exchange Advisory Task Force began meeting and making plans for the exchange in November 2011, and it continued into early 2013. Much of its work occurred before the federal

¹⁶ Maximus acknowledged to us that it had differences of opinion with exchange staff about development of system requirements. Maximus said exchange staff focused on the requirements for each module, while Maximus wanted to look at processes "end-to-end" to make sure the various products would fit together effectively. Maximus also told us it submitted a timely project plan but that exchange staff provided inadequate feedback.

¹⁷ The amendment said "the State will take over program management, methodology, and responsibility for building the Solution."

¹⁸ Lucinda Jesson, Commissioner, Department of Human Services, e-mail message to James Schowalter, Commissioner, Department of Management and Budget, "Maximus Talking Points," January 9, 2014. In January 2013, federal officials conveyed to states a list of 70 business functions that needed to be in place.

¹⁹ MNsure board and federal relations manager, e-mail to MNsure Board members, "MNsure Maximus Background for Committee," January 3, 2014.

government issued any rules regarding implementation of health insurance exchanges (in March 2012).²⁰

The lack of timely federal regulations and guidance slowed Minnesota’s pace of building its exchange.

States needed additional federal direction to fully implement exchange-related provisions of the federal law, but many of these rules were not issued until 2013. Exhibit 2.5 shows a sampling of the rules. As federal requirements changed in the weeks and months prior to the beginning of open enrollment, state officials and software vendors scrambled to make adjustments. According to one Minnesota official who was involved in developing Minnesota’s exchange, “We were building software in quicksand.”

In addition, states developing their own health insurance exchanges faced challenges linking to the federal government’s “Data Services Hub.” The federal hub is a critical part of the enrollment process; it verifies applicant information—for example, regarding income and citizenship. According to the U.S. Government Accountability Office, state officials developing eligibility and enrollment rules for their exchanges said they “did not have complete information on the requirements of the federal data services hub.”²¹ The U.S. Centers for Medicare and Medicaid Services did not authorize the newly developed federal hub to operate until early September 2013. MNsure received federal authorization to connect to the hub on September 27, 2013, just days before open enrollment began. The federal hub was not available for MNsure to connect with until October 1, 2013, the first day of open enrollment.

Exhibit 2.5: Examples of Key Federal Rules Governing Health Exchanges Issued in 2013

- “Essential health benefits” that must be offered by products on health insurance exchanges (February 2013)
- Health insurance premium tax credits (February 2013)
- Health insurer rate review (February 2013)
- Health insurance exchanges for small businesses (June 2013)
- Medicaid eligibility notices and appeals (July 2013)
- Exchange eligibility and enrollment (July 2013)
- Consumer assistance tools and standards for navigators (July 2013)

SOURCE: Health Reform GPS, <http://www.healthreformgps.org/wp-content/uploads/ACA-Rule-Appendix-7312013.pdf>, accessed October 27, 2014.

²⁰ 77 *Fed. Reg.* 18,310, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers” (2012). In the meantime, state governments and private sector officials said that uncertainty about the federal rules “contributed to lack of progress” on the exchanges; see Engelberg Center for Health Care Reform at Brookings, *Aligning Public and Private Sector Timelines for Health Insurance Exchange Implementation* (Washington, DC, December 2011), 2-3.

²¹ Government Accountability Office, *Seven States’ Actions to Establish Exchanges Under the Patient Protection and Affordable Care Act* (Washington, DC, April 2013), 24.

Deadline for Implementation

From the time the Affordable Care Act passed in 2010, the timeframe for implementing state-based health insurance exchanges presented a significant challenge. In addition to designing and implementing exchanges, states had to consider upgrades to their Medicaid eligibility determination systems to comply with the act. As one analysis of exchange implementation observed:

Of all the [Affordable Care Act] implementation threads..., [information technology (IT)] infrastructure development is perhaps the most challenging. Development of IT systems for public programs typically takes years. As a result of the [act's] requirements and tight deadlines, both the federal and state governments are developing IT systems simultaneously, in mere months, often in advance of key policy decisions.²²

Developing a complex health insurance exchange by the deadline of October 1, 2013, presented a major challenge to Minnesota.

With a challenging timeline for implementation, Minnesota's exchange relied considerably on commercial "off-the-shelf" software products. Computer systems for the state's public health care programs were old, and building new systems from scratch would have taken a long time. Despite using off-the-shelf products for the exchange, the software vendors did a lot of customization. This reflected the need to adapt to federal exchange regulations and Minnesota's complex eligibility rules for public programs.

It also took time and was a major challenge to integrate off-the-shelf software products that had not been built to work together. A MNsure consultant observed that the integration of several software products—each with "separate and unique user interfaces, application logic, rules engine(s) and databases" resulted in "a complex system environment."²³ Partly because of time spent trying to integrate these pieces, this complex environment was not adequately tested before October 2013 (as discussed below).

State officials we interviewed generally believed that the federal government's October 1, 2013, deadline for starting online enrollment was nonnegotiable. We asked U.S. Department of Health and Human Services officials about this. We were told that the department strongly wanted states that had committed to building state-based exchanges to have those exchanges operating on October 1, 2013. However, there were two options for states unable to make this deadline. First, a state could have sought federal approval to use the federal exchange until

²² Michael Tutty and Jay Himmelstein, *Establishing the Technical Infrastructure for Health Insurance Exchanges Under the Affordable Care Act: Initial Observations from the "Early Innovator" and Advanced Implementation States* (Washington, DC: National Academy of Social Insurance, September 2012), 5.

²³ Deloitte Consulting, *MNsure Phase II Project: Deliverable #5, Technical Assessment*, July 16, 2014.

its state-based exchange was completed. Federal authorization for such a plan would have been required several months in advance of October 1, 2013, to ensure that the state could properly connect to the federal exchange. Two states that had committed to building state exchanges (Idaho and New Mexico) used the federal exchange instead during the first year of open enrollment. Second, a state could have implemented a manual system of enrollment, without a functional online enrollment option. Oregon—which had an inoperable enrollment website and never enrolled anyone through it—did all of its enrollments through manual processes. We are not aware of federal guidance that clearly communicated the option of an entirely manual enrollment process.

Minnesota never requested an exemption from its plan to start online enrollment through its exchange in October 2013. State officials made some decisions in early 2013 that narrowed the exchange project’s scope somewhat, and they remained hopeful that technical problems could be addressed prior to or shortly after October 1, 2013. In the end, however, they miscalculated their ability to deliver a well-functioning exchange by the federal deadline.

WEBSITE FUNCTIONALITY ISSUES

MNsure’s online enrollment system experienced serious problems during the year following its launch. These problems affected the experience of users who tried to enroll, as we discuss in Chapter 5. In addition, an analysis by a Yale University economist suggested that MNsure’s technical problems may have increased the costs of insurers for their enrollees in the individual insurance market.²⁴ The study said that states that experienced “severe glitches” in their exchange operations saw an increase in average insurance costs relative to states that had well-functioning exchanges, after accounting for other factors.²⁵ The study suggested that technical problems experienced by exchange users in Minnesota and five other states may have stopped enough healthy people from enrolling in insurance to cause “adverse selection,” a problem the Affordable Care Act was intended to mitigate.²⁶ (“Adverse selection” is the tendency of healthy people to defer buying insurance. In general, insurance is more affordable if it covers a wide array of people, not just those who are less healthy.)

Below, we discuss key causes and implications of MNsure’s technical problems.

²⁴ Amanda Kowalski, *The Early Impact of the Affordable Care Act by State* (Washington, DC: Economic Studies at Brookings, September 2014), 28-29.

²⁵ Kowalski found that insurance costs in the “individual market” were higher than they would have been had the Affordable Care Act not been implemented and state-level trends in coverage, premiums, and costs since 2008 had persisted. The study also assumed no change in the generosity of the insurance products sold. The individual market is insurance sold directly to individuals rather than insurance sold to a group or provided through an employer’s health plan.

²⁶ The other states experiencing “severe glitches” were Hawaii, Maryland, Massachusetts, Nevada, and Oregon. Due to data anomalies, Massachusetts was omitted from the statistical analysis. The author estimated that individual market participants in the states that experienced the worst technical problems, including Minnesota, were \$750 worse off on an annualized basis compared with individual market participants in other states with their own exchanges.

Involvement of State Technology Experts

Development of the exchange (and simultaneous upgrading of the state's eligibility system for public health care programs) was a large, complicated information technology project, and exchange staff needed all the help they could get. When the Department of Commerce issued a request for proposals to develop the exchange's "technical infrastructure" in June 2011, the only information technology specialist working for the exchange was a Department of Health employee.

MNsure's limited use of state government information technology experts may have hindered development of the exchange.

In 2011, the Legislature created a consolidated agency (now called the Office of MN.IT Services) to oversee information technology development throughout state government's executive branch, but this office had a limited role in MNsure's development. The former Commissioner of the Office of MN.IT Services told us that her initial efforts to involve her office in planning for the exchange's software components were resisted by exchange staff. She said she was concerned about the lack of information technology experience among the exchange staff, so she "muscled" the Office of MN.IT Services into some aspects of the software planning process. However, her office's role in overseeing development of the MNsure enrollment system remained limited; exchange officials played the lead role in negotiating contracts with information technology vendors, and they managed those vendors while building the exchange.

The Office of MN.IT Services tried, at its own initiative, to implement structures for making exchange-related information technology decisions, but exchange officials did not sustain these over time. The state's contract with Maximus specified that the Department of Commerce should establish a project governance structure, which is important for soliciting input from stakeholders, setting priorities, monitoring progress, and controlling changes in project components. The department did not, so the Office of MN.IT Services established one in late 2012.²⁷ Exchange officials initially used the governance structure to make decisions. Later, when technical problems arose, exchange officials went into what one participant described as "firefighting mode" and stopped using the decision-making structures. In a July 2014 report, an external consultant to MNsure said: "The cumulative effect [of a diluted project governance structure] has been to create confusion among most leads and stakeholders, inconsistent adherence to processes, [and] untimely decision making and issue resolution."²⁸

²⁷ The governance structure included an Executive Steering Committee, which provided overall project direction and oversight. The structure also included a Solutions Architecture Team, a Business Architecture Committee, a Technical Architecture Committee, and a Security Architecture Committee.

²⁸ Deloitte Consulting, *MNsure Phase II Project: Deliverable #2, Program and Project Management Assessment*, July 11, 2014.

Although the Office of MN.IT Services inserted itself into many exchange discussions and decisions, the office's role was eclipsed in 2013 by a change in state law. Legislators passed statutory language that exempted MNsure from much of the Office of MN.IT Services' authority. For example, the Office of MN.IT Services is required by law to evaluate whether information technology projects proposed by state agencies will meet users' needs and assess the projects' costs and benefits against other options.²⁹ This statutory requirement was part of the 2011 Legislature's effort to ensure proper oversight of large information technology projects in state government. However, the Legislature passed legislation in 2013 that said this section (and many others related to the Office of MN.IT Services) did not apply to MNsure.³⁰

Because the Office of MN.IT Services ultimately assumes responsibility for supporting the software developed by agencies and vendors, it is important for this office to be a key partner in the development process. But, during the development of MNsure, vendor staff were generally not paired with counterparts at the Office of MN.IT Services so the state staff could learn about the vendor-designed systems; this was in contrast to practices on many other state information technology projects. In addition, some Office of MN.IT Services staff told us that the MNsure vendors did not fully communicate the nature of the data that would reside in the systems. Thus, as of late 2014, Office of MN.IT Services staff were still learning what they needed to know to support this system when the vendors finish their work.

RECOMMENDATION

The Legislature should amend *Minnesota Statutes 2014, chapter 62V*, to ensure that MNsure's future information technology work is subject to oversight from the Office of MN.IT Services.

The 2011 Legislature integrated the state's information technology staff and authority into a single agency, partly to help ensure the success of difficult projects. We think it was unwise for MNsure to undertake a large information technology project in 2011 without forging a close working relationship with the Office of MN.IT Services. It was also unwise for the 2013 Legislature to exempt MNsure from ongoing oversight by the Office of MN.IT Services. While there were many reasons for the technical problems MNsure's enrollment system encountered, a state law that limited the Office of MN.IT Services' project oversight and decision-making authority did not help.

During the past year, a stronger working relationship has developed between MNsure, DHS, and the Office of MN.IT Services. These agencies have jointly designed an information technology governance structure to facilitate orderly decisions on the health insurance exchange and modernization of Minnesota's enrollment systems for public health care programs.

²⁹ *Minnesota Statutes 2014*, 16E.03, subds. 3 and 4.

³⁰ *Laws of Minnesota 2013*, chapter 9, sec. 5.

MNsure is an organization that relies considerably on its online enrollment system. This system will need to change over time. The involvement of the state's technology experts in these changes should not be dependent solely on the informal working relationships of officials at MNsure and the Office of MN.IT Services. We suggest that the Legislature amend MNsure's governing statute to subject MNsure's information technology projects to the oversight that other state agencies receive.

Pre-Launch Indicators of System Readiness

Because development of the health insurance exchange was a difficult project with an ambitious timeline, we looked at documents that showed the progress of this project as the first open enrollment period neared.

Various “red flags” in the weeks and months prior to October 1, 2013, suggested that the launch of the exchange might not go well.

Some early “red flags” came in reports prepared by an independent contractor for exchange officials and the federal government. In February 2013, the exchange contracted with a vendor to provide “independent verification and validation” (IV&V) that the exchange's software and systems met expectations and requirements. The vendor produced quarterly reports that assessed the exchange in several areas, as summarized in Exhibit 2.6. In the areas of scope, schedule, staffing, and quality, the vendor indicated “marginal” or “unsatisfactory” performance in reports issued prior to October 1, 2013 (and thereafter).³¹

Exhibit 2.6: Independent Assessments of Overall Project Status for MNsure, April 2013 to January 2014

Project Areas Assessed	Overall Project Status, as of:			
	4/19/2013	7/31/2013	10/31/13	1/31/2014
Scope	Marginal	Marginal	Unsatisfactory	Unsatisfactory
Schedule	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory
Cost	Good	Good	Good	Good
Staffing	Marginal	Marginal	Marginal	Marginal
Quality	Marginal	Marginal	Marginal	Marginal

NOTES: The reports that assessed the “overall health” of the MNsure project also rated the health of the project aimed at modernizing the Department of Human Services' eligibility and enrollment systems. The ratings shown in this table are only the ratings for the MNsure project.

SOURCES: Software Engineering Services, *Minnesota Insurance Exchange and Eligibility and Enrollment System Modernization Internal Verification and Validation* (Bellevue, NE, May 28, 2013, August 30, 2013, December 11, 2013, and March 20, 2014).

³¹ In addition to these ratings of “overall project health,” the reports presented ratings for a variety of more specific project activities.

In addition, the IV&V vendor prepared an urgent notice to MNsure on September 12, 2013, which said:

Critical dates for [an October 1] deployment of MNsure are not being met and [we are] very concerned that the functionality of the system being deployed on [October 1] is not well understood and the system will be deployed without adequate testing or contingencies in place.³²

Another series of “red flags” were the project status reports prepared by the Office of MN.IT Services during much of 2013. Each week, this office developed color-coded reports that summarized the status of exchange elements related to information technology. Items were coded green if they were performing as expected; yellow indicated caution regarding an item’s performance, and red indicated that there were critical issues. From June 2013 through September 2013, the Office of MN.IT Services consistently coded as red the overall status of the exchange project. This reflected concerns about the project’s scope, schedule, and risk as October 1, 2013, approached.

In addition, the federal Centers for Medicare and Medicaid Services expressed concern about some issues as the system prepared to go live. Federal officials conducted reviews of Minnesota’s progress at several points during exchange development. In a September 2013 review, federal officials identified many areas in which they said MNsure had demonstrated the exchange’s functionality. But the federal report said that, as of September 12, the system had 270 unresolved defects, including 97 “major” defects “with no workarounds.”³³ The report said that resource availability to address these concerns before October 1, 2013, was “a big concern.” Further testing on September 19 led federal officials to state: “At this time, Minnesota is unsuccessful in completing multi-tax household eligibility determinations, cannot generate systems logs for validating appropriate access to the [Federal Data Services] Hub, and is having significant difficulty with systems testing and defects.” Although the reports identified areas of concern, the federal government authorized Minnesota’s exchange to connect to the Federal Data Services Hub.

MNsure failed to adequately test the exchange’s website and software before enrollment started in October 2013.

When a complex information technology system is developed, it is important to ensure that it will work as expected. Thus, system developers plan for various types of testing. For example, “integration testing” examines whether various system components work together effectively. “Load testing” examines whether a system can handle particular numbers of users or amounts of data. “User acceptance testing” determines whether a system works as intended for the user.

³² Software Engineering Services, *MNsure IV&V Urgent Time Critical Notice*, September 12, 2013.

³³ Center for Medicare and Medicaid Services, “Minnesota Operation Readiness Review Summary” (September 2013), unpublished.

The project schedule for Minnesota’s health insurance exchange called for the state to approve a testing plan by mid-December 2012, but the testing plan that Maximus produced was not finalized until February 26, 2013. It was then reworked by a different vendor (EngagePoint) when exchange staff amended the duties of the contractors. The revised testing plan was completed in late May 2013.

Actual tests of the exchange’s enrollment system also occurred later than expected. This reflected delays in development of the software and other parts of the system, as vendors made ongoing changes to their products and the federal government continued to issue new exchange rules well into 2013. Key tests were not completed until immediately prior to the start of open enrollment, and the results were not summarized until open enrollment was already underway. Exhibit 2.7 shows the dates when tests were supposed to be completed and when they actually were.

Exhibit 2.7: Target and Actual Dates for Completion of MNSure System Testing

Type of Testing	Target Dates for Completion of Testing			Actual Completion
	MNSure Project Schedule (November 2012)	Maximus Testing Plan (February 2013)	EngagePoint Testing Plan (May 2013)	
Integration Testing	6/28/13	6/28/13	8/15/13	10/1/13
Load Testing	7/5/13	7/5/13	9/15/13	10/2/13
User Acceptance Testing	9/9/13	9/9/13	9/15/13	10/1/13

NOTES: Testing is completed when the test results have been compiled into a report. According to the testing reports, load testing and user acceptance testing ended September 30, 2013, while integration testing ended August 5, 2013.

SOURCES: MNSure, *Project Schedule*, <http://www.mnsure.org/images/MNHIX-ProjectSchedule11-19-12.pdf>; accessed June 15, 2014; *Minnesota Health Insurance Exchange (MNSure) Test Report, Release 1* (October 1, 2013); Nick Richardson, *SOASTA CloudTest Summary Report* (October 2, 2013); Maximus, Inc., *Minnesota Health Insurance Exchange Final Testing Plan* (February 26, 2013); and EngagePoint, *Testing Plan, Version 2.04* (May 30, 2013).

The results of the tests showed significant problems. For example, load testing in late September 2013 found that the MNSure website could not handle more than 1,000 simultaneous users. This was well short of the goal (10,000 users) set by system developers. Tests showed that when the number of users surpassed 1,000, people trying to access the system would receive error messages or be logged out of the system. Another test looked at the enrollment system’s ability to accurately handle a variety of “scenarios.” For example, a scenario might test whether the system worked as intended for a user with specific demographic characteristics. Of 143 scenarios that testers examined, 53 (37 percent) failed. Based on this and other testing results, an October 1, 2013, report concluded: “[User Acceptance Testing] overall status is red.” This meant that the system defects shown by the testing were a significant problem.

People involved in the exchange’s development generally agreed that an inadequate amount of testing occurred. A top official with the Office of MN.IT

Services said that perhaps 40,000 scenarios should have been tested before October 1, 2013, given the wide variety of individual and household characteristics among potential applicants. The number of scenarios actually tested was less than 1 percent of this amount. Consequently, as one MNsure Board member told us, MNsure “ended up testing on the citizens in Minnesota.”³⁴

The inadequacy of testing partly reflected time constraints, but it also reflected a general inadequacy of MNsure’s provisions for quality assurance. The exchange did not have a quality assurance manager until May 2013, just five months before open enrollment started. According to the Office of MN.IT Services, the quality assurance manager and his staff largely performed business support tasks rather than quality assurance work. An Office of MN.IT Services manager told us that the quality assurance leadership was inexperienced and hindered by constant changes in the exchange software.

Problems After the Exchange Opened

The MNsure website did not experience serious technical problems when it was initially launched on October 1, 2013.³⁵ This contrasted with the websites of the federal government’s exchange and some other state-based exchanges. Still, there were some problems with the functionality of MNsure online enrollment process in early October. MNsure customers encountered difficulties getting their identities verified through the MNsure system; state staff told us this reflected problems with the design of system elements at both the federal and state levels. Also, the eligibility part of MNsure’s enrollment system initially allowed people to submit multiple applications. For example, an applicant might submit a second application to correct an error made in the first one; the MNsure system did not have the ability to accept changes. When MNsure received multiple applications, it was unclear which application was the correct one.

MNsure’s technical problems escalated through Fall 2013 and continued well into 2014.

Significant problems with the MNsure enrollment system emerged in mid-November. MNsure made system changes in an effort to fix errors that had been programmed into the system, but these changes triggered a problem that caused some applications to get trapped in the MNsure system. In such cases, it was difficult for staff to view or retrieve the applicants’ information. Based on our

³⁴ In addition, testing of the MNsure site often occurred in what is called the “production environment,” which is a version of the system that consumers use. Testing in this environment can disrupt users, and the cost of fixing a problem identified in this environment is typically greater than the cost of fixing a problem identified earlier in the process.

³⁵ MNsure delayed opening its website until the afternoon of October 1 so that it could conduct additional testing of the system.

document review, the number of MNsure cases affected by this problem peaked in December 2013 and again in March 2014.³⁶

In mid-December 2013, Governor Dayton sent a letter to the chief executive officer of the IBM Corporation, expressing concerns about the functionality of the IBM product used for MNsure's eligibility determinations. The Governor asserted that IBM's product was not as "ready out-of-the-box" as IBM had conveyed to exchange officials in 2011, and other state officials agreed that the product needed many modifications. The Governor said the IBM product "did not properly perform eligibility determinations or verify individuals' application information, as required under federal law."³⁷ Office of MN.IT Services experts we spoke with said the software used for IBM's portion of the exchange was "immature," suggesting that it needed substantial modification for use in MNsure. IBM said that most of the concerns raised in the Governor's letter were not attributable to IBM's product or had been resolved prior to the Governor's letter. However, IBM sent a team of staff to St. Paul in December 2013 to help address issues with the functionality of its software.³⁸

In January 2014, MNsure contracted with a health care consulting firm (Optum) to give an external assessment of MNsure's problems. Regarding MNsure's software, Optum said a "large gap exists between required functionality and what has been delivered."³⁹ Optum highlighted weaknesses in the MNsure system's technical capabilities, such as the following:

- MNsure did not have a way to link all data related to a given consumer. It is important for an enrollment system to specify an authoritative data source—often called a "system of record"—especially when the system relies on data from multiple sources. This helps to ensure the integrity of the data. A system of record was not built into the MNsure enrollment database until late 2014.
- MNsure lacked the ability to process insurance changes due to "life events." Changes in income or family size, for example, are common and can affect someone's eligibility for public health care programs and tax credits. Thus, it is important for a health insurance exchange to efficiently make such changes. MNsure manually processed changes due to life events through 2014; it hopes to have a more automated process sometime in 2015.

³⁶ This application limbo was known as the Process Instance Error (PIE) queue. Records we obtained from the Office of MN.IT Services were not available for all dates, but there were 1,800 cases in the PIE queue as of December 15, 2013. Records show that the number declined sharply in January 2014, but it climbed to more than 2,500 in March 2014 before declining to near zero in late April 2014.

³⁷ Governor Mark Dayton, letter to Virginia Rometty, Chairman, President, and CEO, IBM Corporation, December 13, 2013.

³⁸ Although IBM asked the state to have 200 workstations available for its staff, and some media reports said IBM sent "dozens" of staff to St. Paul, we were told the actual number sent was about nine.

³⁹ Optum, *MNsure Assessment Summary: Contact Center; Technical Program Management; Software and Data*, January 17, 2014.

In April 2014, MNsure contracted with Deloitte Consulting for a more in-depth assessment of MNsure’s technical functionality and its information technology governance and management. In addition, Deloitte became the “lead primary point of contact with all vendors” as it helped MNsure make necessary fixes.⁴⁰ Deloitte assessed the status of 73 functions that it said “are expected in a robust Health Insurance Exchange.”⁴¹ Some of these functions (such as renewals of insurance coverage) were ones MNsure did not need to implement for its first enrollment year, but many should have been functional in October 2013. In June 2014, Deloitte reported that only 26 of the 73 functions worked as expected. Exhibit 2.8 shows examples of issues Deloitte identified.

Deloitte observed that:

Several aspects of the MNsure system architecture are contemporary and consistent with industry practices. The system’s foundation, however, centers on the integration of four unique and independent [commercial off-the-shelf] products.... The system architecture is complex, ...with each...product presenting a separate user interface, a separate rules engine, and a separate database architecture. The resulting architecture requires a high level of effort to maintain the system on an ongoing basis.⁴²

Exhibit 2.8: Examples of MNsure Technical Problems Cited by Deloitte, June 2014

In the enrollment website, applicants could not edit data they had entered, view their eligibility status, or view their enrollment information.

The system used a less-than-ideal process for applicant identity matching, potentially resulting in duplicate cases for the same person.

The system lacked functionality to process renewals of already-enrolled individuals. Changes made by caseworkers did not necessarily result in the expected eligibility determinations.

The system incorrectly indicated that some applicants did not qualify for a tax credit.

The system did not process effectuation and termination notices from insurers, so MNsure enrollment information may have been out-of-date.

Outside of open enrollment, the system lacked functionality to handle new applicants or make changes in existing cases due to “life events” (births, deaths, marriage, etc.).

Caseworkers processed paper applications as time permitted but did not always have the ability to backdate eligibility to the date the application was received.

The system could not authorize navigators or brokers to complete an online application on behalf of a client.

MinnesotaCare clients could not make online payments.

SOURCE: Deloitte Consulting, MNsure Phase II Project, Deliverable #3, Phase 1 Functional and Technical Assessment, June 18, 2014.

⁴⁰ MNsure, Professional and Technical Services Contract with Deloitte Consulting LLP, April 2014.

⁴¹ Deloitte Consulting, *MNsure Phase II Project: Deliverable #3, Phase 1 Functional and Technical Assessment*, June 18, 2014, 7.

⁴² Deloitte Consulting, *MNsure Phase II Project, Deliverable #5, Technical Assessment*, July 16, 2014, 7 and 13.

Deloitte provided a “roadmap” for addressing the deficiencies it cited. MNsure then worked with Deloitte, other vendors, DHS, and the Office of MN.IT Services on these issues over the next several months. By most accounts, applicants during MNsure’s second open enrollment period (starting in November 2014) had a better user experience than applicants in the first open enrollment period.

MNsure’s technical problems resulted in a wide variety of time-consuming “workarounds.”

When the online processes for enrolling individuals through MNsure did not work as smoothly as anticipated, other agencies and individuals stepped in to help. Often, it was necessary to process enrollments manually rather than through an automated process. Also, many individuals completed paper applications, often because of difficulties encountered with the online application process.

There are no definitive estimates of the fiscal impact of the “workarounds” that were developed in response to technical problems, but some examples of these impacts are discussed below.

- MNsure has devoted significant numbers of its customer service staff to manually process online applications that got stuck in the MNsure system. Even high-ranking MNsure officials spent many hours during 2013 and 2014 trying to address individual cases that encountered technical problems.
- Due to technical problems with the MNsure website, the volume of paper applications MNsure received was larger than anticipated.⁴³ During MNsure’s first year of enrollment, it received more than 85,000 paper applications. Until November 2014, staff from the Minnesota Department of Human Services manually processed most of these paper applications. The department billed MNsure for a portion of the costs.
- MNsure-certified navigators provided follow-up services to an unexpectedly large share of consumers. Follow-up often occurred when the consumers’ identities could not be verified in an automated way or their applications could not be readily retrieved from MNsure’s enrollment system.
- As we discuss in Chapter 5, health insurers and counties devoted a significant amount of time to MNsure processes that were supposed to have been automated.

⁴³ The creation of an online health insurance exchange was never intended to eliminate the option of paper applications for people seeking to enroll in public health care programs—for example, for people without access to a computer. However, exchange and DHS officials hoped that the ability of individuals to access MNsure’s online enrollment process at counties or by working with assisters (such as navigators) would limit the number of cases requiring paper applications.

Eligibility Determination Issues

The Minnesota Department of Human Services (DHS) is responsible for ensuring that individuals' eligibility to receive benefits from the state's public health care programs is determined correctly. These programs include Medical Assistance (the state's Medicaid program), MinnesotaCare, and the Children's Health Insurance Program.

In recent years, DHS has explored ways to modernize and integrate the eligibility systems for these and other programs. DHS undertook these efforts, sometimes with direction from the Legislature, separate from implementation of Minnesota's health insurance exchange.⁴⁴ In 2011, DHS rated vendor demonstrations of products that could be used to redesign the state's eligibility determination systems; IBM Curam was ranked the highest. The following year, the exchange selected IBM Curam to develop a portion of its enrollment system, and the modernization of DHS's eligibility systems and the development of the exchange became, in effect, a joint venture.⁴⁵

Eligibility determinations for public health care programs are a critical function of MNsure. As of November 2014, enrollees in these programs accounted for 85 percent of the people who enrolled through MNsure.

There have been serious problems with eligibility determinations for persons newly enrolling in public health care programs through MNsure.

For more than ten years, the Office of the Legislative Auditor (OLA) has raised concerns about DHS's ability to ensure that its eligibility determinations for public programs are correct. The development of MNsure provided the agency with an opportunity to improve in this area. However, in November 2014, OLA issued a report on DHS's oversight of eligibility determinations that had occurred through MNsure's enrollment system, and the report still found significant problems.⁴⁶ For example:

- In a sample of persons who enrolled through MNsure, 17 percent were not eligible for the program in which they were enrolled. For cases in which individuals had duplicate accounts in public health care programs, the state paid too much to insurers for health care benefits.

⁴⁴ *Laws of Minnesota* 2011, First Special Session, chapter 9, art. 9, sec. 17, directed DHS to issue a request for information regarding an integrated service delivery system. DHS entered into a contract with a vendor in August 2012 to conduct planning related to system modernization. In earlier years, DHS initiated development of a failed eligibility system without legislative direction.

⁴⁵ Minnesota Department of Human Services, *Redesigning Service Delivery: Planning for an Integrated Service Delivery System, A Report to the 2012 Minnesota Legislature* (St. Paul, January 2012), 39.

⁴⁶ Office of the Legislative Auditor, *Department of Human Services, Oversight of MNsure Eligibility Determinations for Public Health Care Programs, October 2013 through April 2014* (St. Paul, November 12, 2014).

- DHS did not ensure that the records of individuals who enrolled through MNsure in public programs were accurately and completely transferred from MNsure to DHS's medical payment system. Inadequate controls over such data transfers increased the risk that data could have been lost or altered during the transfer process or accessed by people without authorization.
- DHS did not charge premiums for MinnesotaCare recipients for the first three months of 2014, and MNsure's enrollment system did not properly calculate premiums after this time.⁴⁷
- DHS did not have an effective process to resolve discrepancies between Social Security, citizenship, and immigration information reported by MNsure applicants and information maintained by the state and federal governments.

DHS attributed many of these issues to the implementation of MNsure's new eligibility determination system. The DHS Commissioner described the OLA findings as "serious" and said DHS is "working to improve compliance as we move forward with technology improvements."⁴⁸ She said some of the problems cited in the audit had been addressed already or would be soon. Nevertheless, the audit showed that MNsure's new eligibility system had significant weaknesses, and future audits will determine the extent to which these have been addressed.

Due to problems with MNsure's functionality, DHS postponed annual eligibility reviews for people who had enrolled in public health care programs before October 2013. Some recipients did not have their eligibility reviewed for two years.

Initially, DHS intended to use the new MNsure system to enroll or re-enroll most of its public health care programs participants.⁴⁹ Fiscal notes for the 2013 legislation that created MNsure estimated that 621,000 individuals would enroll or re-enroll in Medical Assistance through MNsure during 2014.⁵⁰ The actual total, as of October 2014, was much lower (233,000). All of the Medical Assistance recipients who enrolled through MNsure from October 1, 2013, to late 2014 were new enrollees; none were renewals.

DHS delayed re-enrolling existing Medical Assistance cases through MNsure until the MNsure system worked better. DHS told counties that the extent of the

⁴⁷ *Ibid.*, 29-31. The audit said DHS had not billed MinnesotaCare recipients for the January to March 2014 premiums as of September 2014. In its response to the audit, DHS said it intended to identify calendar year 2014 billing errors and send statements to enrollees by June 2015.

⁴⁸ *Ibid.*, 51.

⁴⁹ The Affordable Care Act and state legislation changed the basis on which income is evaluated to determine eligibility for public health care programs. Effective January 1, 2014, "modified adjusted gross income"—as defined for federal income tax purposes—is the income measure used. Some people qualify for public health care programs using other criteria, such as disabilities; these individuals do not enroll in these programs through MNsure.

⁵⁰ See fiscal notes for H.F. 5-8E, 2013 Leg., 88th Sess. (MN); and S.F. 1-7E, 2013 Leg., 88th Sess. (MN).

delay would depend on MNsure's ability to process eligibility changes related to consumers' "life events," such as changes in income, household size, address, or citizenship. DHS also said it would consider the overall functionality of the MNsure system before moving existing cases to this system.

In addition, DHS asked the federal government for permission to defer eligibility re-evaluations for Minnesota's existing Medical Assistance recipients; these reviews are required annually. The federal government approved this request. This meant that individuals could continue to receive Medical Assistance without having their eligibility redetermined. Initially, this waiver of the federal renewal requirement was for January through March 2014, but it was extended and was still in effect in late 2014.

So far, relatively few of the people who enrolled in public programs before October 2013 have had their eligibility reviewed since MNsure's enrollment system opened. Through the end of 2014, DHS had renewed about 63,000 MinnesotaCare enrollees through MNsure. In November 2014, DHS postponed the review of about 600,000 Medical Assistance recipients who enrolled before October 1, 2013. DHS hopes to conduct these reviews between March and December 2015.⁵¹

The postponement of eligibility redeterminations has undoubtedly had fiscal implications, although the exact magnitude is hard to estimate. Inevitably, redeterminations find that some people no longer meet eligibility criteria, and they are terminated from public programs or transferred to different ones. But, as of late 2014, some individuals in public health care programs had not had their eligibility reviewed for two years. This means that some people who should have been deemed ineligible—for example, due to increases in income or reductions in family size—are still enrolled in public programs.

In an effort to consider the possible impacts of deferred eligibility redeterminations, we obtained monthly trend data on what DHS calls "disenrollments" of Medical Assistance recipients. For this analysis, a "disenrollment" was defined as an individual who was not eligible for Medical Assistance in the current month but was in the previous month.⁵² We observed that the total number of disenrollments for January to August 2014 was less than half the number that occurred during comparable periods in the previous two years. The deferral of eligibility redeterminations may be a factor in Minnesota's reduced number of Medical Assistance case closures, although there may have been other factors, too. If fewer Medical Assistance cases were closed due to the deferral of annual case reviews through MNsure, this may have resulted in higher program costs than would otherwise have been the case.

⁵¹ DHS has obtained federal approval to temporarily keep cases in its old eligibility system (MAXIS) and, starting in late 2014, conduct determinations there until cases can be transitioned to MNsure.

⁵² The analysis was limited to individuals (1) whose enrollment occurred prior to October 1, 2013, and (2) whose continuing eligibility would likely be based on "modified adjusted gross income." As noted in Chapter 1, this income measure is used to determine eligibility for most enrollees in public health care programs, as of January 2014.

Chapter 3: Governance

MNsure is governed by a seven-member board. The board consists of six members appointed by the governor, plus the Commissioner of the Department of Human Services (or the commissioner's designee). The board appoints the agency's chief executive officer.

This chapter discusses the role the MNSure Board has played in the development of Minnesota's exchange. It also discusses MNSure's compliance with board policies and state law, and communication between MNSure's administrative leadership and other state officials. We recommend a change in the process for appointing the MNSure chief executive officer, and we suggest that the Legislature consider whether to keep a governing board for MNSure.

KEY FINDINGS IN THIS CHAPTER

- **The MNSure Board had little influence over exchange operations prior to the launch of the MNSure enrollment website.**
 - **MNSure staff withheld key information from the board and other state officials during 2013.**
 - **The multi-agency governing structure for MNSure's online enrollment system lacks formal authority.**
 - **MNSure leadership has not implemented some internal policies and state requirements.**
-

BOARD ROLE

MNSure's statutory authority resides with the MNSure Board, except in cases where this authority has been formally delegated to staff. However, state law did not give the board significant authority until several months after the board was created.

Due to statutory provisions, the MNSure Board had little influence over exchange operations prior to the start of open enrollment in October 2013.

The Governor signed MNSure's enabling legislation in March 2013 and appointed board members on April 30, 2013. However, the board was required by statute to adopt internal bylaws, policies, and procedures before it could assume its authority.¹ The board developed various policies—for example, a fiscal policy and a policy on public involvement in the board's decision-making

¹ *Laws of Minnesota* 2013, chapter 9, sec. 14.

process. The board assumed its statutory authorities and responsibilities on August 21, 2013. This was less than six weeks before the exchange’s enrollment website opened.

The months prior to when the board assumed its statutory authority were a critical time in MNsure’s development. Vendors developed key software components, and staff made plans for MNsure’s contact center, outreach grants, and marketing. But the board complied with statutes and adopted a series of internal policies, rather than giving its full attention to operational issues. During this time, MNsure administrative staff made key system development decisions, and the Commissioner of Management and Budget temporarily fulfilled the board’s role.

After assuming full governance responsibilities, the board played a more active role in oversight of MNsure operations.

State law requires the MNsure Board to meet “at least quarterly.”² In fact, the board has met much more frequently than this. During the board’s first four months—the period when it adopted policies and bylaws—the board averaged two meetings per month. From September 2013 through the first open enrollment period (ending in March 2013), the board averaged about 2.6 meetings per month. From April 2014 through November 2014, the board averaged 1.5 meetings per month.

When problems with the MNsure enrollment system’s functionality occurred in Fall 2013, the board explored ways to fix the problems. The board chair began going to the MNsure offices daily during the period when enrollment difficulties peaked. A consultant’s report said the board “essentially stepped into the [executive director] role, responsible primarily for daily operations.”³ In addition, the board initiated two external reviews of MNsure that were conducted in 2014.⁴ While a part-time board cannot be expected to oversee all of the details of MNsure’s day-to-day operations, board members rightly raised questions about MNsure’s performance and asked appropriate questions of staff.

BOARD POLICIES

Because the board’s main focus between May 2013 and September 2013 was adopting a set of internal policies, we examined whether these policies have been followed.

Some of the MNsure Board’s initial policies have not been implemented on schedule.

² *Minnesota Statutes* 2014, 62V.04, subd. 10.

³ Deloitte Consulting, *MNsure Phase II Project: Deliverable #2, Program and Project Management Assessment*, July 11, 2014, 18.

⁴ These were the 2014 reviews by Optum and Deloitte Consulting.

First, MNsure staff have not prepared monthly and quarterly financial reports for the board, contrary to board policy.⁵ As of September 2014, the board had received only one quarterly financial report (for January to March 2014), and it had received no monthly financial reports. MNsure finance staff told us that, initially, their time was needed to help individuals who were encountering enrollment problems. However, MNsure's financial status merits close and ongoing attention. Legislators of both parties expressed concern to us about the brevity of the budget MNsure presented to legislators in 2014. Also, MNsure's financial viability will be important to monitor as MNsure's federal grants are exhausted.

Second, board policy called for staff to submit a set of annual goals for MNsure to the board, but this has not occurred.⁶ Measures were supposed to address at least the following categories: (1) access to health insurance, (2) affordability of health insurance, (3) consumer experience, (4) health plans, and (5) finance. Staff were supposed to set "start-up" goals initially, with longer-term goals related to strategic priorities in subsequent years. In October 2013, the board heard suggestions from several external groups about possible measures. As of early 2015, MNsure leadership has not proposed goals in each of the required areas to the board.⁷

Third, board policy requires that the board receive, for approval, a three-year financial plan "based on critically evaluated assumptions that are provided to the Board along with an operations plan."⁸ The three-year plan presented to the board in December 2014 provided limited information on the plan's underlying assumptions. The plan included assumptions regarding MNsure's number of enrollments in qualified health plans (which affect the amount of premium revenues MNsure collects), but it did not discuss other assumptions regarding revenues or expenditures.

Fourth, the board adopted a policy in August 2013 that required the board to initially evaluate its own performance no later than April 2014.⁹ The evaluation was supposed to consider ten "dimensions" of performance and would involve either a board survey or structured interviews. As of early 2015, the board has not conducted a self-evaluation.

⁵ MNsure Board Policy #07.1 (Fiscal Policy: Financial Planning, Budgeting, Financial Reporting and Asset Protection).

⁶ MNsure Board Policy #09 (Reporting, Measurement and Evaluation for MNsure).

⁷ MNsure staff presented a three-year financial plan to the board in December 2014, which included forecasts of revenues and expenditures. Because the plan was based partly on assumptions about enrollments in qualified health plans, it contained some measures related to health insurance access and finance, as required by the board's policy.

⁸ MNsure Board Policy #07.1 (Fiscal Policy: Financial Planning, Budgeting, Financial Reporting and Asset Protection).

⁹ MNsure Board Policy #10 (Reporting, Measurement and Evaluation for Board of Directors).

RECOMMENDATION

The MNsure Board should ensure implementation of its policies or, if necessary, revise policies that are not realistic to implement.

After October 1, 2013, the board spent much of its time trying to ensure that MNsure's operational issues were addressed. This was appropriate, in our view. Still, we are concerned that implementation of some of the board's key policies related to financial management and organizational accountability have been deferred. If board members believe that some of the previously adopted policies are no longer reasonable, this should be the subject of board discussion. Where necessary, the board should adopt new schedules for implementing its policies and adhere to them.

COMPLIANCE ISSUES

MNsure's governing statutes—adopted by the Legislature in 2013—establish a framework for the exchange's operations. We examined MNsure's compliance with key requirements.

Three state requirements of the MNsure Board were not properly implemented.

First, the board has not yet established formal policies for the operation of MNsure's Navigator Program, call center, and customer service provisions (discussed in Chapter 6), contrary to state law. State law required the implementation of board policies and procedures for these activities by January 1, 2015.¹⁰ The board delayed establishing navigator policies to (1) prevent a disruption to the Navigator Program during the open enrollment period that ended February 15, 2015, and (2) allow for potential legislative action in 2015.¹¹ It intends to initiate a rule-making process regarding navigator policies later in 2015, with rules to take effect in Fall 2015. The board has not outlined a plan for establishing call center or customer service policies.¹²

Second, the board has not fully complied with state rules regarding assister compensation rates. State rules require the MNsure Board to (1) annually set compensation rates for consumer assisters and (2) publish the initial compensation rates and any changes in rates in the *State Register*.¹³ The MNsure Board did not set the assister compensation rates used in the second open

¹⁰ *Minnesota Statutes* 2014, 62V.05, subd. 4(a).

¹¹ MNsure Board Policy #15 (Consumer Assistance Program: Roadmap for Designing a Navigator Program for the Future).

¹² The board adopted a call center policy related to vendor contracting, but it has not established policies related to training standards, working with other state customer service resources, or customer service measures.

¹³ *Minnesota Rules*, 7700.0090, subp. 1, posted July 11, 2013.

enrollment period.¹⁴ Also, for the first year of open enrollment, a notice that the rates would be posted on MNSure's website was published in the *State Register*, but there was no subsequent publication in the *State Register* when MNSure staff changed the rates prior to the first open enrollment period. MNSure belatedly published rates in the *State Register* for the second open enrollment period in early February 2015.

Third, MNSure did not establish until 2015 an interagency agreement with the Office of MN.IT Services required by state law. MNSure's enabling statute, which was enacted in March 2013, required the MNSure Board to establish "an agreement with the chief information officer of the Office of MN.IT Services for information technology services that ensures coordination with public health care programs."¹⁵ An agreement between the two agencies was executed in February 2015.¹⁶

RECOMMENDATIONS

The MNSure Board should:

- **Adopt consumer assister compensation rates annually and ensure that changes in the rates are published in a timely manner in the *State Register*; and**
 - **Adopt navigator, call center, and customer service policies in 2015.**
-

GOVERNANCE OF THE MNSURE ENROLLMENT SYSTEM

As our office's auditors and evaluators have worked with staff at MNSure, DHS, and the Office of MN.IT Services on this and other recent reviews, we have been asked to make a clear distinction between the *agency* called MNSure and the MNSure *enrollment system* these agencies have worked to develop. In addition, we have been asked to acknowledge that while the MNSure Board governs the agency, the MNSure enrollment system needs a different governance structure—one that provides DHS and the Office of MN.IT Services explicit authority to participate with MNSure in decisions about the system's maintenance and

¹⁴ For the first open enrollment period, MNSure issued the initial assister compensation rates in April 2013, before the MNSure Board was appointed. MNSure officials are not sure whether the Commissioner of Management and Budget—in his capacity to fulfill the duties of the MNSure Board before that board assumed its full statutory duties—authorized those rates.

¹⁵ *Minnesota Statutes* 2014, 62V.05, subd. 7(a)(1).

¹⁶ *Minnesota Statutes* 2014, 62V.05, subd. 7(a)(2), separately requires the MNSure Board to establish an agreement with DHS "for cost allocation and services regarding eligibility determinations and enrollment for public health care programs." Also, MNSure has a data-sharing agreement with the Office of MN.IT Services. However, these agreements are different than the one between MNSure and the Office of MN.IT Services required in statute regarding coordination of public health care programs.

modification. In our view, a clearly defined governance structure is necessary to manage changes to the enrollment system and hold state officials accountable for that system's performance.

Recognizing this need, administrators from MNSure, DHS, and the Office of MN.IT Services jointly established in late 2014 a governance structure for information technology decisions related to the health insurance exchange's enrollment system. There is now a decision-making body (the Executive Steering Committee) that includes representatives of each of these agencies and is chaired by a DHS deputy commissioner. There are other governance bodies in this structure, and there is also a Project Management Office staffed by the Office of MN.IT Services.¹⁷

We think that the creation of this structure was a worthy attempt to ensure more coordinated decision making on exchange-related information technology issues. But, in our view, the underpinnings of the current structure are inadequate.

The multiagency governing structure that began overseeing MNSure's enrollment system in late 2014 has no formal authority.

This information technology governance structure is not established in state law, so there is no assurance that it will continue as agency leadership changes. The affected agencies did not adopt bylaws, policies, or interagency agreements when they created this structure for MNSure's enrollment system. As a result, the scope of this structure's authority and the duties of its bodies are not clearly specified.

It is important to note that DHS has expressed concerns about the adequacy of this structure for overseeing the MNSure enrollment system. Individuals in public programs account for most of the system's enrollees, and DHS thinks that it should have legally defined authority and play a large role (along with counties) in the structure. DHS relies on the MNSure enrollment system for proper eligibility decisions for public health care programs, and DHS is held accountable for these decisions by both the federal and state governments.

RECOMMENDATION

The Legislature should establish in state law a structure for governing MNSure's online enrollment system.

At a minimum, this structure should include representatives from MNSure, DHS, the Office of MN.IT Services, and counties. We offer no recommendations on the exact make-up of this structure, but the Legislature should carefully consider its composition and leadership. Even if the Legislature adopts a structure that closely resembles the one informally implemented by executive branch agencies

¹⁷ The other governance bodies include a "Project Management Team" and "Change Control Board," each comprised of MNSure, DHS, and Office of MN.IT Services staff. As of late 2014, there were no written policies outlining the functions of the various governance components.

in 2014, there will be value in formalizing such an arrangement in law. This structure will make key decisions about information technology issues, and how to deploy resources to address them.

COMMUNICATIONS ISSUES

The development of a state-based health insurance exchange was a large undertaking, with many risks. For this reason, it was important for exchange staff to effectively convey information about the project's status to state leaders and project stakeholders.

Before the first open enrollment period, MNsure staff withheld key information from the board and other state officials.

Key officials told us they did not know until shortly before October 1, 2013, (or later, for some officials) about many of the system difficulties that staff were struggling to address. For example, the MNsure Board chair and the Commissioner of the Department of Management and Budget told us they do not recall being shown the Independent Verification and Validation reports that raised concerns about the exchange's readiness. (We discussed these reports in Chapter 2. MNsure hired a contractor to prepare these reports for the federal government on system readiness.) Some MNsure Board members said that the information on exchange operations they received from staff in the early months following their appointment was not very detailed; one said that staff responses to "deep questions" posed by the board tended to be brief. The board was unaware of some key staff decisions—such as the decision not to contract with an "overflow" call center before the online enrollment system started.¹⁸

In public meetings just prior to October 1, MNsure's executive director did not emphasize the system's remaining risks or incomplete testing. There was no mention in these meetings of contingency plans, in case the system did not work as intended. When asked by the co-chair of the MNsure Legislative Oversight Committee if the system was ready, MNsure's executive director said she was aware of "no smoking guns" that would argue for deferring the start of online enrollment within the next week.¹⁹ The next day, when asked by the chair of the MNsure Board whether the system was ready, the executive director said: "At this point, we feel that we've mitigated all of the areas that we've been tracking, and that we will be ready to go."²⁰ People we talked with said the executive director usually presented a fairly positive view of the system's readiness in public and private discussions. Board members did not believe they received

¹⁸ In Summer 2013, MNsure sought an overflow call center to assist MNsure's contact center if there was a large volume of calls. However, MNsure staff decided not to enter into a contract. As we discuss in Chapter 6, MNsure's contact center was overwhelmed by calls in Fall 2013.

¹⁹ MNsure Executive Director April Todd-Malmlov, comments to MNsure Legislative Oversight Committee (September 24, 2013). She also said staff would seriously consider any issues that came to light in their final reviews of the system.

²⁰ MNsure Executive Director April Todd-Malmlov, comments to MNsure Board (September 25, 2013).

enough information about system readiness, and some felt misled by MNsure staff leadership.

Officials in the Governor's Office told us they were surprised to learn in the weeks leading up to October 1 that there were significant issues that could threaten the new enrollment system's functionality. They said that, before the Governor was told in September 2013 of possible technical problems with the website, the exchange's executive director provided limited information about the exchange's progress. An official in the Governor's Office said the exchange's statutory governance structure—which gave the Governor less direct authority over the exchange than he had for other state agencies—may have contributed to MNsure's weak communication with the Governor's Office.

We also heard concerns from key stakeholders about communication during the exchange's planning stages. For example, insurers said exchange staff were not always forthcoming about known problems and did not listen enough to the advice insurers offered.²¹ Likewise, county officials said the functionality of MNsure's new enrollment system was more limited than what they were expecting, and some said their concerns had not received sufficient attention from MNsure and DHS.

MNsure leaders made greater efforts in 2014 to keep the MNsure Board and key stakeholders apprised of exchange developments than MNsure leaders did in 2013.

This largely reflected the change in MNsure's executive director in December 2013. Many people praised the intelligence and hard work of MNsure's first executive director but said she did not always communicate effectively with others about the exchange. Her replacement received better marks from people we talked with for soliciting input from various groups and trying to make MNsure's activities more transparent.

Counties expressed continued frustration to us well into 2014 that MNsure and DHS were not giving sufficient attention to their concerns about the exchange's functionality.²² However, MNsure, DHS, and the Office of MN.IT Services included a county representative on the Executive Steering Committee of the information technology project governance structure they recently established, which was a useful step.

²¹ While insurers expressed concern about their communication with exchange staff at MNsure and its predecessor agency (the Department of Management and Budget), they expressed no significant concern about communications—before or after the enrollment system opened—with the departments of Commerce and Health, which also perform exchange-related tasks.

²² During planning for the MNsure enrollment system and after its implementation, counties had opportunities to discuss the system at DHS's County Roles and Responsibilities Workgroup. In early 2014, DHS hired a MNsure Implementation Director who had extensive experience working with counties.

GENERAL GOVERNANCE RECOMMENDATIONS

The Legislature established MNsure as a state agency, but it gave MNsure a different structure than most departments of state government. First, MNsure is, by law, governed by a part-time board rather than a commissioner. When a state agency is governed by a multi-member board, the agency's accountability is more diffuse than it would be if it were governed by a single administrator. Second, MNsure's chief executive officer is appointed by the MNsure Board and not the governor. While the board has statutory authority to govern MNsure, the staff have played a large role in MNsure's development and ongoing operations—perhaps a larger role than the board. However, the accountability of staff to the governor is indirect, occurring only through the selection of the chief executive officer by the governor-appointed board. In our view, the Legislature should amend MNsure's governance structure.

RECOMMENDATION

The Legislature should amend state law to give the governor, rather than the MNsure Board, authority to appoint the MNsure chief executive officer.

In our view, an agency with the importance and visibility of MNsure should be directly accountable to the governor. At a minimum, we recommend that the Legislature make MNsure's top administrative position one that is appointed by the governor. MNsure is an agency with widespread public impacts, and some of MNsure's problems in its short history have had profound impacts on consumers trying to apply for health insurance. We think the staff leader of MNsure should be accountable to the state's highest elected official and not just to an unelected board. Establishing this direct line of accountability might also promote better communication between the governor and MNsure.

OPTIONS FOR CONSIDERATION

The Legislature should consider whether to retain the MNsure Board as a governing body or to make it advisory.

If the Legislature makes the chief executive officer position directly accountable to the governor, the Legislature should also re-evaluate the status of the MNsure Board. Exhibit 3.1 discusses two options.

One option would be for the MNsure Board to serve in a purely advisory capacity to MNsure's top administrator. This approach would maintain a mechanism for MNsure to receive public input, while giving greater authority to a MNsure administrator who is directly accountable to the governor. This option—vesting authority in an administrative appointee rather than a board—would also be

Exhibit 3.1: Reasons for Changing or Keeping the MNsure Board's Role

Reasons to Change the MNsure Board to Serve as an Advisory Role, Not a Governing Role (Option 1)

- Most state departments are governed by individual administrators, not governing boards. This is because accountability is more diffuse and less direct when governance rests with a multi-member board rather than one administrator.
- Administrative staff have direct, daily involvement in issues that may be less familiar to members of a part-time board.
- For issues requiring swift action, an agency administrator can usually act more quickly than a part-time board.
- It may be more challenging to recruit strong board members in the future. Under state law, MNsure Board members now receive a salary; starting in 2016, they will receive more limited compensation.^a

Reasons to Maintain the MNsure Board's Role as a Governing Body (Option 2)

- MNsure policy decisions should be made by individuals who understand the needs of key users (consumers and small employers) or have specialized expertise (for example, in health care purchasing or health care delivery systems). State law requires MNsure Board members to meet such requirements;^b there are no specific statutory requirements for MNsure's top administrator.
- Board members may provide a more independent perspective regarding policy issues and agency oversight than an administrator who is an agency employee.
- A governing board that holds public meetings may provide transparency that would be difficult to achieve if governing authority rested with MNsure administrative staff.

^a *Minnesota Statutes* 2014, 62V.04, subd. 12.

^b *Ibid.*, subd. 2.

SOURCE: Office of the Legislative Auditor.

consistent with the governance structure of most of Minnesota's executive branch departments.

A second option would be to have both a governor-appointed MNsure administrator and a governor-appointed governing board. This model is used by the Minnesota Pollution Control Agency (MPCA). The MPCA's commissioner directs that agency's day-to-day administrative activities and is a member of the governor's cabinet.²³ The board consists of eight members appointed by the governor with the advice and consent of the Senate, plus the MPCA commissioner. The MPCA board sets policy and agency direction, and it makes final decisions on important or controversial issues. Having a governing board may help to ensure that an agency makes decisions through a public, deliberative process.

We offer no recommendation about which option to adopt. As described earlier, the MNsure Board did not yet have formal authority at the time when most key decisions related to the 2013 launch of the exchange occurred. Thus, within

²³ *Minnesota Statutes* 2014, 116.02, subd. 1.

MNsure, primary responsibility for MNsure's shortcomings in the initial enrollment period rested with staff, not the board. Since the launch, the board has exercised more active oversight of MNsure. In our view, however, it would make sense to reconsider the board's role if the MNsure chief executive officer becomes a governor-appointed position.

MNsure's governing officials—whether the top administrator, the board, or both—will face important challenges in coming months and years.

First, hundreds of thousands of persons currently enrolled in public health care programs may start using MNsure to re-enroll in 2015. This transition has been delayed several times already, due to the problems with MNsure's enrollment system. It remains to be seen whether MNsure's technology can accommodate this influx of enrollees, and whether its enrollment system can accurately determine eligibility.

Second, MNsure's future financial viability will depend partly on the number of people who choose to enroll in commercial products through MNsure. Expenditures from MNsure's large federal grants are expected to decline. Thus, MNsure's expenditures will increasingly be paid by a "withhold" of a portion of premiums for insurance products sold through MNsure. MNsure's number of 2014 enrollments in commercial products was lower than the target set by staff in October 2013, and in late 2014 the MNsure Board revised its budget projections based on new, less ambitious assumptions regarding the number of future enrollees in commercial programs.

Third, the MNsure Board must decide whether—and how—to restrict which products are sold through MNsure. Through 2015, insurers participating in MNsure have been allowed to sell any products that meet the certification requirements of the Affordable Care Act. However, starting in 2015, state law authorizes the MNsure Board to determine which products may be offered through MNsure.²⁴

Fourth, MNsure must improve the consumer enrollment experience. Although various "fixes" to some of the problems with the MNsure website and customer service center have already been implemented, MNsure officials told us the consumer experience needs additional attention. This may include enhancements to MNsure's own technology and customer service strategies.²⁵

Fifth, the MNsure Board is considering whether there is a need for changes in MNsure's relationship with the Department of Human Services (DHS). A board work group recently identified two options for organizing the exchange. On the one hand, it said, MNsure could continue to be the lead agency for enrolling

²⁴ *Minnesota Statutes* 2014, 62V.05, subd. 5(e).

²⁵ Also, MNsure could consider ways to use private health insurance exchanges or web-based brokers, which sell insurance from multiple insurers through their websites, in the enrollment process. Federal regulations authorize private exchanges and web-based brokers to provide enrollment assistance, although exchanges still must perform eligibility determinations before people can enroll in qualified health plans.

individuals into public health care programs and qualified health plans. Alternatively, the work group said, DHS could become the lead agency for enrolling individuals into public programs. The latter option would be a fundamental governance modification and would require statutory changes. As of late 2014, these options were still in the early stages of board consideration.

If the Legislature retains the MNsure Board in either a governing or advisory capacity, it may wish to consider whether there is any need to change the board's composition. We offer no recommendation on the proper composition of the board. There was legislative debate in 2013 about whether health care industry professionals (such as people working for insurers) should be allowed to serve on the board. This remains a reasonable topic for discussion. Current MNsure law prohibits certain categories of people from serving on the MNsure Board.²⁶ Some people maintain that such a prohibition is unnecessary because state laws regarding conflict of interest provide sufficient protection against board members making decisions based on their economic interests. For example, the statutes governing the Minnesota Pollution Control Agency do not prohibit representatives of regulated businesses from serving on the MPCA Board, but members of this board are required by state rules to recuse themselves from certain decisions in which they have a financial or employment interest.²⁷ In addition, some people think there would be value in having knowledgeable people from the health care industry serving on the MNsure Board.

²⁶ *Minnesota Statutes* 2014, 62V.04, subd. 4(a), states: "Within one year prior to or at any time during their appointed term, board members...shall not be employed by, be a member of the board of directors of, or otherwise be a representative of a health carrier, institutional health care provider or other entity providing health care, navigator, insurance producer, or other entity in the business of selling items or services of significant value to or through MNsure."

²⁷ *Minnesota Statutes* 2014, 116.02, subd. 3. The law says that no MPCA Board member other than the commissioner shall be an officer or employee of the state or federal government. The law limits to two the number of members who are officials or employees of a municipality or governmental subdivision; neither may be a member ex officio or otherwise on the management board of a municipal sanitary sewage disposal system. *Minnesota Rules*, 7000.9000, subp. 1, posted April 20, 2004, established a policy for MPCA members regarding conflict of interest.

Chapter 4: Enrollment

MNsure’s success depends on its ability to enroll people in health insurance. MNsure’s enrollment system has three primary responsibilities: (1) to determine consumers’ eligibility for the public health insurance programs administered by the Department of Human Services—chiefly Medical Assistance and MinnesotaCare; (2) to serve as a marketplace that facilitates the comparison and purchase of certain commercial health insurance products, known as qualified health plans; and (3) to determine consumers’ eligibility for federal tax credits and cost-sharing reductions that lower the premiums and out-of-pocket expenses associated with qualified health plans.¹ In this chapter, we critically examine MNsure’s reported enrollment, analyze the characteristics of enrollees, and discuss what is known about the extent to which MNsure enrollees were previously uninsured.

KEY FINDINGS IN THIS CHAPTER

- **MNsure met its overall enrollment target for the first enrollment period, but this target was seriously flawed due to a Department of Human Services error that significantly underestimated Medical Assistance enrollment.**
- **Survey results showed that 28 percent of individuals who enrolled in commercial insurance through MNsure were uninsured immediately before they enrolled.**
- **MNsure’s data reporting capabilities are weak, limiting its ability to produce information for management and decision-making purposes.**

TOTAL ENROLLMENT

Before discussing MNsure’s total number of enrollments, it is important to discuss how MNsure counts enrollments for reporting purposes. We think there are several distinctions worth making.

First, what it means to be “enrolled” by MNsure depends on whether one obtains public or commercial insurance. For public programs, MNsure considers a person to be enrolled from the point at which the person is deemed eligible for that program. For qualified health plans (that is, commercial insurance), MNsure considers individuals to be enrolled when they select an insurance product.

¹ MNsure also sells health insurance for employees of small businesses and stand-alone dental insurance. These types of insurance are not discussed in this chapter.

Second, the definition of enrollment in a qualified health plan is different in 2015 than it was in 2014. In 2014, individuals were given several options for payment methods, and they had to select a method—in addition to selecting an insurance product—to be considered enrolled. In 2015, individuals no longer have a choice of payment method, so they are considered enrolled as soon as they select an insurance product.

Third, MNsure’s definition of “enrolled” is different from an insurer’s definition of “enrolled.” An insurer considers people who selected qualified health plans through MNsure to be enrolled only when they pay their first month’s premiums. MNsure’s enrollment data (unlike the enrollment data of the insurers) do not take into account whether payments have been made.

Between October 1, 2013, and November 11, 2014, MNsure reported that it processed about 371,000 enrollments in health insurance for 2014 coverage.

The total number of reported enrollments included 234,751 enrollments in Medical Assistance; 80,387 enrollments in MinnesotaCare; and 55,900 enrollments in qualified health plans.

MNsure’s publicly reported total of enrollments is a cumulative measure; it does not reflect any attrition that occurred. Although qualified health plan enrollees are supposed to notify MNsure if they terminate their insurance coverage, such communication does not always occur. In our September 2014 survey of a sample of enrollees in qualified health plans, 13 percent said that they had terminated or never received their coverage by the time of our survey.² This is generally consistent with a statement made by MNsure’s chief executive officer at a MNsure Board meeting in September 2014. He said that the actual number of MNsure-enrolled qualified health plan enrollees as of that month was about 85 percent of MNsure’s reported cumulative enrollment figure, according to data from the insurers.³

The attrition rate for Medical Assistance appears to be much lower than the attrition rate for commercial products. Data from the Minnesota Department of Human Services indicate that there was an average of 242 “disenrollments” of MNsure-processed Medical Assistance enrollees per month between February and August 2014.⁴ This would suggest an attrition rate of about 0.9 percent of

² See the Introduction for a description of the survey. Some MNsure “enrollees” may never have actually obtained insurance coverage, although we were unable to determine the extent of this. In our survey of enrollees, 8 respondents (out of 281) indicated in written comments that they had never received insurance coverage through MNsure. Because respondents did not provide this information in response to a direct question about ever receiving insurance coverage from MNsure, there may have been others we surveyed who never obtained coverage.

³ Thus, about 47,500 persons would have been enrolled in qualified health plans as of Fall 2014, compared with the cumulative 55,900 qualified health plan enrollments reported by MNsure.

⁴ A “disenrollment” was defined for these purposes as someone who was eligible for Medical Assistance in the previous month but not eligible for Medical Assistance in the current month (for example, eligible in January 2014 but not in February 2014).

MNsure's reported Medical Assistance enrollments over the course of MNsure's first year.⁵

Access to Management Information

In the early stages of our evaluation, we talked with staff from MNsure and the Office of MN.IT Services about how we could obtain enrollment data for analyses we wanted to conduct. We learned that the ability of staff to access and extract data from the MNsure system was limited.

The MNsure enrollment system lacks good reporting capabilities, making it difficult for MNsure to extract data needed for management and decision-making purposes.

During the first year of enrollment, MNsure's enrollment system contained various personal identifiers—such as Social Security numbers and something called the “MNsure ID”—but no single identifier provided a consistent, reliable basis for tracking consumers end-to-end in the enrollment process. The data were stored in nearly 3,000 tables, making it very difficult for analysts to know where to look to find any particular data field. Staff were still learning the system components and at times felt “completely dependent” on the information technology vendors to understand the system.

Deficiencies in MNsure's data reporting capabilities created additional work for insurers with respect to federal reporting of enrollees' receipt of tax credits. The federal Centers for Medicare and Medicaid Services (CMS) requires aggregated monthly reporting of the total premiums owed and the total tax credit amount selected by all individuals enrolled in each insurance product sold through MNsure. CMS uses the reports to make payments to insurers for those enrollees receiving tax credits. CMS requires that this reporting be done either by MNsure or by the insurers, but it must be done by only one or the other. MNsure generated reports for CMS in December 2013 and January 2014. However, MNsure found these reports “very challenging” to produce. As a result, the subsidy reporting responsibility was shifted to the insurers—with their assent—making this task one of several that insurers have had to complete that they originally expected to be done by MNsure.

Staff from the Office of MN.IT Services have been unable to generate “repeatable” reports from MNsure's enrollment data, making the data retrieval process time intensive. One solution to this problem would be to develop an electronic “data warehouse,” a storage system that facilitates efficient and intuitive data retrieval. Information technology staff told us that, in many systems, there is an advantage to building a data warehouse after the system is actually operating. In mid-2014, a MNsure official told us that it was MNsure's intention to construct such a warehouse over a three- to five-year period. However, we were also told that the eligibility software that MNsure selected for

⁵ MNsure reports that there were 196,027 cumulative Medical Assistance enrollments as of September 8, 2014. There were 1,695 MNsure-processed Medical Assistance disenrollments by the end of August 2014 not accounted for in the cumulative enrollment number.

its enrollment system is dependent on having a data warehouse to translate the data and make it accessible, which suggests there should be some urgency in addressing that issue.

RECOMMENDATION

MNsure should develop ways to improve its access to the applicant and enrollee data it collects—for the purpose of assessing MNsure performance, generating management reports, and responding to public inquiries.

We recognize that development of a data warehouse has not been MNsure's top priority, given the need to address the basic functionality of the MNsure enrollment process. But, for management and accountability purposes, it is important for MNsure to more readily access the information it collects.

Until late 2014, MNsure did not have what information technology experts call a "system of record" in its enrollment data that would have provided comprehensive and authoritative documentation of consumers' ultimate enrollment choices. In late 2014, the Office of MN.IT Services developed a "system of record" within the MNsure enrollment system. As of early January 2015, however, MNsure was not able to transmit electronic enrollment records of acceptable quality to insurers in the expected format (known as an 834EDI file). Such files normally require little manual processing by insurers, but the files they received from MNsure were delayed by weeks and contained what insurers believed to be "obvious" errors and duplicated enrollment data. To ensure accuracy, insurers had to rely on supplemental data provided by MNsure in an alternate format (known as an 834ST file), which required extensive manual processing. The recent development of a "system of record" within MNsure's enrollment system should help MNsure to track the records associated with individual consumers who have applied or enrolled through MNsure. We suggest that MNsure develop additional improvements in its ability to extract and analyze applicant and enrollee data.

Duplicate records in MNsure's data have made it more difficult for MNsure to accurately report on enrollment.

While analyzing MNsure's enrollment data, we saw many instances of duplicate records. Some appeared to reflect real duplications of individual enrollments, while others did not. For example, some individuals went through the application and enrollment process more than once because of technical problems they encountered. Also, some individuals submitted more than one application in an effort to amend information submitted in previous applications. As a result, some individuals actually had multiple records within MNsure's data. Information on dependents (spouses and children) sometimes appeared in MNsure records as duplicates of the person who submitted the application. In such cases, MNsure had to manually enroll the dependents because the enrollment system had lost their enrollment information. Because of uncertainty

about the nature of duplicate records in MNSure's data, we had to make certain assumptions when analyzing enrollee characteristics.⁶

Some of the duplicate records hindered MNSure's ability to publicly report on its enrollments. For instance, some duplicate enrollments indicated that an individual had selected more than one insurance product, perhaps on the same date. Thus, for purposes of reporting the products individuals purchased, MNSure had to make an effort to deduce which product the person ultimately selected. MNSure often used payment data to make this determination, but sometimes even these data did not enable MNSure to determine this conclusively. In these cases, MNSure relied on communications with the insurers or the consumers to determine which product the individuals actually purchased.

ENROLLEE CHARACTERISTICS

We used enrollee data obtained from the Office of MN.IT Services, MNSure, and the Department of Human Services to examine some characteristics of enrollees, such as where they lived, whether they received subsidies, and their age and gender. We did not examine the racial and ethnic characteristics of enrollees because enrollees were not required to provide race/ethnicity data and often did not.⁷ Thus, although MNSure set enrollment goals for racial/ethnic groups and developed strategies to achieve these goals, MNSure cannot (and we could not) evaluate MNSure's success in this area.⁸ Exhibit 4.1 shows those characteristics that we could reliably measure for most enrollees based on the available data.

Enrollments by Region

For each region of Minnesota, we examined the number of MNSure enrollees (ages 18 to 64) as a percentage of the number of uninsured people (ages 18 to 64)

⁶ If an individual had multiple enrollment records, we looked only at the record corresponding to the latest date of enrollment. If there were multiple enrollments on the latest date of enrollment, we chose any one of that person's records to examine, but treated any information that differed across records from that same date as unknown. For example, if someone enrolled with more than one insurer on the same last date, we treated that person's insurer as unknown.

⁷ The application questions on race and ethnicity allowed respondents to write in a response. Those responses included many that were not amenable to standard categorization. The written responses further revealed that many people experienced website difficulties with the race question. Specifically, some users commented that the box for "Japanese" was already checked for them, and those users who wished to uncheck the box were not able to do so.

⁸ As discussed below, the overall enrollment projection was seriously flawed. Any derivative projections—such as those for race and region of the state—were likewise flawed.

Exhibit 4.1: Characteristics of MNsure Enrollees (October 1, 2013, to June 30, 2014)

Attribute	Qualified Health Plan	Medical Assistance	MinnesotaCare
Gender			
Female	51.3%	51.3%	53.3%
Male	<u>48.7</u>	<u>48.7</u>	<u>46.7</u>
	100.0%	100.0%	100.0%
Age (years)			
0-17	9.7%	35.7%	2.4%
18-24	5.8	13.7	11.5
25-34	19.1	20.8	27.4
35-44	14.9	10.8	17.0
45-54	19.3	10.3	18.6
55-64	31.0	8.6	20.7
65+	<u>0.3</u>	<u>0.1</u>	<u>2.4</u>
	100.0%	100.0%	100.0%
Region (Rating Area)^a			
South East (1)	6.5%	7.2%	6.7%
North East (2)	6.0	5.9	6.3
South Central (3)	3.8	4.5	4.0
South West (4)	1.7	2.0	1.8
Mid Central (5)	3.4	3.8	3.6
West Central (6)	3.6	4.1	3.9
North Central (7)	8.0	9.0	8.9
Twin Cities (8)	66.0	62.3	63.6
North West (9)	<u>1.0</u>	<u>1.3</u>	<u>1.2</u>
	100.0%	100.0%	100.0%
Metal Level			
Platinum	26.8%		
Gold	12.1		
Silver	34.2		
Bronze	25.3		
Catastrophic	0.9		
Unknown	<u>0.8</u>		
	100.0%		
Insurer			
Blue Cross Blue Shield	22.5%		
HealthPartners	12.0		
Medica	4.6		
PreferredOne	58.9		
UCare	1.4		
Unknown	<u>0.6</u>		
	100.0%		
Total Enrollment	54,026	152,671	56,654

NOTES: Our total enrollments may differ from what MNsure had reported as of July 10, 2014, due to differences in when the data were extracted and in how we removed duplicate enrollment records. Duplicate records are instances when two or more observations in the data have the same identifying information. "Unknown" categories represent individuals for whom the data contained duplicate records from the same (most recent) enrollment date that did not all report the same metal level or insurer.

^a The counties in each rating area are shown in Appendix C.

SOURCE: Office of the Legislative Auditor, analysis of MNsure enrollment data provided by the Office of MN.IT Services.

in that region.⁹ Appendix C shows a list of counties in each region. Our analysis was not intended to indicate how many uninsured people enrolled in MNsure. Rather, we used the number of uninsured people as a rough measure of the relative size of MNsure's potential customer pool in each region. Results are shown in Exhibit 4.2.

Exhibit 4.2: Enrollment of Nonelderly Adults as a Share of the Uninsured Population by Region (October 1, 2013, to June 30, 2014)

Region/Rating Area	Uninsurance Rate, Overall	Uninsurance Rate, Ages 18-64	Overall Enrollment ^a	Qualified Health Plan Enrollment ^b	Medical Assistance Enrollment ^c	MinnesotaCare Enrollment ^d
South East (1)	7.9%	10.7%	48.7%	20.2%	58.2%	53.8%
North East (2)	8.6	11.4	56.9	24.8	63.1	68.9
South Central (3)	7.9	10.1	51.2	21.5	54.5	61.3
South West (4)	8.7	12.3	42.3	16.6	49.3	50.4
Mid Central (5)	8.6	11.4	50.3	17.4	66.0	59.9
West Central (6)	8.0	10.9	52.5	19.1	67.5	67.3
North Central (7)	10.3	13.9	50.3	18.3	61.8	63.1
Twin Cities (8)	8.5	11.0	54.7	23.3	66.5	65.1
North West (9)	9.6	12.9	36.4	11.0	52.3	45.0
Margin of Error	0.1 - 0.6	0.2 - 0.8	0.9 - 2.7	0.6 - 1.7	2.2 - 7.1	3.0 - 9.3

NOTES: These calculations were derived from aggregated, county-level data, making it difficult to estimate a precise standard error. We show the approximate range of margins of error for each column to indicate that there is some degree of uncertainty around the estimates.

^a Overall enrollment is expressed as the ratio of the number of people in the region ages 18 to 64 enrolled in any plan or program through MNsure to the number of uninsured people ages 18 to 64 in that region.

^b Qualified health plan enrollment is expressed as the ratio of the number of people in the region, ages 18 to 64, enrolled in a qualified health plan through MNsure to the number of uninsured people of any age in that region with incomes at least 200 percent of the federal poverty level. For a single adult with no dependent children, 200 percent of the federal poverty level was equal to \$23,340 in annual income in 2014.

^c Medical Assistance enrollment is expressed as the ratio of the number of people in the region, ages 18 to 64, enrolled in Medical Assistance through MNsure to the number of uninsured people of any age in that region with incomes between 0 and 138 percent of the federal poverty level. For a single adult with no dependent children, 0 to 138 percent of the federal poverty level was equal to \$0 to \$16,105 in annual income in 2014.

^d MinnesotaCare enrollment is expressed as the ratio of the number of people in the region, ages 18 to 64, enrolled in MinnesotaCare through MNsure to the number of uninsured people of any age in that region with incomes between 139 and 200 percent of the federal poverty level. For a single adult with no dependent children, 139 to 200 percent of the federal poverty level was equal to \$16,106 to \$23,340 in annual income in 2014.

SOURCES: Office of the Legislative Auditor, analysis of MNsure enrollment data and uninsurance rates from the 2009-2013 American Community Survey.

⁹ The regions are the nine "rating areas" as defined by the departments of Commerce and Health. This analysis included all public program and qualified health plan enrollees who were ages 18 to 64 as of June 30, 2014. We used county-level data on the uninsured population from the 2009-2013 American Community Survey (ACS); we aggregated those data into regional-level data. The ACS is conducted annually by the U.S. Census Bureau and is representative of the civilian, noninstitutionalized U.S. population. Use of the five-year pooled sample achieves a sample size that permits estimation of the number of uninsured people for all Minnesota counties.

The number of MNSure enrollees relative to the size of MNSure's potential pool of customers was lowest in northwest and southwest Minnesota.

For example, the number of MNSure enrollees in northeast Minnesota was 57 percent of the number of uninsured people in that part of the state. In contrast, the number of MNSure enrollees in northwest Minnesota was about 36 percent of the number of uninsured people in that part of the state. Similarly, the number of Medical Assistance enrollees in the Twin Cities metropolitan area was 67 percent of the number of uninsured people with incomes below 138 percent of the federal poverty level in that part of the state. In contrast, the number of Medical Assistance enrollees in northwest Minnesota was about 52 percent of the number of uninsured people with incomes below 138 percent of the federal poverty level in that part of the state, and in southwest Minnesota it was about 49 percent.

Receipt of Subsidies

We also examined the extent to which qualified health plan enrollees obtained subsidies through MNSure. As described in Chapter 1, people who enrolled through MNSure in a qualified health plan may have been eligible for (1) an advanced premium tax credit (APTC) or (2) a cost-sharing reduction (CSR). These subsidies help to lower premium costs or out-of-pocket health care expenses.¹⁰

Qualified health plan enrollees can be divided into two categories: those who requested that MNSure check their eligibility for subsidies, and those who did not. We estimate that the former group, which includes both people who are determined eligible for a subsidy and those who are determined ineligible for a subsidy, constituted approximately 82 percent of qualified health plan enrollees. We estimate that 18 percent of qualified health plan enrollees chose not to check their eligibility for subsidies while enrolling.¹¹ The extent to which these persons would have qualified for subsidies had they completed the eligibility determination process is unknown.

Our analysis found that at least 41 percent of qualified health plan enrollees received the advanced premium tax credit, and 13 percent received a cost-sharing reduction.

MNSure reported that 45 percent of current qualified health plan enrollees received the advanced premium tax credit and 14 percent received cost-sharing reductions, as of August 2014. This was based on data MNSure obtained from health insurers, and it reflected persons enrolled at the time the data were collected. We made our own estimate, using data on individuals who enrolled in a qualified health plan at any time from October 2013 through June 2014. Our

¹⁰ The availability of tax credits was one of the most-cited reasons by survey respondents when asked why they purchased health insurance through MNSure rather than directly from an insurer. That response was given by 37 percent of survey respondents.

¹¹ Consumers had the option to answer additional application questions to determine their eligibility for subsidies and public insurance programs, or not.

analysis indicated that 41 percent of individuals who were ever enrolled in a qualified health plan received an APTC, and 13 percent received a CSR. It is worth noting that some enrollees qualify for both an APTC and a CSR.

Both MNsure's and our estimates were based on those who qualified for a tax credit greater than \$0 and who chose to take at least some of that tax credit as a monthly reduction in premiums. Neither estimate included those enrollees who qualified for the tax credit but chose to get a refund on their taxes rather than apply the credit to monthly premiums. MNsure's enrollment data did not allow us to determine how often this occurred. As mentioned earlier in this chapter, MNsure depends on health insurers to accurately report APTC eligibility and amounts to the federal Centers for Medicare and Medicaid Services, but the insurers do not have data on persons who will be receiving their tax credit as a tax refund.¹² Therefore, both MNsure's and our estimates of tax credit usage are likely to be undercounts.

MNsure's enrollment data do not allow for a complete determination of all individuals who were eligible for a tax credit. In the MNsure data we examined, it was only possible to see the amount of tax credit that a consumer selected to receive as a monthly reduction in premiums, which was not necessarily the full amount that the person was qualified to receive.¹³ All qualified health plan enrollees who did not select an amount greater than \$0 appeared in the data as having selected a tax credit of \$0. Therefore, the following groups were not differentiated in the data: (1) those who chose not to have their eligibility for a tax credit determined; (2) those who were found ineligible for the tax credit; and (3) those who were found eligible for the tax credit but chose to defer it as a tax refund.¹⁴ Exhibit 4.3 shows the median selected tax credit by age, gender, and other characteristics among those enrollees who selected a tax credit greater than \$0.

ENROLLMENT PROJECTIONS

It was challenging for MNsure to project participation in the health insurance exchange, given that the state had no prior experience running an exchange. MNsure contracted with experts to help it project participation levels, and it refined projections over time. Most of MNsure's enrollment projections were for 2016; our analysis focused on MNsure's projections for 2014.

¹² The insurers do not need such data because the consumer is paying the entirety of his or her premium.

¹³ When consumers were deemed eligible to receive a tax credit, they were shown the maximum amount of tax credit for which they qualified. They then had to select how much of that tax credit they wanted to apply toward their monthly premiums; they could choose any amount from \$0 up to the maximum.

¹⁴ Another group that is shown in the data as having a selected tax credit of \$0 is persons who met the eligibility requirements for the tax credit but received a maximum credit of \$0 because the "benchmark plan" in their service area costs less than their required contribution. The benchmark plan is the second-lowest-cost silver plan in a given service area.

Exhibit 4.3: Median Monthly Amount that MNsure Enrollees Selected for Advanced Premium Tax Credit (October 1, 2013, to June 30, 2014)

Head of Household Attribute	Median Advanced Premium Tax Credit
Gender	
Female	\$146
Male	154
Age (years)	
0-17	\$100
18-24	69
25-34	41
35-44	57
45-54	118
55-64	199
65+	213
Region (Rating Area)^a	
South East (1)	\$344
North East (2)	195
South Central (3)	201
South West (4)	201
Mid Central (5)	166
West Central (6)	154
North Central (7)	161
Twin Cities (8)	116
North West (9)	138
Metal Level^b	
Platinum	\$137
Gold	146
Silver	184
Bronze	122
Insurer	
Blue Cross Blue Shield	\$208
HealthPartners	117
Medica	256
PreferredOne	132
UCare	111
Overall Median	\$154

NOTES: The data in this exhibit are representative of qualified health plan enrollees who were identified in their MNsure application as "head of household." The median amounts presented here refer only to heads of household who qualified for a tax credit and who chose to accept at least some of that tax credit as a monthly reduction in premiums. (N=14,505)

^a The counties in each rating area are shown in Appendix C.

^b MNsure's data showed that the median amount of a tax credit selected by people who enrolled in catastrophic plans was \$10. However, people who enrolled in a catastrophic plan were not eligible for subsidies. It is unclear why the data showed that some of these people received subsidies.

SOURCE: Office of the Legislative Auditor, analysis of MNsure enrollment data provided by the Office of MN.IT Services.

During the first open enrollment period, MNsure enrolled more persons than it had projected, but only because the projection for Medical Assistance enrollment was a flawed underestimate.

MNsure staff presented 2014 enrollment projections to the MNsure Board in October 2013. The projections were broken out by those that would occur during the first open enrollment period (ending March 31, 2014) and those that would occur during the remainder of calendar year 2014. In Exhibit 4.4, we compare the projected and actual enrollments for the first open enrollment period.

Exhibit 4.4: Projected and Actual Enrollments for the First Open Enrollment Period (October 1, 2013, to March 31, 2014)

Type of Enrollee	Projection	Actual Enrollment
Qualified Health Plans	69,904	47,902
SHOP (small business)	8,925	726
MinnesotaCare	44,084	37,985
Medical Assistance	<u>12,240</u>	<u>99,531</u>
TOTAL	135,153	186,144

NOTES: Projections were presented to the MNsure Board on October 16, 2013. "Actual enrollment" reports enrollments as of April 13, 2014. The figures for SHOP represent individuals, not businesses.

SOURCES: MNsure staff documents presented to MNsure Board, specifically *2014 Enrollment Goals* (St. Paul, October 16, 2013) and *Enrollments by Program, April 13, 2014* (St. Paul, April 16, 2014).

The actual MNsure enrollment in Medical Assistance (MA) far exceeded MNsure's projected MA enrollment. That projection, along with the MinnesotaCare projection, was prepared by the Department of Human Services' (DHS's) Reports and Forecasts Division in September 2013. In response to our inquiry about the MA projection, DHS said that its projection was an error; it did not include all of the new MA cases DHS intended to include. We think this error should have been obvious since the projection of 12,240 new MA enrollees over a six-month period was much lower than past enrollment numbers. In just a single month (August 2013), DHS enrolled 23,178 new people in MA, nearly twice as many as it projected for all of MNsure's first open enrollment period. DHS said it noticed its error in the spring of 2014. MNsure's total enrollment goal of 135,153 was never revised; MNsure continued to use the original projection as a benchmark for its enrollment success. If a more realistic projection of MA enrollment had been included in MNsure's projections (at least 100,000), actual total enrollments through MNsure for the first open enrollment period would have fallen far short of the overall projection, since other types of enrollment were low.

MNsure projected large increases in its number of MA and MinnesotaCare enrollees for the remainder of 2014 beyond open enrollment. Those projections envisioned a large-scale eligibility redetermination and conversion of hundreds of thousands of existing public program enrollees from DHS's existing

enrollment systems to MNSure's system. However, as discussed in Chapter 2, concerns over the MNSure system's lack of functionality led DHS to scrap that original plan. Only a relatively small number of conversions occurred by the end of 2014, with the rest now planned to be moved into either the MNSure enrollment system or the existing DHS system (MAXIS) by the end of 2015.¹⁵

For the remainder of 2014 beyond open enrollment, MNSure projected to enroll an additional 32,896 persons in qualified health plans, for a total of 102,800 qualified health plan enrollees. As of November 11, 2014, 55,900 persons had enrolled in qualified health plans, or 54 percent of the 2014 target. In late 2014, MNSure lowered its qualified health plan enrollment goals for the second open enrollment period. MNSure now bases its fiscal year 2015 budget on a target of 67,000 qualified health plan enrollees, including 37,000 renewals of coverage year 2014 enrollees and 30,000 new enrollees.

Gruber-Gorman Reports

In 2011, the Minnesota Department of Commerce hired Jonathan Gruber, professor of economics at the Massachusetts Institute of Technology, and the firm Gorman Actuarial to estimate the impact of the ACA and a state-based health insurance exchange on Minnesota.¹⁶ Together, the amount of the contracts was \$560,000.

The Gruber-Gorman estimates of the Affordable Care Act's impacts on Minnesota were for 2016, making it premature to fully assess their accuracy.

Legislators and legislative staff have posed some questions about the accuracy of the Gruber-Gorman projections. Appendix E compares the 2013 Gruber-Gorman projections for 2016 with what is known as of early 2015. In some cases, the projections appear to be quite different from what has actually occurred. However, we think that a fair assessment of the projections cannot be made until the full period of the projections has passed.

MNSURE'S IMPACT ON THE UNINSURED POPULATION

The State Health Access Data Assistance Center (SHADAC), a health policy research center at the University of Minnesota, released a report in June 2014 that examined aggregate shifts in health insurance coverage among Minnesotans

¹⁵ In November 2014, DHS started processing Medical Assistance enrollee renewals in MAXIS, based on modified adjusted gross income. The Centers for Medicare and Medicaid Services has approved this type of eligibility determination process for Minnesota and some other states.

¹⁶ Professor Gruber worked as a consultant for Massachusetts when that state implemented its health reforms in 2006. Those reforms became a basis for the Affordable Care Act, and Professor Gruber served as a consultant to the federal government during the crafting of that legislation.

occurring between September 30, 2013, and May 1, 2014.¹⁷ The analysis used a methodology that has been employed by the Minnesota Department of Health since the early 1990s of taking the total state population and subtracting from it the number of people known to have various types of insurance. After all types of insurance have been taken into account, the remaining share of the population is assumed to be uninsured.

The number of uninsured Minnesotans fell significantly after MNsure opened for business, but the impact of MNsure on this reduction is unclear.

SHADAC determined that the number of uninsured Minnesotans decreased by 180,520 over the seven-month period of analysis. This represented a 40.6 percent decline in the uninsurance rate, which fell from 8.2 percent to 4.9 percent of the state's population. As of May 1, 2014, SHADAC estimated that 264,480 Minnesotans remained uninsured.

Most of the drop in the uninsurance rate occurred because Medical Assistance enrollment grew by about one-third, from 11.5 percent of the state's population in September 2013 to 15.3 percent in May 2014.¹⁸ As discussed in Chapter 1, the expansion of Medical Assistance, Minnesota's Medicaid program, was a state policy decision authorized by the ACA. Gains in Medical Assistance enrollment may have been due to the expanded eligibility criteria for the program, increased efforts through MNsure to enroll individuals in public programs, the possibility of a tax penalty for not complying with the ACA's mandate to purchase health insurance, or a combination of these factors. The Minnesota Department of Health (MDH) estimated that 67 percent of the state's 2013 uninsured population was eligible for a public health insurance program under the criteria that were in effect at the time.¹⁹

MDH and SHADAC conduct a statewide survey every two years to determine, among other things, the health insurance coverage status of Minnesota's population. That survey, known as the Minnesota Health Access Survey, was last conducted between August and November 2013, during the weeks leading up to and the first few weeks of MNsure's first open enrollment period. To get a sense of how the distribution of insurance coverage had changed for some groups since MNsure opened, MDH and SHADAC conducted a follow-up survey, known as the Minnesota Health Insurance Transitions Study (MN-HITS), from

¹⁷ 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, University of Minnesota, June 2014).

¹⁸ Enrollment in MinnesotaCare fell by 43 percent during this time period. Combined with the increased Medical Assistance enrollment, there was a net increase of 20.6 percent in the share of the population enrolled in a state public health insurance program.

¹⁹ *Health Insurance Coverage in Minnesota: Results from the 2013 Minnesota Health Access Survey* (St. Paul: Health Economics Program, Minnesota Department of Health, May 2014).

August to October 2014.²⁰ The MN-HITS survey re-contacted persons who participated in the 2013 Minnesota Health Access Survey and had reported at that time that they were uninsured.²¹

The 2013 Minnesota Health Access Survey found that 8.2 percent of the state's population—about 445,000 people—were uninsured. According to preliminary findings from the MN-HITS, 50 percent of that group (about 222,500 people) have since gained insurance coverage; the other 50 percent remain uninsured. Among those who gained coverage, 53 percent (about 118,000 people) enrolled in public coverage, including state programs, Medicare, and Veterans Assistance/military coverage; 25 percent (about 55,000 people) enrolled in group coverage through an employer; and 22 percent (about 49,000 people) enrolled in individual market coverage. Among those who gained coverage, 44 percent (about 98,000 people) reported doing so through MNsure. The MN-HITS survey asked respondents the reasons they gained (or lost) insurance coverage since the 2013 Minnesota Health Access Survey. Among those who had gained coverage, 38 percent reported that they had done so for ACA-related reasons. Such reasons included complying with the law's mandate for individuals to have health insurance and that MNsure made it easy to sign up for insurance coverage.

The MN-HITS was not able to determine the characteristics of all of the remaining uninsured population in Minnesota, nor could it determine the types of insurance previously held by the population who signed up for coverage through MNsure. Answers to those questions will only be available through a large population survey, such as the next Minnesota Health Access Survey, which is scheduled to be conducted in the fall of 2015 with results available in early 2016.

In the meantime, we attempted to determine the prior insurance status of people who gained coverage through MNsure by conducting a smaller-scale survey of MNsure enrollees. Our survey sample was representative of adults ages 18 to 64, who were listed in their MNsure applications as heads of households, and who enrolled in qualified health plans between October 1, 2013, and June 30, 2014.²² That target population consists of 37,205 members. We distributed the survey in September 2014 to a random sample, stratified by region of the state, of 1,000

²⁰ Primary funding for the MN-HITS was provided by the Robert Wood Johnson Foundation's State Health Reform Assistance Network, with additional financial support provided by MDH. We present preliminary findings here, with additional findings expected to be forthcoming in future publications from MDH and SHADAC.

²¹ The MN-HITS also recontacted people who reported that they were covered by individual market insurance or by the Minnesota Comprehensive Health Association (the state's high-risk pool) at the time of the 2013 Minnesota Health Access Survey. We do not report any results for those populations. Only respondents who were ages 0 to 63 at the time of the 2013 Minnesota Health Access Survey were recontacted for the MN-HITS so as not to include those who had aged into Medicare.

²² We chose to limit the sample to nonelderly adults to eliminate, on one end of the age spectrum, the need for proxy reporting of children's responses by an adult in the household, and to avoid, on the other end, sampling people who are now very likely to be enrolled in Medicare. We assumed the person listed in the application as head of household or a "self" purchaser (rather than "spouse" or "dependent") was likely to be the person who had filled out the household's application, meaning that the person could report his or her direct experience. Moreover, by limiting the survey to only one member of a household, we were able to reduce the response burden on survey participants that would have resulted from having each person in the household respond separately.

members of the target population. The survey had a response rate of 29 percent.²³

According to our survey, just over one-quarter of qualified health plan enrollees were uninsured immediately before enrolling in coverage through MNsure.

Our survey found that 28 percent of qualified health plan heads of households were uninsured immediately before enrolling in insurance through MNsure.²⁴ In a similar national study that looked at persons who enrolled in individual market insurance through an exchange, the percentage of previously uninsured persons was 57 percent.²⁵ The box on this page shows the distribution of the types of insurance coverage reported by our survey respondents.²⁶

Survey Respondents' Insurance Coverage Immediately Before Purchasing a Qualified Health Plan Through MNsure

- Uninsured (28 percent)
- Insurance purchased directly from an insurer (27 percent)
- Employer-sponsored insurance, including coverage through a labor union and continuation coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (24 percent)
- Dependent coverage through a parent, spouse, or domestic partner (10 percent)
- Public insurance, including Medical Assistance and MinnesotaCare (5 percent)
- Minnesota Comprehensive Health Association (5 percent)
- Did not know (1 percent)

Many newly insured qualified health plan enrollees had been uninsured for two years or more.

Our survey found that 23 percent had been uninsured for at least two but less than five years; 29 percent had been uninsured for five years or more. The remainder had been uninsured for less than two years.

²³ There were 281 valid responses to the survey out of 975 valid mailings. To produce representative estimates, survey results have been weighted to reflect both the probability of the respondent's selection into the sample, which differed by region, and the probability of responding to the survey, based on age and gender.

²⁴ Following the definition used by the National Center for Health Statistics, "uninsured" includes both those who reported that they had no insurance at all and those who reported having only a single-service plan, such as dental or hospitalization insurance. The uninsured category would also have included anyone who reported being enrolled in the Indian Health Service, but no respondents reported that type of coverage.

²⁵ Liz Hamel, Mira Rao, Larry Levitt, Gary Claxton, Cynthia Cox, Karen Pollitz, and Mollyann Brodie, *Survey of Non-Group Health Insurance Enrollees* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, June 19, 2014).

²⁶ These results should be interpreted with caution. Research shows that consumers' self-reports of health insurance status are most reliable when stating whether or not they have any health insurance. Their reports about what type of insurance they have are considerably less reliable. Coverage through Medicaid, in particular, tends to be underreported in population surveys.

COMPARISON WITH OTHER STATES

Researchers have attempted to make state-to-state comparisons on the performance of exchanges, including states' cost per enrollee and their success in enrolling the populations meant to be attracted to the exchanges. This section reviews some of that research but shows why it is particularly difficult to compare Minnesota's experience with that of other states.

The availability of MinnesotaCare hinders the ability to make meaningful comparisons between MNsure's enrollment performance and that of other states' exchanges.

Below, we briefly comment on two previous studies.

Angoff Study

This analysis found that Minnesota ranked 37th out of 51 states (including the District of Columbia) on exchange cost per enrollee.²⁷ At the time of the study, Minnesota had enrolled 48,495 people in qualified health plans. The study assumed that Minnesota had spent \$155 million, which was the total amount of federal grants Minnesota had received for the exchange at the time, resulting in a per-enrollee cost of \$3,197. The median cost per enrollee for all states was \$1,715.²⁸

However, Minnesota's enrollment figures as presented in this study are not comparable to those of other states. MinnesotaCare enrollees would, in any other state, be eligible to enroll in subsidized qualified health plans. Similarly, many children who are covered by Medicaid in Minnesota would be eligible to enroll in subsidized qualified health plans in some other states. (Some states have less generous Medicaid eligibility rules for children than Minnesota.) About 38,000 people had enrolled in MinnesotaCare through MNsure at the time of this analysis; adding this number to Minnesota's qualified health plan enrollment, the per-enrollee cost is reduced to approximately \$1,792. That revised calculation would move Minnesota from 37th to 27th on exchange cost per enrollee out of all states plus the District of Columbia, and the 5th lowest cost per enrollee out of states operating their own exchanges in 2014.²⁹

Moreover, this study's figures on the total amount spent on each exchange are somewhat misleading. First, Minnesota had spent only a portion of its federal grants at the time of the analysis, and the same may have been true of other

²⁷ Jay Angoff, "Cost-per-Enrollee in Each State's Exchange" (Washington, DC, May 7, 2014), <http://kaiserhealthnews.files.wordpress.com/2014/05/5-7-14-exchanges-report.pdf>, accessed December 29, 2014.

²⁸ This analysis reported that the state with the lowest cost per enrollee was Florida (\$76 per enrollee), and the state with the highest was Hawaii (\$23,899 per enrollee).

²⁹ It is not feasible to do a similar correction based on Medicaid eligibility levels for children, as any such correction would need to be applied to all states, and we did not have data on Medicaid enrollment by age for each state.

states. Second, Minnesota's spending helped enroll individuals in both public and commercial insurance, while federal expenditures assigned to states that used the federal health insurance exchange generally focused on enrolling individuals in commercial insurance.

Urban Institute Study

An analysis by the Urban Institute looked at how many individuals each state enrolled relative to the institute's estimate of the potential pool of exchange enrollees in that state.³⁰ Using a simulation model and American Community Survey data, the Urban Institute projected that 75,000 people would enroll in qualified health plans through Minnesota's exchange for the 2014 coverage year. As of data available in April 2014, Minnesota had enrolled 48,495 people, or 64.7 percent of the projected enrollment. By that measure, Minnesota's percentage of projected enrollment ranked 45th lowest out of 51 states (including the District of Columbia). However, similar to the previous analysis, Minnesota's number of enrollees was an undercount because of the existence of MinnesotaCare. As of April 2014, MinnesotaCare had enrolled approximately 38,000 people. If they are added to the qualified health plan enrollees at the time, Minnesota enrolled 115 percent of the total projected by the Urban Institute. Based on that revised calculation, Minnesota ranked 17th overall among states in the percentage of its projected pool of exchange consumers that were enrolled.

³⁰ Linda J. Blumberg, John Holahan, Genevieve M. Kenney, Matthew Buettgens, Nathaniel Anderson, Hannah Recht, and Stephen Zuckerman, *Measuring Marketplace Enrollment Relative to Enrollment Projections: Update* (Washington, DC: Urban Institute, May 2014).

Chapter 5: User Experiences

The purpose of MNsure, as declared by the MNsure Board, is “to ensure that every Minnesota resident and small business, regardless of health status, can easily find, choose, and purchase a health insurance product that they value and does not consume a disproportionate share of their income.”¹ In this chapter, we look at consumers’ experiences with MNsure. We also examine the experience of some key MNsure stakeholders—specifically, health insurers and counties.

KEY FINDINGS IN THIS CHAPTER

- **Consumers and the people who helped them enroll encountered numerous technical problems during MNsure’s first year of enrollment.**
 - **Individuals who enrolled through MNsure generally reported more satisfaction than dissatisfaction with the products they purchased.**
 - **Problems with MNsure’s enrollment system had a significant impact on the ability of insurers and counties to manage individuals’ cases.**
-

USER EXPECTATIONS

Before discussing users’ actual experiences with the MNsure website, it is important to consider what expectations users may have had. To some extent, these expectations reflected the way state officials described the exchange to the media, in their publications, and on the exchange website.

MNsure created unrealistic expectations about the experience that users of the health insurance exchange would have.

On a number of occasions, exchange officials likened the process of purchasing health insurance through a state exchange to the process of making purchases at popular consumer websites. For example:

- In a 2011 press release, the exchange’s executive director compared the exchange “to a website much like Travelocity or Expedia.com.”²

¹ MNsure Board Policy #01 (Charter and Bylaws), Article 1, Section 1.2.

² MNsure, “Minnesota Receives \$1-Million Federal Grant to Plan Health Insurance Exchange” (February 25, 2011), <https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-53893>, accessed October 6, 2014.

- In a newspaper opinion article, the Department of Commerce commissioner said: “Envision for a moment a consumer-friendly website much like Orbitz.com (<http://Orbitz.com>) or Expedia.com (<http://Expedia.com>) where Minnesotans can shop for affordable health coverage.”³
- A Minnesota television station’s story included the following comment from MNsure’s executive director: “Hopefully the end product to the consumer will look [like] something as consumer friendly as searching for an airline ticket on Travelocity or using something like Zappos to buy shoes.... We’re hoping that it’s that simple for consumers.”⁴
- According to the exchange’s marketing and communications plan, the exchange “is a user-friendly website like Priceline.com or Orbitz.com, an easier way for Minnesotans to purchase private health insurance or determine eligibility for public programs like Medical Assistance.”⁵
- MNsure’s homepages have used the terms “easy” and “simple” to describe the enrollment process. For example, MNsure’s webpages have said the exchange makes it “easy to find” and “easy to compare” insurance, and that the exchange is “easy-to-use.”

Comparisons with other consumer websites may have helped people understand that an exchange would provide an online shopping experience. However, buying insurance is a more complex transaction than buying many other products. For example, insurance purchases may require a consumer to provide income and family information to determine whether the consumer qualifies for public programs or tax credits. In addition, insurance products have many variables—the extent of coverage, the breadth of the provider networks available, the quality of health care provided, premium costs, and out-of-pocket costs. As we discuss below, the actual user experience was not as simple as MNsure suggested it would be.⁶

³ Mike Rothman, “Get Started on Minnesota’s Own Health-Insurance Exchange,” *Pioneer Press*, April 27, 2011, http://www.twincities.com/alllistings/ci_17933791?source=rss, accessed October 14, 2014.

⁴ “MNsure Website Underway in St. Paul,” April 25, 2013, <http://www.kttc.com/story/22083332/2013/04/25/mnsure>, accessed October 9, 2014.

⁵ Minnesota Department of Commerce, *2012 Integrated Marketing Communications Plan* (St. Paul, August 2012), 2.

⁶ Problems with the MNsure website contributed to the complexity of the enrollment process. As one MNsure-certified assister told us: “People came into our office extremely exasperated when trying to do it themselves at home. The advertisement [that] you can easily complete an application at home is completely false! Browser incompatibilities, web server down, programming incomplete made it a complete mess.”

CONSUMER ENROLLMENT PROCESS

We used several approaches to assess the consumer enrollment process during MNsure’s first open enrollment period. First, we conducted surveys of individuals who provided assistance to consumers. Specifically, we surveyed representative, random samples of MNsure-certified navigators, brokers, and certified application counselors.

The box above shows the consumer assisters we surveyed, and Chapters 1 and 6 discuss these assisters further.⁷

Consumer Assisters We Surveyed

- Brokers (or insurance “agents”) sell insurance products on behalf of insurance companies.
- Navigators work for community organizations and provide general enrollment assistance.
- Certified application counselors typically work for hospitals and provide enrollment assistance to patients.

Second, we surveyed a representative random sample of heads of households who purchased a qualified health plan through MNsure.⁸ The experience of successful enrollees may not represent the experience of others who visited the MNsure website (and perhaps even created accounts) but did not enroll. However, due to the limitations of MNsure’s data systems, we were unable to obtain information on all individuals who created accounts but did not enroll.

Third, we obtained access to a test version of the MNsure enrollment website from the first open enrollment period. This allowed us to view the content of the website firsthand. Because this was a test version and not a live version of the website, we did not fully experience the website’s technical functionality—for example, whether heavy traffic at the site caused slowdowns, errors, or other problems.

Complexity

As noted earlier, MNsure created expectations that its enrollment website would be relatively simple to use. In fact, the website proved to be challenging for many consumers.

⁷ Not counting members of our samples whose contact information was incorrect, we sent survey invitations by e-mail to 313 navigators, 292 certified application counselors, and 547 brokers. We received responses from 222 navigators (71 percent), 167 certified application counselors (57 percent), and 295 brokers (54 percent). The survey results reported in this evaluation only include those of respondents who said they did, in fact, work with MNsure applicants during the first open enrollment period. Each sample of respondents was large enough that we can be 95 percent confident that the true percentage of the population who would have selected a particular response was within 5 or 6 percentage points of the survey respondents’ answers, depending on the question.

⁸ Not counting members of our sample whose contact information was incorrect, we sent survey invitations by U.S. mail to 975 MNsure enrollees. We received responses from 281 enrollees (29 percent). The sample of respondents was large enough that we can be 95 percent confident that the true percentage of the population who would have selected a particular response to a survey question was within 6 percentage points of the survey respondents’ answers.

MNsure's enrollment website was difficult for some people to navigate and the enrollment process was often lengthy.

The enrollment process often took a considerable amount of time. In our survey of consumers who purchased qualified health plans, 58 percent reported that they spent at least four hours on the enrollment process.⁹ In addition, majorities of consumer assisters said the enrollment process took what they considered to be an unacceptable amount of the consumer's time. Specifically, 52 percent of navigators, 56 percent of certified application counselors, and 86 percent of brokers said the process was unacceptably long.

People who helped individuals enroll through MNsure generally said the process was not an easy one. In our surveys of MNsure-certified assisters, 62 percent of navigators said the process was not simple; 74 percent of certified application counselors and 96 percent of insurance brokers said likewise.

Among the consumers we surveyed who enrolled in a qualified health plan, 64 percent said the MNsure website was not easy to use. Consumer difficulties are illustrated in the following comment from a MNsure enrollee:

The insurance we ended up with, after MONTHS of effort, is a product that we are glad to have. However the process and experience we had with MNsure was HORRIBLE! My wife and I both have extensive experience with computer software and applications. MNsure was not ready for deployment, and we spent over 150 hours trying to apply and trying to resolve multiple problems with our application. We were without insurance for two months because of the problems we encountered.

The complexity and length of the enrollment process did not necessarily mean that consumers struggled to understand the application questions. In our surveys of consumer assisters, a majority of navigators and certified application counselors said that, in general, MNsure's application questions were written in language that was easy for consumers to understand; most brokers disagreed.¹⁰

⁹ Consumer assisters we surveyed generally reported spending less than this amount of time, on average, with the people they helped. Our surveys of assisters asked for the average amount of time it took to complete the online portion of the enrollment process; in contrast, our survey of consumers asked for the total time spent online, on the phone, or with an assister. The median response for navigators and certified application counselors was one to two hours; we did not ask this question of brokers.

¹⁰ The percentage of assisters who said the application questions were written in language that was easy for consumers to understand was 58 percent for navigators, 67 percent for certified application counselors, and 38 percent for brokers. The percentage that disagreed was 41 percent for navigators, 30 percent for certified application counselors, and 60 percent for brokers.

Technical Issues

One reason that the enrollment process was time-consuming and complex is that the MNsure website did not work as well as intended.

Consumers and MNsure-certified assisters experienced numerous technical problems with the MNsure website during the first open enrollment period.

Even individuals who successfully enrolled in a qualified health plan had difficulties with the MNsure website. Among people we surveyed who enrolled through MNsure in a qualified health plan, 75 percent reported having “significant” technical problems with the website.¹¹

Assisters who helped consumers enroll also experienced many technical problems. When asked whether “MNsure’s enrollment website was generally free of technical problems and ‘glitches’ during the first open enrollment period,” only 7 percent of navigators said it was, as did 8 percent of certified application counselors, and 1 percent of brokers. When asked how often they experienced technical problems that caused significant delays, a majority of brokers (62 percent) said this happened in 76 to 100 percent of the applications with which they assisted. Navigators and certified application counselors reported somewhat better experiences but 50 and 56 percent of respondents, respectively, said they had significant technical problems with at least half of the applications they handled.

The MNsure enrollment website was not equally compatible with all web browsers. For a while, MNsure’s customer service staff who answered phone and e-mail questions directed consumers to complete the first part of their application in one browser and then switch to a different browser to complete the application. MNsure had some information on its website about which browsers to use when enrolling, but this guidance was not particularly easy to locate.

Once applicants accessed the online enrollment system, they encountered a variety of technical problems. For example, one person who purchased insurance through MNsure said:

I’m very thankful that MNsure exists. It allowed me to start my own company and insure my family with a much better plan than I thought was possible for a reasonable price. However, the entire website was a disaster top to bottom. Disjointed navigation, basic website features found everywhere online were missing or broken, slow, error prone, different user experience across sections of the website—incredible that such a bad product could come from such a huge expenditure.

¹¹ On the survey, 75 percent of respondents disagreed or strongly disagreed with the following statement: “During the enrollment process, I did not encounter any significant technical problems with the MNsure website.”

Another MNsure enrollee said:

The website for obtaining [information] about subsidies and for enrollment was poorly designed. As a former software engineer with [graphical user interface] experience, it was painfully clear to me that (1) the software/system was not adequately designed or tested, (2) the servers could not handle the load of inquiries, (3) the user interface was cumbersome, (4) data had to be entered twice: first for qualifying for subsidies and then again for enrollment.

As noted in Chapter 2, many MNsure applications got “stuck” inside the enrollment system. It sometimes took weeks or months for MNsure to find these applications, resolve the remaining issues, and get the individuals enrolled. Users encountered a variety of other technical problems, such as: inability to access accounts if usernames contained characters such as @ or #; error messages for reasons that were unclear; and online screens that froze.

Website Content

Consumers who tried to enroll in insurance through MNsure expected a website without technical problems; they also expected the website to have clear, understandable guidance. For people purchasing a qualified health plan through MNsure, the process consisted of multiple steps:

- Create a MNsure account and have your identify verified.
- Provide information that will be used to determine eligibility for tax credits or a public health care program.¹²
- Shop on the MNsure website for an insurance product.

The MNsure website provided consumers with the option of shopping “anonymously”—that is, the ability to look at health plan options and prices prior to creating a MNsure account and starting the enrollment process. In our view, this option was not very well publicized during the first open enrollment period, perhaps causing some users to go through the more tedious steps in the enrollment process before fully understanding what options MNsure might offer them.¹³

Below, we discuss issues related to website content.

¹² Individuals were not required to request an eligibility determination for subsidies or public health care programs, but most people who enrolled did.

¹³ Also, MNsure’s anonymous shopping process was more complex than those of other exchanges, according to a website that helps consumers find health insurance. This website said that “among single web site exchanges with anonymous health plan comparisons, testers found Minnesota’s exchange, MNsure, had the most steps at 18.” It noted that “more steps increase the risk of web site visitors abandoning the shopping process.” See Healthpocket, “Healthpocket Compares State Health Insurance Exchanges,” October 17, 2013, <http://www.healthpocket.com/healthcare-research/infostat/ranking-state-health-insurance-exchanges#.VH3D5smZiSo>, accessed December 1, 2014.

Account Creation

For people seeking to purchase a qualified health plan, the first real step in the enrollment process—creating a MNsure account—provided ample opportunities for consumer confusion or frustration. The initial webpage was titled “Introduction to Identity Proofing and Obtaining an Account.” The process of authenticating the identity of a MNsure applicant is an essential one; however, the term “identity proofing” was not defined on this page, and it was jargon that many users might not immediately understand. Furthermore, the MNsure website did not provide clear assistance or instructions for persons with limited English proficiency who were trying to create an account.

When creating an account, users were asked to provide personally identifying information, including name, address, contact information, birthdate, and Social Security number. Users then encountered a visual security test (known as a “CAPTCHA”) that is intended to ensure that the account is being created by a person rather than a computer.¹⁴ This type of test is used by many websites, but it can be frustrating even for users who have encountered them before.

To complete the account creation process, users were asked to provide answers to several security questions and a “shared secret.” The security questions were intended to help MNsure verify the identity of someone trying to access a user’s account at a later date. A person creating a MNsure account was given eight options for security questions (such as “What city would you like to retire to?”) and had to provide responses to five. Some of the security questions were vaguely worded or prompted responses that might have been hard for a user to recall at a later date.¹⁵ A user was then asked to provide a “shared secret” to MNsure, with no guidance about the nature or topic area of the secret—perhaps making the “shared secret” hard for the consumer to remember later.¹⁶ Also, while these types of security provisions are used by many websites that store personal information, the requirement for MNsure users to provide a “shared secret” plus responses to five security questions may have taxed a consumer’s patience.

Some individuals who successfully completed the account creation process later encountered problems if they needed to get their password reset or did not recall their responses to the security questions. For example, a MNsure-certified consumer assister was told by MNsure customer service staff in late 2014 that

¹⁴ CAPTCHA stands for Completely Automated Public Turing test to tell Computers and Humans Apart. The user is typically shown a distorted image of letters and numbers and is asked to type in what he or she sees. Sometimes the distortion makes it difficult for users to provide an accurate response. CAPTCHAs have also been criticized for providing a difficult challenge for some people with disabilities.

¹⁵ For example, a question asking for the city in which someone would like to retire might be difficult for a young adult to answer. A question that asked the consumer to specify “your grandfather’s occupation” did not specify which grandfather it referenced. A question asking for “the most memorable date in your life” may have been intended to solicit a calendar date, but it did not specify the proper format for entering the date.

¹⁶ MNsure uses the “shared secret” to help verify user identity during phone contacts with MNsure contact center staff.

there was no recourse if consumers did not recall the answers to security questions.

Application Questions

A person seeking to enroll in either a subsidized qualified health plan or in a publicly funded health care program was required to complete a lengthy series of application questions. Some of these questions were clear and well explained. In our view, other questions were potentially confusing. Exhibit 5.1 shows examples.

The application process did not make sufficient accommodations for consumers with limited English skills. A question about whether the applicant needed an interpreter occurred well into the application process. Also, MNsure's website provided a sortable directory of in-person assisters for the first open enrollment period, but website users could not sort this directory by language. This may have made it harder for some limited English speakers to find an assister who spoke their language at a nearby location.

MNsure had potentially helpful advice on its website, but it was not always easy to find. The website had separate "Get Help," "Learn More," "Frequently Asked Questions," and glossary sections. It was not always clear which of these sections contained answers to particular questions.

Shopping for Insurance Products

Individuals who wished to purchase a qualified health plan could choose from dozens of products available through MNsure.

MNsure provided consumers with potentially useful online shopping tools, although consumer assisters and MNsure officials said these tools need further improvement.

On the MNsure website, consumers had the opportunity to narrow the health insurance products under consideration by specifying certain variables that "matter most to me." These variables included things such as the type of insurance product, whether the product included a particular clinic or hospital, whether the insurance covered wellness programs, and the level of the deductible. These shopping options enabled useful comparisons.

Exhibit 5.1: Examples of Potentially Confusing Application Questions from the First Open Enrollment Period

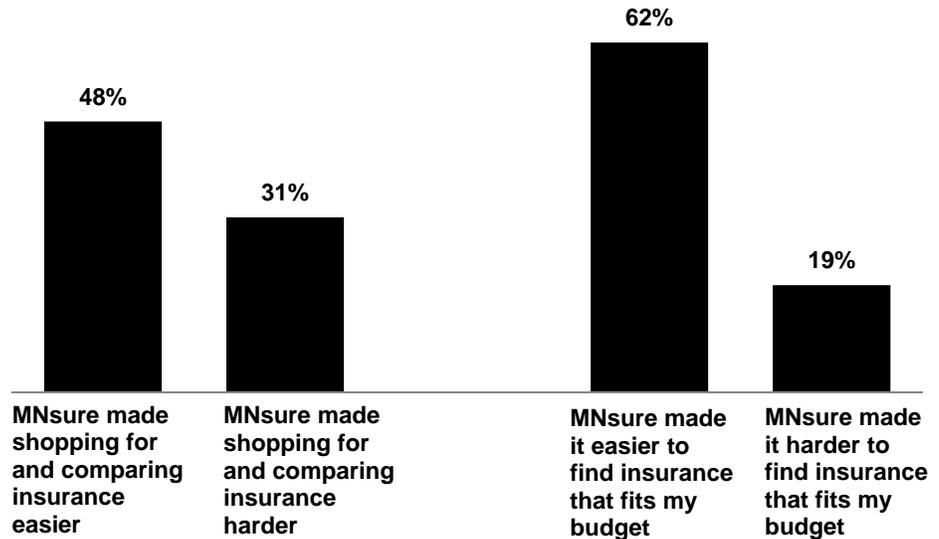
- The application had separate paths for persons applying for health insurance “with discounts” and “without discounts.” However, the term “discounts” was not adequately explained. Users may have been confused about whether “discounts” referred to tax credits, public programs, or specially priced insurance products.
- When checking for “discounts,” consumers were asked some questions without being clearly told the reason for the questions and what bearing their answers may have for eligibility determinations. For example: “Is anyone getting services from the Center for Victims of Torture?”
- Some questions asked for information but did not clearly specify the format in which the consumer should reply—for example, whether Social Security numbers should include dashes, or the proper format for reporting birthdates. Consumers had to click on a separate help button to find the proper format.
- Regarding income, the applicant was prompted to enter “Amount” in one question, and then “Frequency” in the next. This was potentially confusing. “Frequency” was intended to refer to the period—such as “Annual”—for which the “Amount” question was answered, not the frequency of the consumer’s pay periods.
- The application asked the consumer to report current “taxable income.” It urged consumers to check their tax forms to see how this was defined or to visit the IRS website. Consumer assisters told us there was considerable confusion over this question.
- One question in the application was a run-on sentence, which should have been corrected during the editing process: “Does [the primary applicant] pay for certain things that can be deducted on an income tax return, telling us about them could make the cost of health insurance a little lower.”
- The application contained the following statement: “I know I’ll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and won’t have to cooperate.” Below this statement, there was a box that simply said “Medical Support.” The box had to be checked to proceed with the application, but the application did not clearly indicate what a marked box indicated. There were several other checkboxes that had similar problems.
- If consumers appeared to be eligible for Medicaid or the Children’s Health Insurance Program (CHIP), the application asked them to answer a number of questions to “ensure that [they got] the right services.” (Medicaid and CHIP were not explained.) Some of these questions were very personal. For example, consumers were asked whether any members of the household “have a communicable disease (HIV, AIDS, tuberculosis, hepatitis, etc.)?” or “Have any of these people been determined as being seriously and persistently mentally ill or as being severely emotionally disturbed?” This part of the application had no further explanation about why this information was being collected, whether this information was relevant to the MNsure application, how respondents would be directed to the “right services,” or with whom this information would be shared for the purposes of getting people to the right services.

SOURCE: Office of the Legislative Auditor.

In our survey of consumers who purchased a qualified health plan, we asked about the value of MNsure’s online shopping tools. We focused on responses from individuals who had previous experience purchasing health insurance. As shown in Exhibit 5.2, those who said MNsure made the shopping experience easier than what they had previously experienced outnumbered those who said MNsure made it harder (48 percent vs. 31 percent). Likewise, among persons with previous experience shopping for insurance, 62 percent said MNsure made it easier to find insurance that fit their budget, and 19 percent said MNsure made it harder.

Exhibit 5.2: Perceptions of MNsure Enrollees Who Had Prior Experience Buying Insurance, 2014

Percentage of Respondents Who Said:



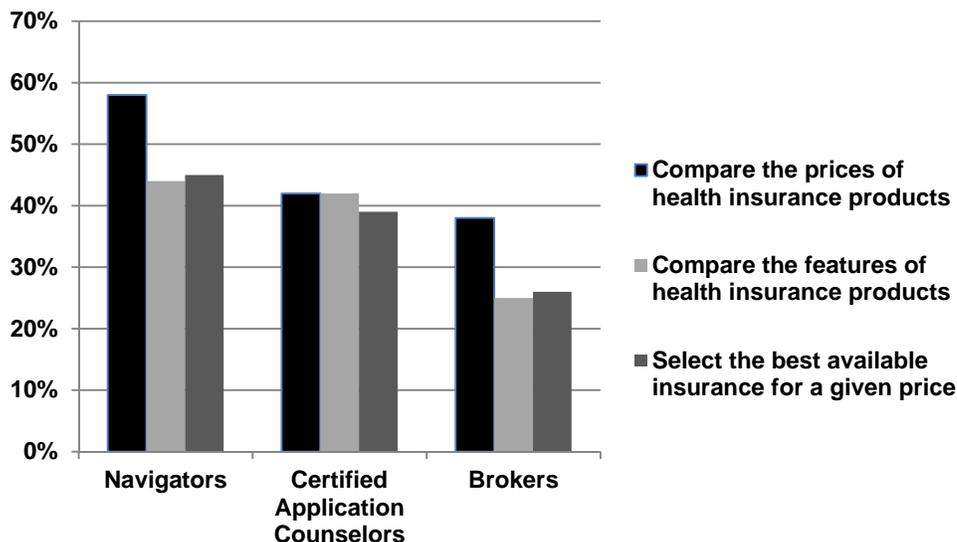
NOTES: The survey was conducted in September to November 2014. Respondents who offered no opinion or said that MNsure made no difference are not shown. Overall, the sample of respondents was large enough that we can be 95 percent confident that the true percentage of the population who would have selected a particular response to a survey question was within 6 percentage points of the survey respondents' answers.

SOURCE: Office of the Legislative Auditor, survey of heads of households who enrolled in qualified health plans (N=205).

We also asked assisters about the adequacy of online tools MNsure provided for making comparisons among qualified health plans. As shown in Exhibit 5.3, navigators and certified application counselors were generally more favorable in their assessments than brokers. For example, 45 percent of navigators, 39 percent of certified application counselors, and 26 percent of brokers said MNsure provided useful tools for helping consumers select the best available insurance for a given price. In our discussions with MNsure board members and administrators, several told us they would like to see improvements in the consumer shopping experience on the MNsure website. However, much of leadership's focus during the website's first year was on addressing the site's technical problems.

Exhibit 5.3: Satisfaction of Consumer Assisters with Tools MNSure Provided to Consumers, 2014

Percentage of Survey Respondents Who Said MNSure Provided Useful Tools to:



NOTES: The surveys were conducted from July through October 2014. The sample of respondents was large enough that we can be 95 percent confident that the true percentage of the population who would have selected a particular response to a survey question was within 5.0 to 6.6 percentage points of the survey respondents' answers. The percentages of assisters who offered no opinion on these questions ranged from 17 to 21 percent for navigators, 25 to 27 percent for certified application counselors, and 4 to 5 percent for brokers.

SOURCE: Office of the Legislative Auditor, surveys of navigators (N=203), certified application counselors (N=124 to 125), and brokers (N=252 to 253).

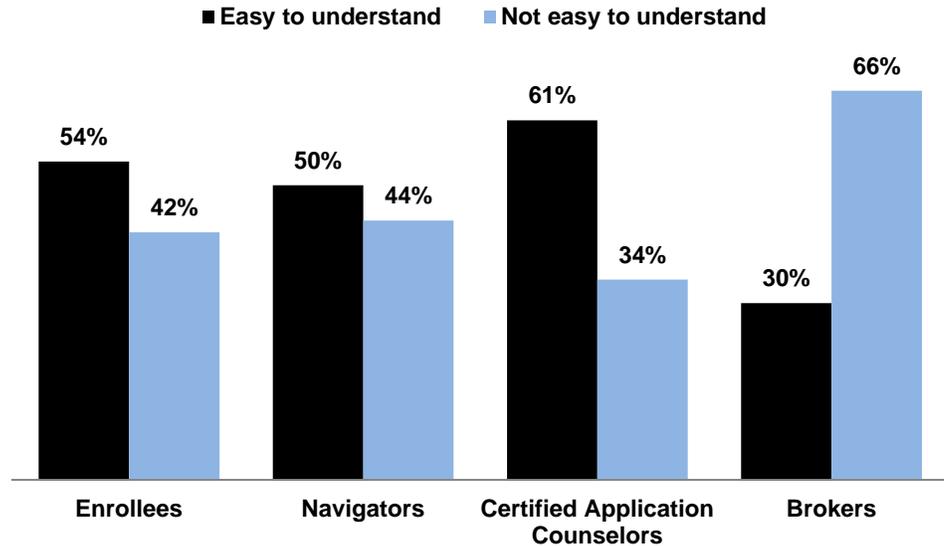
Most consumers we surveyed said that the MNSure website provided adequate information on the insurance products for sale, while consumer assisters had mixed opinions.

We surveyed a sample of individuals who purchased qualified health plans. As shown in Exhibit 5.4, 54 percent of respondents said “MNSure’s online information on health insurance products was easy to understand.” Likewise, our surveys of MNSure-certified consumer assisters asked whether MNSure provided information about health insurance products in language that was easy for consumers to understand. The percentage who said MNSure did so varied among the assister groups surveyed—50 percent of navigators, 61 percent of certified assistance counselors, and 30 percent of brokers.¹⁷

¹⁷ The percentages of respondents who said that MNSure did not provide information on health insurance products in understandable language were 44 percent for navigators, 34 percent for certified application counselors, and 66 percent for brokers.

Exhibit 5.4: User Perceptions of Information MNsure Provided on Health Insurance Products, 2014

Percentage of Survey Respondents Who Said MNsure's Information about Health Insurance Products was:



NOTES: Survey respondents who offered no opinion are not shown in the graph. The surveys were conducted in July through November 2014. The samples of respondents were large enough that we can be 95 percent confident that the true percentage of the population who would have selected a particular response to a survey question was within 5.3 to 6.3 percentage points of the survey respondents' answers.

SOURCE: Office of the Legislative Auditor, surveys of heads of households who enrolled in qualified health plans ($N=268$) and surveys of MNsure-certified navigators ($N=203$), certified application counselors ($N=128$), and insurance brokers ($N=256$).

In our view, some descriptions of insurance products on the MNsure website were potentially confusing to consumers. For example, many of PreferredOne's products had "non-embedded deductibles."¹⁸ This term was not defined in PreferredOne's product information or in MNsure's online glossary, and even some health care experts we talked with were unfamiliar with the term.

Exhibit 5.5 shows the opinions of consumer assisters about the online information MNsure provided on various aspects of insurance products. Specifically, the exhibit shows the percentage of assisters who said the MNsure website's information was "often," "almost always," or "always" sufficient. Assisters expressed mixed satisfaction with the information that MNsure's website provided. Assisters expressed the least satisfaction with information on provider networks; only about one-fourth of the assisters said this information

¹⁸ Insurance plans with embedded deductibles include individual deductibles and a family deductible. Having the individual deductibles embedded within the family deductibles allows for each member of the family to have expenses covered before the entire amount of the family deductible is reached. Insurance plans with a non-embedded deductible require the policy holder to incur expenses equaling the entire amount of the family deductible before the insurer will pay for any medical bills.

Exhibit 5.5: Consumer Assister Satisfaction with Information Provided by MNsure on Specific Elements of Insurance Products, 2014

Percentage of Respondents Who Said MNsure's Website "Always," "Almost Always," or "Often" Provided Sufficient Information on the Topic.^a

Topic	Percentage of Respondents		
	Navigators	Certified Application Counselors	Brokers
Scope of the insurance coverage	46%	33%	31%
Provider networks	35	27	23
Deductibles	57	42	61
Copayments	47	36	50
Out-of-pocket maximums	46	37	47
Tax credits and cost-sharing reductions	47	39	29
The final price of insurance for a qualified health plan after discounts	50	34	37

NOTES: The surveys were conducted from July through October 2014. The samples of respondents were large enough that we can be 95 percent confident that the true percentage of the populations who would have selected a particular response to a survey question was within 4.9 to 6.6 percentage points of the survey respondents' answers.

^a Respondents had a choice of "Always or almost always," "Often," "Sometimes," "Rarely or never," or "No opinion." This exhibit shows the total percentage that provided one of the first two responses.

SOURCE: Office of the Legislative Auditor, surveys of navigators (N=202 to 203), certified application counselors (N=124 to 126), and brokers (N=249 to 253).

was sufficient. Assisters expressed the most satisfaction with information on health plan deductibles.¹⁹

We also asked consumers why they bought insurance through MNsure rather than directly from an insurer; Exhibit 5.6 shows the responses to our survey. The most common reasons cited by respondents were that MNsure was less expensive, provided access to tax credits not available elsewhere, or allowed consumers to compare various insurance products.

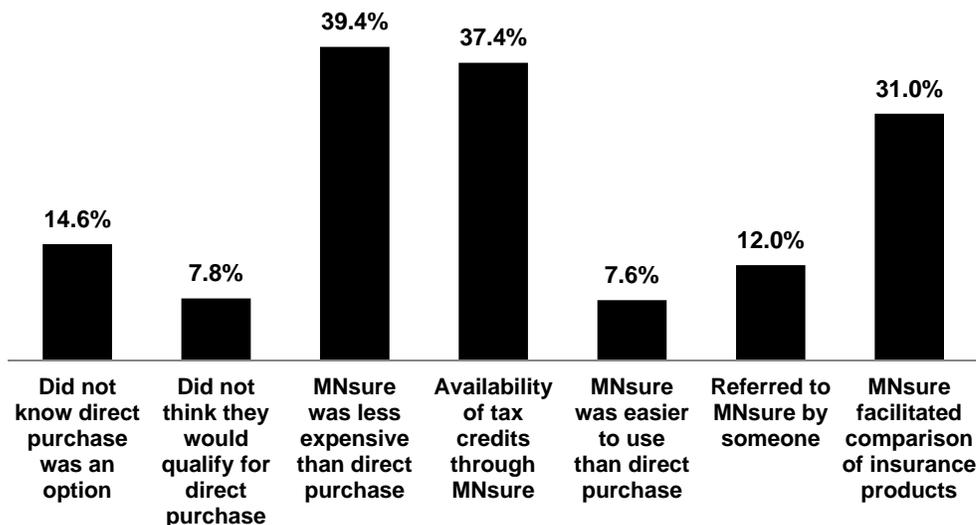
Consumer Notifications

Consumers who shop online expect businesses to provide prompt confirmation that their purchases were successfully processed. In the case of MNsure, consumers expected to quickly learn what benefits they were eligible to receive, whether their applications were processed, and whether they were successfully enrolled in a health insurance plan or public program.

¹⁹ Between 25 and 32 percent of certified application counselors offered no opinion to these questions, compared with 15 to 21 percent for navigators and 4 to 8 percent for brokers.

Exhibit 5.6: Enrollees' Reasons for Buying Insurance through MNsure Rather than Directly from an Insurer

Percentage of Respondents Who Cited These Reasons:



NOTES: Respondents could select more than one option. Respondents who responded “No opinion” or who wrote in another response are not shown. The sample of respondents was large enough that we can be 95 percent confident that the true percentage of the population who would have selected a particular response to a survey question was within 6 percentage points of the survey respondents’ answers.

SOURCE: Office of the Legislative Auditor, September to November 2014 survey of heads of households who enrolled in a qualified health plan ($N=281$).

In many cases, MNsure customers received inadequate information about (1) the status of their application for insurance or (2) their eligibility for public programs or tax credits.

When people make online purchases, they usually get confirmation of their purchase at the end of the process and receive a confirmation e-mail. But, for the first open enrollment period, and even into the second one, the MNsure website did not provide a confirmation page to individuals at the end of the application, stating that they had successfully enrolled in public or commercial plans. In addition, MNsure did not send consumers a confirmation e-mail. Our survey of insurance brokers asked whether the MNsure website provided sufficient confirmation that the enrollment process had been completed; two-thirds said it did not.²⁰ As one broker suggested to us, “Brokers should be able to print online applications with a confirmation number showing the application successfully was completed and went through the system.”

²⁰ Two other groups of assisters we surveyed were less critical than brokers of MNsure’s online confirmations. Still, 32 to 40 percent of navigators and certified application counselors said the confirmations were not sufficient (depending on the type of enrollees we asked about).

MNsure also created a process for communicating with applicants by mail. Specifically, applicants were to receive letters that informed them of their eligibility for tax credits or public health care programs. Also, applicants for public programs whose applications were incomplete were to be informed by letter that their applications were “pending.” (Applications were incomplete if information regarding identification, income, citizenship, tribal membership, or other issues could not be verified by state or federal sources.) The Minnesota Department of Human Services (DHS) was supposed to mail consumers letters on behalf of MNsure. But, for several months in 2014, these processes for written notifications did not work as intended.

First, from January to July 2014, DHS did not provide written notification to individuals whose applications for public programs were pending. DHS found errors in the notices being sent to individuals, and DHS and MNsure suspended the notification process on January 8, 2014. Later that month, DHS determined that the errors had been corrected. However, due to miscommunication between DHS and a vendor, immediate resumption of these mailings did not occur. This problem came to the attention of top DHS officials in June 2014, and mailing of the pending notices resumed in July 2014.²¹ According to DHS, more than 14,000 MNsure applications had pending issues as of June 2014 but had not received a DHS notification.²²

The impact of this problem was that many MNsure applicants were not told for weeks or months that they did not have insurance coverage, nor were they told what steps to take to get it. During this period, some of these individuals may have been alerted by county staff that their applications were not yet complete.²³

Second, during this same time period, MNsure applicants did not receive written notification of their eligibility for tax credits or public programs. Initially, MNsure and DHS halted the mailing of these letters in January 2014 because the letters had incorrect dates of eligibility. This took several weeks to fix. Exchange officials then identified additional changes that were needed in the content of the letters. Mailings of letters to individuals regarding their eligibility for tax credits or public programs resumed in July 2014.

²¹ In early 2014, a MNsure vendor (EngagePoint) told DHS that it was sending notices of pending applications to DHS to be mailed to consumers. Months later, however, a DHS official said the vendor’s internal review showed that notices may not have been printed since January 7, 2014. Staff in some counties told us that, on occasions prior to June 2014, they expressed concern to DHS about the apparent lack of notices being sent to program applicants. High-level DHS officials said they were unaware that pending notices were not being mailed until June 2014.

²² In addition to 14,467 cases pending as of June 2014 that had not yet been notified by DHS, there may have been other individuals whose pending issues were resolved during the first six months of 2014, thus negating the need for DHS notification of pending status in June 2014.

²³ DHS sent counties lists of pending cases on three occasions during the first half of 2014 and asked counties to follow up with these individuals to obtain the necessary information.

CONSUMER SATISFACTION WITH PRODUCTS PURCHASED

It is important for consumers to have a relatively trouble-free experience when enrolling in health insurance through MNsure, but it is also important for consumers to find products they like. Our survey of a sample of consumers who purchased qualified health plans provided an early picture of consumers' views. Most of these consumers probably bought their plans during the first open enrollment period, which ended March 31, 2014; we conducted our survey in September 2014. It may take some consumers longer than a few months to use their health insurance and determine what they think of it.

Persons who enrolled through MNsure in the first open enrollment period generally reported more satisfaction than dissatisfaction with the products they purchased.

In our survey of people who purchased a qualified health plan through MNsure, 67 percent said they would choose the same product again, if given the choice; 24 percent said they would not. It is worth noting that most people who purchased a qualified health plan during MNsure's first open enrollment period did not have the opportunity to buy the same product through MNsure in the second open enrollment period. The insurer (PreferredOne) that accounted for about 59 percent of the qualified health plans sold during MNsure's first open enrollment period decided not to offer products through MNsure in the second year. People who had purchased a PreferredOne product the first year could only re-enroll in a PreferredOne product outside of MNsure. In doing so, the consumer would not have been eligible to receive tax credits available only by purchasing insurance through MNsure.

Our consumer survey also asked how likely the respondent would be to recommend MNsure to friends or family looking to purchase health insurance. Using a scale from 0 ("not at all likely") to 10 ("extremely likely"), each survey recipient was asked to select a response that reflected the likelihood of making such a recommendation. On one hand, we found that more respondents chose options 6 through 10 than options 0 through 4; this suggests that, on balance, there was a level of satisfaction with what they had purchased. On the other hand, when this question format is used in consumer research, it is often analyzed with the assumption that only persons responding "9" or "10" are satisfied to the point of being "promoters" of the product.²⁴ Using this alternative method of analysis, MNsure's customers included more of what researchers call "detractors" than "promoters."

We also asked respondents to identify any specific benefits or negative impacts MNsure has had on them. Exhibit 5.7 shows the responses. The percentage of

²⁴ See a discussion of the method in Frederick Reichheld, "The One Number You Need to Grow," *Harvard Business Review* 81, n. 12 (December 2003), 46-54. Under this approach, ratings of 9 and 10 are considered "promoters" of a product, and ratings of 0 through 6 are considered "detractors." Persons rating a product as 7 or 8 are considered "passively satisfied."

survey respondents who cited any of the benefits shown in the exhibit (63 percent) outnumbered those who cited any negative impacts (42 percent). Interestingly, the most common benefit mentioned by the enrollees was lower costs (cited by 43 percent of respondents), while the most common negative effect mentioned was higher costs (cited by 26 percent of respondents).

Exhibit 5.7: Enrollee Perceptions of Positive and Negative Effects of MNsure, 2014

Benefits from MNsure that Enrollees Said They Received	Percentage of Surveyed Enrollees Who Cited this Benefit
Lowered my health insurance costs	43%
Increased my choices for insurance	25
Improved my insurance coverage	23
Improved my access to the health care providers I want to see	11
Improved my access to medication	8
Total who cited at least one of the benefits above	63%

Negative Effects of MNsure that Enrollees Said They Experienced	Percentage of Surveyed Enrollees Who Cited this Negative Effect
Increased my health insurance costs	26%
Reduced my health insurance coverage	16
Reduced my choices for insurance	11
Reduced my access to the health care providers I want to see	9
Reduced my access to medication	6
Total who cited at least one of the negative effects above	42%

NOTES: The survey was conducted in September to November 2014. The sample of respondents was large enough that we can be 95 percent confident that the true percentage of the population who would have selected a particular response to a survey question was within 6 percentage points of the survey respondents' answers.

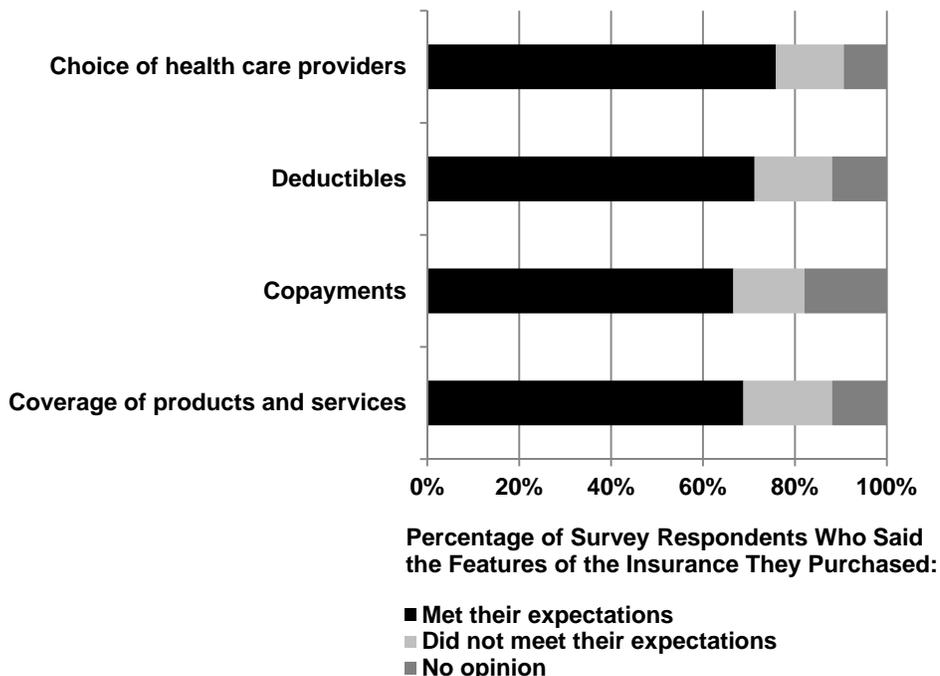
SOURCE: Office of the Legislative Auditor, survey of heads of households who enrolled in qualified health plans (N=281).

In addition, we asked people who bought qualified health plans through MNsure about specific aspects of the product they purchased. As shown in Exhibit 5.8, at least two-thirds of surveyed enrollees said (in response to separate questions) that the product they purchased through MNsure had met their expectations regarding choices of health care providers, policies regarding deductibles, policies regarding copayments, and coverage of products and services.

For enrollees who had health insurance immediately before enrolling in MNsure, survey respondents reported mixed views on their MNsure product compared with their previous insurance—particularly regarding premiums and out-of-pocket costs.

Exhibit 5.8: MNsure Enrollees' Views of Certain Aspects of the Insurance They Purchased, 2014

Features of Insurance Purchased by Enrollees



NOTES: In our survey of MNsure enrollees, we asked whether the insurance enrollees purchased through MNsure met their expectations. For example, we asked them if the insurance they purchased offered the choice of health care providers or the deductibles that they expected. The survey was conducted in September to November 2014. The sample of respondents was large enough that we can be 95 percent confident that the true percentage of the population who would have selected a particular response to a survey question was within 6 percentage points of the survey respondents' answers.

SOURCE: Office of the Legislative Auditor, survey of heads of households who enrolled in qualified health plans (N=276 to 277).

Exhibit 5.9 shows how people who purchased insurance through MNsure compared this insurance with what they had previously. Forty-eight percent of consumers who had been insured immediately prior to MNsure reported that their premiums (after tax credits) were lower through MNsure than they were previously; 32 percent said their MNsure premiums were higher. In addition, 43 percent of previously insured people said they paid higher out-of-pocket costs with the insurance they bought through MNsure than with the insurance they had previously. Most people reported no change in the options their new insurance offered for primary care doctors.

Exhibit 5.9: Enrollees’ Comparison of Insurance Purchased Through MNsure with Insurance They Had Previously, 2014

Insurance Characteristic	Percentage of Respondents Who Said the Insurance They Purchased through MNsure was “Better Than,” “About the Same,” or “Worse Than” the Insurance They Had Previously:		
	Better	Same	Worse
Coverage for health care services and products	16%	48%	30%
Out-of-pocket costs	30	23	43
Options for primary care doctors	9	69	15
Premiums (after any tax credits)	48	14	32

NOTES: The survey was conducted in September to November 2014. The sample of respondents was large enough that we can be 95 percent confident that the true percentage of the population who would have selected a particular response to a survey question was within 6 percentage points of the survey respondents’ answers. Respondents who said “don’t know” are not shown in this table. This survey question was not asked of individuals who said they did not have insurance immediately prior to purchasing insurance through MNsure.

SOURCE: Office of the Legislative Auditor, survey of heads of households who purchased a quality health plan through MNsure (N=202 to 204).

IMPACTS ON KEY STAKEHOLDERS

MNsure was developed to help consumers enroll in insurance. A variety of stakeholders have assisted in this process. In this section, we focus on the experience of two groups: (1) health insurance companies whose products were sold through MNsure and (2) counties that administer the public health care programs in which most MNsure enrollees participate.

Health insurers and counties were frustrated by the impact of MNsure’s problems on their workloads, business practices, and ability to serve consumers.

To help us better understand the experience of these stakeholders, we used interviews and surveys to solicit input from representatives of all five health insurers that participated in MNsure in its first year. In addition, we obtained input from officials in 12 county human services agencies.

Health Insurers

Once a person signs up for health insurance through MNsure, MNsure notifies the insurer of the enrollment. This enables the insurer (also known as a “carrier”

or “health plan”) to correspond with the enrollee, collect premiums, and eventually pay the enrollee’s claims.²⁵

MNsure had insufficient processes for transmitting information on enrollees to insurers during MnSure’s first open enrollment period.

Originally, MnSure planned to send insurers specially formatted electronic enrollment files with information on new enrollees. But shortly before October 1, 2013, MnSure informed insurers that the files would not be available right away, and that some of them would not be available in the format the insurers were expecting. About two months into the open enrollment period, MnSure sent the first files to insurers. Many of these files were created manually rather than automatically by MnSure’s system, not formatted in the way the insurers expected, and did not include all information the insurers needed. Later, MnSure began sending separate files that contained the missing information. Insurers said they devoted considerable time to manually entering and matching these files, due to (1) the unexpected format in which MnSure sent many of the files, (2) the differing dates on which insurers received separate reports on the same individuals, and (3) questions about the accuracy of the data MnSure provided. One carrier official summarized the difficulties as follows:

The inability to automate files from MnSure to health plans was the greatest difficulty during open enrollment. This inability led to numerous manual workarounds, and every time a new workaround is necessary the possibility of errors in the information being shared increases. The overall inability to receive accurate, timely enrollment files from MnSure delayed processing on our end, delayed the delivery of membership materials [to consumers], resulted in inaccurate enrollments, and necessitated extensive resources to track and verify information.

Insurers cited a variety of other problems:

- MnSure collected initial premium payments from some consumers during part of the first open enrollment period, and MnSure has been collecting ongoing premium payments from small businesses that enroll through MnSure.²⁶ However, MnSure was unable to send payment files to insurers in the format expected by insurers, so insurers had to enter payment information manually into their information systems.

²⁵ This notification of the insurer is known in the insurance industry as an “834 EDI transmission.” It is not a new process; it is used by employers, insurance brokers, health insurance exchanges, and governments to provide insurance companies with descriptive information on individuals that have purchased or enrolled in policies.

²⁶ During the latter part of the first open enrollment period, insurers assumed responsibility from MnSure for collecting initial premium payments from individuals. One insurer said MnSure assessed its limited abilities to handle payments and “made the right decision” to give this responsibility to insurers that have long experience with customer billing.

- Contrary to original expectations, MNsure’s system cannot identify which enrollees are still covered by the plans they purchased, and which enrollees terminated their coverage mid-year. Consequently, MNsure has relied on insurers to provide it with up-to-date information on enrollees so it could inform individuals of the need to re-enroll.
- Insurers have produced monthly reports for the federal government that indicate the number of individuals enrolled through MNsure receiving premium tax credits or cost-sharing reductions. MNsure originally intended to prepare this report.
- Insurers spent considerable time working with MNsure to address applications that were “stuck” in the MNsure system. Technical problems left some consumers frustrated and without coverage for a period of time.²⁷
- Insurers collected documents from external sources to verify individuals’ eligibility to enroll outside of open enrollment periods (due to “life events,” such as changes in residence, income, or family size) because MNsure was not doing these verifications.
- Many individuals submitted paper applications, but insurers said MNsure’s processes for handling this type of application were inadequate.²⁸ They said this resulted in enrollment delays.
- When consumers who purchased insurance through MNsure in 2014 logged into their online accounts to renew their coverage for 2015, MNsure planned to provide them with information about their current insurance policies and rates. This feature was meant to allow consumers to use their existing policy as a point of reference as they shopped for a new policy. MNsure was unable to do this, and insurers thought this placed customers at a disadvantage as they shopped for their 2015 coverage.

Overall, the insurers did not think the MNsure enrollment process for their customers in public health care programs was an improvement over the process used previously. Additionally, insurers participating in MNsure that also sold commercial products outside MNsure said that MNsure’s enrollment process for commercial customers was more difficult. One insurer told us that it spent at least \$500,000 to modify its information systems in response to changes MNsure made in its original plans.

²⁷ Some insurers told us that consumers were given retroactive coverage for the period when their applications were “stuck,” but in the meantime enrollees may have postponed health care visits or worried about the status of their coverage.

²⁸ Examples of problems cited with MNsure’s process for handling paper applications were: lack of systems for tracking which applications had been received or the status of these applications; no option on the paper applications for applicants to select the health plan they wanted; and no process for applicants to verbally authorize an application when missing application information was provided by phone.

Counties

Counties are the “front lines” for Minnesota’s public health care insurance programs. The state sets overall health care policy for these programs, operates statewide information and eligibility determination systems, and oversees program implementation, while the counties assist with the enrollment process, manage individual cases, and troubleshoot issues that arise for enrollees. A recent estimate said that the 2011 county cost of administering health care programs on behalf of the state was about \$100 million dollars.²⁹

Due to weaknesses in MNsure’s enrollment system, counties have not been able to effectively manage the MNsure cases for which they are responsible.

Perhaps the largest county frustration has been the absence of a well-functioning “caseworker portal” into the MNsure enrollment system. The portal was supposed to provide a special point of entry for county staff, allowing them to view the status of MNsure applications and enrollments so they could actively manage these cases. However, county officials told us the portal does not show staff how many Medical Assistance cases are on their caseloads at a given time. In addition, the MNsure caseworker portal provides information to counties on tasks that need to be completed (such as closing the case of a person who has moved out of state), but it only allows county staff to view 500 tasks at a time. This may be a small fraction of a large county’s total case-related tasks.³⁰

Furthermore, county staff have had limited ability to address the tasks identified in the caseworker portal, due to problems with MNsure’s technology. For example, county staff could not add a newborn to a MNsure-enrolled case until mid-2014. Over time, DHS has developed manual workarounds for counties so staff can perform tasks they were initially unable to perform through the portal. But the time it now takes for a county to add a newborn to a MNsure case is 60 to 90 minutes; such a task required only a few minutes in the case management system (MAXIS) that DHS previously used to manage Medical Assistance cases. There continue to be many tasks in the MNsure caseworker portal that county staff are not authorized to complete. For example, as of late 2014, when MNsure enrollees died or moved, or when their incomes rose to a level above eligibility thresholds, county staff could not close the enrollees’ cases.

Other concerns we heard from county staff about their experiences as users of the MNsure system included the following:

- The MNsure system has not given counties the ability to determine how many MNsure applications involving their residents were pending at a given time. (As noted earlier, a “pending” application is one that is incomplete and requires additional information from the applicant.) Because of this limitation in the system, DHS offered to send counties

²⁹ Fiscal note prepared for H.F. 5-8E, 2013 Leg., 88th Sess. (MN), 20.

³⁰ For example, as of mid-2014, Hennepin County had over 20,000 tasks to perform in order to complete enrollment for that county’s MNsure applicants.

lists of their pending cases monthly. But county staff told us they only received these lists once or twice in all of 2014.

- Contrary to MNsure's original intentions, applicants deemed eligible for public health care programs could not select their health plan through the MNsure online enrollment system. Thus, counties had to mail information packets to enrollees for this purpose.
- In mid-November 2014, counties assumed responsibility from DHS for administering all applications for public health care programs submitted in paper form. County staff expressed concerns that this new responsibility—combined with larger caseloads, workarounds delegated to counties by MNsure, and plans to transition all people on public programs to MNsure enrollment during 2015—will stretch county resources thin. Counties hired additional staff to help with MNsure cases and received enhanced federal funding to help cover these costs, but some believe that local property taxes will finance part of the increased workload.³¹
- County staff expressed concern that they had minimal training for using the MNsure enrollment system and little participation in the system's testing.

Some county staff expressed optimism that the new enrollment system, when fixed, may be an improvement over previous processes. Counties like the fact that some people enrolling in public programs through MNsure have been able to complete the entire process on their own, without county help. But, on balance, county staff we talked with were more negative than positive about MNsure's functionality so far. County staff work on the front lines of the enrollment process, answering consumers' questions and confirming their enrollment in public programs. Because of limited access to the MNsure enrollment system and inability to fix certain types of problems, it has been hard for county staff to do their jobs.

³¹ At a November 2014 meeting of the MNsure Legislative Oversight Committee, the Director of the Anoka County Economic Assistance Department testified that his county's administrative costs for people in public health care programs rose \$1 million in 2014 and is expected to increase another \$1 million in 2015.

Chapter 6: Operations

Federal rules require that states provide resources to help consumers make informed decisions when obtaining health insurance through an exchange, including: application assistance, a toll-free phone number, and outreach and education.¹ In this chapter, we discuss the design, implementation, and performance of these resources. We also examine other operational issues from the first year of enrollment, including advertising and data security.

KEY FINDINGS IN THIS CHAPTER

- **Many consumers were referred back and forth between brokers and navigators, due to differences in the roles and compensation practices for these assisters.**
 - **MNsure’s contact center failed to provide adequate customer service during the first open enrollment period.**
 - **MNsure has some—but not complete—ability to analyze who has accessed private data on enrollees.**
-

CONSUMER ASSISTERS

MNsure provides consumers with application and enrollment assistance through its partnerships with external organizations and individuals. Exhibit 6.1 defines MNsure’s three types of application assisters—“navigators,” “certified application counselors,” and brokers—and highlights some of the differences between them.²

Navigators, which are typically employed by community-based organizations, help consumers enroll in both public health insurance programs and commercial products offered through MNsure. When consumers need help with an application, they locate navigators through MNsure’s online assister directory. MNsure’s contact center also refers consumers to navigators for help. Navigators must help any MNsure user that requests their assistance and provide information in a fair, accurate, and impartial manner.³ In order to maintain their impartiality, navigators may not receive any compensation from an insurance company.⁴

¹ 45 *CFR*, sec. 155.205 (2014); and 45 *CFR*, sec. 155.225(a) (2014).

² Throughout this report, we use the term “consumer assisters” to refer to all three types of application assisters: navigators, certified application counselors, and brokers.

³ 45 *CFR*, sec. 155.210(e)(2) (2014); and *Minnesota Rules*, 7700.0040, subp. 1B, posted July 11, 2013.

⁴ 45 *CFR*, sec. 155.210(d) (2014); and *Minnesota Rules*, 7700.0030, subp. 1B, posted July 11, 2013.

Navigators must help consumers understand the differences between their health insurance options, but they may not offer advice about which commercial product to select.⁵

Exhibit 6.1: Overview of MNsure Consumer Assisters

	Navigators ^a	Certified Application Counselors	Brokers ^b
Typical employer	Community organizations and counties	Hospitals or clinics	Insurance agencies
Role	Providing MNsure application assistance and clarifying the distinctions among public and commercial health coverage options, including describing the benefits, terms, or conditions of commercial plans^c	Providing MNsure application assistance to clients as part of regular job duties	Selling insurance plans offered on MNsure through MNsure's online application, and offering advice about the benefits, terms, or conditions of commercial plans^d
Per-enrollment compensation	MNsure pays \$70 per commercial enrollment; DHS pays \$25 for Medical Assistance and \$70 for MinnesotaCare enrollments	None	Insurers pay brokers per enrollment if the broker is appointed to sell plans on behalf of the company ^e
Certification requirements	20 hours of training; passage of exams and background check; works for an organization contracted by the state; compliance with conflict of interest, privacy, and security standards	Same as navigators	2 hours of training; passage of an exam and background check; verification of broker license; compliance with privacy and security standards
Must help anyone who requests it	Yes	No	No
Listed in online assister directory	Yes	No	Yes
Receive referrals from contact center	Yes	No	Yes

^a Throughout this report, we use the term “navigator” to refer to both in-person assisters and navigators. County workers may be certified as in-person assisters and be paid for enrolling consumers in commercial plans, but they may not serve as navigators or be paid for enrolling consumers in Medical Assistance or MinnesotaCare. Counties workers that serve as in-person assisters are not listed in MNsure's Assister Directory.

^b In this report, we use the term “brokers” to refer to “agents” and “insurance producers” licensed under *Minnesota Statutes* 2014, 60K.

^c 45 CFR, sec. 155.210(e) (2014); *Minnesota Rules*, 7700.0040, posted July 11, 2013; and MNsure and the Minnesota Department of Commerce, *Consumer Assistance Partner Bulletin 2013-1* (St. Paul, 2013).

^d *Minnesota Statutes* 2014, 62V.05, subd. 3; *Minnesota Statutes* 2014, 60K.32; and *Minnesota Statutes* 2014, 60K.31, subds. 6, 12, 14, and 15.

^e According to the Henry J. Kaiser Family Foundation, in 2010, brokers in Minnesota earned an average of \$97 per enrollment or renewal that they facilitated, or 3.9 percent of premiums in the individual market.

SOURCES: Office of the Legislative Auditor; 45 CFR, sec. 155.210 (2014); 45 CFR, sec. 155.215 (2014); 45 CFR, sec. 155.220 (2014); 45 CFR, sec. 155.225 (2014); and *Minnesota Rules*, chapter 7700, posted July 11, 2013, and September 26, 2013.

⁵ 45 CFR, sec. 155.210(e)(2-3) (2014), requires navigators to “clarif[y] the distinctions among health care options, including [commercial plans]” and to “facilitate selection of a [commercial plan].” According to *Minnesota Statutes* 2014, 60K.32, and *Minnesota Statutes* 2014, 60K.31, subd. 15, individuals must be licensed as brokers in order to “urg[e] a person to apply for a particular kind of insurance from a particular company.” Also, see MNsure and the Minnesota Department of Commerce, *Consumer Assistance Bulletin 2013-1* (St. Paul, 2013).

MNsure's Navigator Program grew out of the Department of Human Services' (DHS's) Minnesota Community Application Agent Program, which was established in 2007.⁶ Organizations that participated in the Minnesota Community Application Agent Program were paid \$25 for each person they enrolled in a public health insurance program.⁷ In 2013, MNsure contracted with a number of these organizations, as well as others, to provide similar services under its new Navigator Program.⁸ During the first year of the exchange, MNsure and DHS jointly ran the Navigator Program. MNsure used federal grant funds to pay organizations \$70 for each consumer enrolled in a commercial product through MNsure, while DHS paid \$25 for enrollments in Medical Assistance and \$70 for enrollments in MinnesotaCare.⁹ During MNsure's first year, navigators assisted about 12 percent of MNsure's Medical Assistance enrollees and MinnesotaCare enrollees, and 13 percent of MNsure's commercial plan enrollees.¹⁰

Federal rules also required states to develop a program for **Certified Application Counselors** (CACs).¹¹ CACs are often hospital or clinic employees who, as part of their daily job duties, assist clients with health insurance applications. They are not paid by MNsure or insurers for their services.¹² Unlike navigators, CACs are not listed in MNsure's assister directory and are not obligated to help any consumer that contacts them.

Licensed health insurance **brokers** also may be certified by MNsure to sell insurance offered through the exchange.¹³ In 2010, insurers paid brokers \$97, on

⁶ During the first year of operations, MNsure's Navigator Program operated under the policies of the Minnesota Community Application Agent Program, *Minnesota Statutes* 2014, 256.962. *Minnesota Statutes* 2014, 62V.05, subd. 4, required the MNsure Board to establish policies for the Navigator Program that would have become effective January 1, 2015. However, as of early February 2015, the board had not adopted formal policies for the Navigator Program.

⁷ *Minnesota Statutes* 2014, 256.962, subd. 5.

⁸ DHS stopped contracting with organizations under the Minnesota Community Application Agent Program during the first year of the MNsure Navigator Program.

⁹ Federal rules prohibit the exchange from using federal grant funds to pay navigators for enrolling consumers in insurance through MNsure but allow the exchange to use them to pay in-person assisters. As a result, MNsure operates parallel navigator and in-person assister programs that are identical except for their funding mechanisms. Internally, MNsure uses the term "in-person assisters" to refer to organizations paid by MNsure using federal funds for enrolling consumers in qualified health plans, and the term "navigator" to refer to organizations paid by DHS for enrolling consumers in public programs. Most organizations serve as both navigators and in-person assisters. Counties, however, are only paid for in-person assister services. Publicly, MNsure uses the term "navigators" to refer to both types of assisters, and our report follows this practice, too.

¹⁰ Because of problems with MNsure's enrollment and assister data, we could not independently verify the exact number of consumers enrolled with the help of navigators. These figures represent our best estimates given the data made available to us.

¹¹ 45 *CFR*, sec. 155.225(a) (2014).

¹² 45 *CFR*, sec. 155.225(g)(2) (2014); and *Minnesota Rules*, 7700.0020, subp. 5, posted July 11, 2013.

¹³ 45 *CFR*, sec. 155.220(d) (2014); and *Minnesota Statutes* 2014, 62V.05, subd. 3(a). In this report, we use the term "brokers" to refer to insurance agents or insurance producers licensed under *Minnesota Statutes* 2014, 60K.

average, for each person they enrolled in a commercial product in Minnesota.¹⁴ In Minnesota, brokers must be “appointed” (authorized) by an insurance company before selling that insurer’s products.¹⁵ For example, a broker who has been appointed by HealthPartners and Blue Cross Blue Shield of Minnesota, but not Medica, cannot sell a Medica plan to a consumer. When helping consumers purchase insurance through MNSure, brokers must disclose which insurers pay them to sell their products.¹⁶ Like navigators, brokers are listed in MNSure’s online assister directory, and MNSure’s contact center staff refer callers to brokers for help enrolling in a commercial product. Unlike navigators, brokers are not obligated to help everyone who requests it and they are usually not paid for enrolling consumers in public health insurance programs.

For the 2014 enrollment year, MNSure expected to spend 8 percent of its budget, or around \$10 million, on its consumer assister programs. This included expenditures on per-enrollment payments to navigator organizations, grants to organizations for outreach and application assistance, and staffing for program administration.

Training and Certification

All of MNSure’s consumer assisters must be certified by MNSure before they can help consumers enroll in insurance using the exchange.¹⁷ For MNSure’s first two open enrollment periods, navigator and CAC certification required 20 hours of training, passage of exams and a background check, and compliance with conflict of interest, security, and privacy standards.¹⁸ Brokers, on the other hand, only had to complete two hours of training. Like navigators and CACs, they also had to comply with MNSure’s privacy and security standards.

MNSure did not provide sufficient training for its consumer assisters in the first year of enrollment.

We surveyed a random sample of consumer assisters about their experiences with the exchange during the first year.¹⁹ Fifty-three percent of navigators and 72 percent of brokers did not think MNSure provided sufficient training. CACs were more satisfied, with almost two-thirds approving of the training. Assisters were particularly concerned that they received no hands-on training with

¹⁴ According to data compiled by the Henry J. Kaiser Family Foundation, brokers in Minnesota earned, on average, \$97 per enrollment or renewal, or 3.9 percent of premiums in the individual market in 2010.

¹⁵ *Minnesota Statutes* 2014, 60K.49, subd. 2.

¹⁶ *Minnesota Statutes* 2014, 62V.05, subd. 3(e).

¹⁷ *Minnesota Rules*, 7700.0060, posted July 11, 2013.

¹⁸ Organizations also had to sign a contract with the state before their employees could be certified as navigators.

¹⁹ We received responses from 222 navigators (71 percent response rate), 167 CACs (57 percent response rate), and 295 brokers (54 percent response rate).

MNsure's online application. As one navigator said, "The first time I saw the application was with my first applicant."

Many assisters said they wanted more training on how to answer MNsure's application questions related to household income. Consumers trying to find out if they qualified for public health insurance programs, tax credits, or cost-sharing reductions had to estimate their taxable income for the coming year and disclose it on MNsure's application. But it can be challenging for individuals in certain professions or life circumstances to estimate taxable income. For example, farmers may have negative income over the course of a year, and seasonal workers may not know how much they will make over the coming months. Assisters said they were not adequately prepared to help consumers with these types of questions. One certified application counselor said, "We are not accountants that know all tax deductions [available] for consumers."

MNsure had limited success getting assisters certified by the October 1, 2013, launch date. On the first day of open enrollment, MNsure estimated that around 450 brokers and no navigators were certified.²⁰ This meant that application assistance was not available for many consumers when the exchange first opened.

MNsure did not have an adequate method for tracking assister certification in its first year of operation, and this hindered its ability to make accurate payments.

State rules require MNsure to maintain documentation of certification training for navigators and CACs.²¹ MNsure staff provided us with the records they kept of individuals that had been certified. Upon inspection, we found the records to be incomplete. They did not properly document which individuals had successfully finished various portions of the certification process and by what date. We also could not distinguish individuals who had been certified and later dropped out of the program from individuals who were never certified; both types of individuals were labeled "inactive" in the records. Because MNsure did not have an adequate method for tracking assister certification, we could not conclusively determine the total number of assisters who were certified by MNsure during its first year of enrollment.

Weak recordkeeping also made it difficult for MNsure to ensure that it made accurate payments to navigator organizations. For example, MNsure intended to give each navigator a unique identifier so it could (1) track enrollments that were facilitated by navigators and (2) make payments to navigator organizations. But MNsure assigned some identifiers to navigators that it had already allocated to other navigators. This made it hard for MNsure to determine which navigator should get credit for an enrollment. Also, at least two organizations were paid

²⁰ These numbers are based on internal MNsure communication that could not be verified independently by our office.

²¹ *Minnesota Rules*, 7700.0050, subp. 1, posted July 11, 2013.

over \$6,000 for services provided by navigators that were not certified.²² MNsure was aware of a number of these issues, plus some others. The agency intends to reconcile any over- or under-payments that were made to navigator organizations, but staff told us this process might not be complete for a while.²³

Navigator and Broker Roles

MNsure users' options for getting enrollment assistance during the first year of the exchange were, at times, confusing and inefficient. Because brokers only get paid for enrolling consumers in commercial products, it may have been reasonable to expect them to primarily work with consumers shopping for commercial products—and, similarly, for navigators to primarily work with consumers enrolling in public programs. But MNsure's consumer assister programs did not function this discretely in practice.

Many consumers were referred back and forth between brokers and navigators.

Some consumers who were eligible for public programs originally contacted brokers for assistance and were subsequently referred to navigators. Likewise, navigators referred consumers to brokers when the consumers needed help choosing a commercial product. Poor customer service resulted from consumers being referred back and forth between navigators and brokers. As one broker said, "There needs to be a way to identify the best way to help these people. Sending them to two or three places before getting help is inefficient and they should not have to deal with this."

One reason consumers were referred back and forth between navigators and brokers was because navigators could not provide start-to-finish application assistance for all consumers, regardless of the type of coverage they chose.

Navigators could only provide limited assistance to consumers enrolling in commercial insurance products.

Navigators are required by federal rules to clarify the distinctions among commercial health insurance options for consumers.²⁴ But, according to state law, only licensed insurance brokers can urge a consumer to choose a particular product.²⁵ The difference between helping someone understand commercial insurance options and giving them advice on specific products can be a fine distinction. In 2013, MNsure and the Department of Commerce issued guidance

²² Staff told us they discovered that "dozens" of navigators helped consumers enroll before they were certified. They said these navigators will not be paid for these enrollments.

²³ When calculating payments owed to navigator organizations, MNsure compared its records of assister certification with reports that were generated by its online enrollment system which identified which consumers used assisters. Staff told us that problems with the online enrollment system also contributed to the payment errors.

²⁴ 45 *CFR*, sec. 155.210(e) (2014).

²⁵ *Minnesota Statutes* 2014, 60K.32, and 60K.31, subd. 15.

to clarify the kind of assistance navigators are allowed to offer consumers. The guidance said that navigators could *describe* the benefits, terms, or conditions of commercial health products, but they could not *recommend* a specific product *or make a decision* on behalf of a consumer—only licensed brokers could do that. If consumers who had sought help from a navigator wanted help with product selection, they had to schedule another in-person visit with a broker.

The distinction between the help navigators could and could not give consumers enrolling in commercial products was difficult for some consumers, contact center staff, and assisters to grasp. As one navigator explained:

I send people to brokers when they need help in comparing and choosing plans. Sometimes I get the idea that people are told by those they call at MNSure that navigators are supposed to be able to help them. I can't. I don't know insurance, and I don't want to be a broker, I want to be a navigator. Sometimes folks are a bit angry about this because they've been told to contact a navigator for all aspects of getting insurance.

Consumers who met with a navigator may have needed to visit a broker at a later date. For example, some consumers did not know before they met with a navigator and entered information into MNSure's application whether they would qualify for a public program. (If they did not qualify, they had to schedule a separate meeting with a broker if they wanted help choosing a commercial product.) Also, in some households, certain members of the household were eligible for public programs while others were not. If households with mixed eligibility wanted help enrolling in a public program and help choosing a commercial product, they had to visit both a navigator and a broker.

Similarly, if consumers initially chose to meet with a broker instead of a navigator, they could not be sure they would receive all the help they needed in one visit. MNSure-certified brokers were required by federal rules to take consumers through the application questions related to eligibility for public programs, tax credits, and cost-sharing reductions before they could sell the consumers a product.²⁶ So, if consumers were deemed eligible for public programs, some brokers referred them to navigators to complete the enrollment process.

Some brokers helped consumers enroll in public programs, although they received no compensation for doing so.

This was one of the most frequently cited concerns among brokers who submitted written comments to our survey. One broker said, "I think I assisted about 15 to 20 individuals during the open enrollment period, none of which [purchased] a [commercial insurance product]. I worked for hours without making a dime." Another said:

²⁶ 45 CFR, sec. 155.220(c)(1) (2014). Consumers completing MNSure applications on their own had the option of skipping these eligibility questions and simply enrolling in an unsubsidized commercial health insurance product; brokers helping consumers did not have this option.

Clients came into the agency not knowing until we were into the application process that they would qualify for public assistance. I did the work, I provided the information, and I received no compensation.

One reason brokers helped enroll so many people in public programs was because it was the contact center's policy to refer callers whose incomes were on the edge of public program eligibility to brokers, rather than navigators, when they needed application assistance.

Also, brokers were not compensated for their assistance in cases where consumers purchased commercial products through MNsure that the brokers were not authorized to sell.

According to state law, brokers must be “appointed” (authorized) by an insurance company before they are allowed to sell the company's products, for which they are paid a commission.²⁷ In the first year of the exchange, five insurance companies sold products through MNsure. Neither state law nor MNsure required each insurance company selling products through the exchange to appoint each MNsure-certified broker. Some consumers who were receiving help from a broker decided to purchase products their particular brokers were not appointed to sell. As a result, some brokers did not earn a commission for their services. For example, of the 295 MNsure-certified brokers we surveyed, only 34 percent were appointed with PreferredOne, the company that sold a majority of the products during MNsure's first year.²⁸

Some brokers had the impression they would automatically be appointed by all of the insurance companies selling products on MNsure once the brokers received their MNsure certification. As one broker said:

I am extremely disappointed that we were not compensated by the companies that we were not appointed with. [It] was not made clear that we would only be paid if the consumer chose a product through our appointed companies. I uploaded and helped over two dozen families and was compensated for one of them.

Overall, during the first year of the exchange, brokers were frustrated when they were not compensated for assistance they gave to some public program and commercial product enrollees. Some brokers told us they did not plan to seek MNsure certification in the second open enrollment period—as one said, “We lost money trying to assist people.” According to MNsure's count, the number of certified brokers dropped from about 2,300 in April 2014 to about 500 at the start

²⁷ *Minnesota Statutes* 2014, 60K.49, subd. 2.

²⁸ Seventy-eight percent of MNsure brokers we surveyed were appointed to sell products for Blue Cross Blue Shield of Minnesota, 63 percent for Medica, 40 percent for HealthPartners, and 13 percent for UCare.

of the second open enrollment period.²⁹ It is unclear what impact this decline will have on MNsure enrollments. But, if MNsure determines that this smaller number of brokers does not provide consumers with enough access to application assistance and insurance advice, MNsure and DHS should consider whether to pursue changes.

RECOMMENDATION

MNsure and DHS should ensure that brokers are fairly compensated for enrolling consumers in insurance through MNsure.

A first option would be for DHS to use existing state law to pay MNsure-certified brokers for public program enrollments. Under the Minnesota Community Application Agent Program, brokers are eligible to receive \$25 from DHS for each person they enroll in Medical Assistance or MinnesotaCare.³⁰ This program is still authorized in state law, although DHS no longer operates it now that the Navigator Program has taken its place. We were told that few brokers took advantage of reimbursement under the Minnesota Community Application Program. Perhaps brokers were not widely aware of this compensation option; if so, DHS or MNsure could take steps to better publicize it to brokers. If the compensation rate offered through this program is too low to attract brokers, DHS or MNsure could seek an increase through legislative action.³¹

Second, the MNsure Board could consider requiring each insurer that sells plans through MNsure to appoint each MNsure-certified broker to sell its products. Currently, each insurer decides whether or not it will appoint a given broker to sell its products. If the board decides to pursue this option, it could make this requirement part of its approval process for insurers selling plans through MNsure, or it could ask the Legislature for a change in state law.

Application Access for Assisters

When designing Minnesota's health insurance exchange, state officials intended to build a "navigator-broker portal" that would allow assisters to view and edit consumers' applications on their behalf. Because MNsure's navigator-broker portal did not function during the first year of the exchange, assisters were only

²⁹ According to MNsure's reports, the number of brokers rose during the second open enrollment period, reaching around 820 in January 2015.

³⁰ *Minnesota Statutes* 2014, 256.962, subd. 5.

³¹ This compensation rate is lower than others offered to brokers. In 2010, Minnesota insurers paid brokers \$97, on average, for a year's enrollment or renewal in the individual market, according to data we obtained from the Henry J. Kaiser Family Foundation. Under the Minnesota Comprehensive Insurance Act (the former program for people who could not find insurance elsewhere), brokers received \$50 per enrollee from insurers. Also, Minnesota insurers paid brokers from \$120 to \$410 per Medicare enrollee, according to data published in 2013 by the Centers for Medicare and Medicaid Services.

able to view an account if the consumer they were assisting was physically present to log in through MNsure's website.³²

Assisters and MNsure staff told us that many problems resulted from the lack of a functional navigator-broker portal.

Because assisters could not use the navigator-broker portal, it was difficult for them to provide follow-up services. Follow-up is required, for example, when the enrollment system does not produce an immediate determination of public program eligibility. In such cases, assisters often had to schedule follow-up in-person appointments. The largest share of navigators and CACs said it took one to two hours, on average, for them to complete the online portion of enrollment for consumers enrolling in Medical Assistance or MinnesotaCare.³³ Forty percent of navigators said it took more than two hours, on average, to enroll consumers in commercial health plans.³⁴ But as one navigator explained, the application did not account for all of their time; they also spent a lot of time following up on consumers applications:

My major gripe is that navigators were not warned that there would be considerable follow-up required. I work with non-English speaking people and we continue to spend time calling [various help lines] trying to get status updates and figure out why things are delayed. Navigators become the clients' primary contact, which shifts a lot of work to us. I would say the applications themselves only account for a third [of] the time navigators put [in] trying to get the application processed.

At times, assisters had to schedule multiple appointments to finish an enrollment, which was a burden for some consumers.

Sometimes a single appointment was not sufficient to complete a MNsure application. For example, some assisters encountered long contact center wait times, problems connecting with the Federal Data Services Hub (which verified consumers' identities), or problems with the MNsure website. One navigator described the toll this took on consumers, saying, "We are working with clients who have low income, most often with transportation barriers. These clients cannot afford additional visits to our office." Another said:

³² As of February 2015, the navigator-broker portal was still not functional.

³³ Fifty-one percent of navigators and 53 percent of CACs said it took, on average, one to two hours to complete the online portion of enrollment in Medical Assistance through MNsure. Fifty-three percent of navigators and 56 percent of CACs said it took this amount of time for MinnesotaCare enrollments. Also, 50 percent of navigators and 51 percent of CACs said it took one to two hours for enrollments in qualified health plans.

³⁴ Navigators said commercial plan enrollments generally took longer than public program enrollments. Sixteen percent of navigators said it took more than two hours for Medical Assistance enrollments and 18 percent said it took more than two hours for MinnesotaCare enrollments through MNsure.

As a navigator working in a rural area, most of my consumers... [have to] travel long distances to meet with me. It was very frustrating that some people had to schedule multiple appointments to get the application complete.

Some parts of Minnesota had relatively few navigators, which increased the enrollment challenges in those areas. According to MNsure's enrollment data, navigators did not successfully enroll a consumer in 30 of Minnesota's 87 counties. In another 23 counties, fewer than one navigator per 1,000 uninsured residents successfully enrolled a consumer.

Consumer Assister Grants

In its first year of operation, MNsure awarded \$4.75 million in competitive grants to 41 organizations, as seen in Appendix F. The grants had two purposes. First, they supported navigator organizations that provided application assistance to consumers.³⁵ For example, they helped organizations purchase computers, hire navigators, and pay for navigators to travel around communities. Second, the grants supported organizations' outreach efforts to targeted populations, including minorities, rural populations, and small employers. Some organizations received funds for outreach activities only and did not provide application assistance.

Soon after MNsure announced the grant winners, members of the public and Legislature criticized the agency for not awarding funds to any of the primarily African-American organizations that had applied, despite the fact that African Americans are disproportionately likely to be uninsured.³⁶ In response to the criticism, MNsure reallocated funds and awarded an additional \$833,000 to 12 organizations from its original pool of applicants. The organizations that were awarded funds in the second round represented several demographic groups that were initially underrepresented.

Many MNsure grantees failed to reach their outreach or enrollment goals.

Each of the grantees' contracts, which ran through September 2014, included **enrollments goals** developed by the organizations and approved by MNsure.³⁷ Some grantees performed well in terms of their enrollment goals, as shown in Appendix F. For example, Hmong American Partnership enrolled nearly 2,200

³⁵ Organizations could be certified as navigator organizations without receiving grant funds; most did not receive grant funds during MNsure's first year.

³⁶ According to MNsure's assessment of the proposals, 6 of the 29 original grantees intended to serve African Americans in their outreach or enrollment activities.

³⁷ Three grantees received funds for outreach activities only; they did not establish enrollment goals in their contracts with MNsure. None of the contracts for the first round of grantees was finalized until after open enrollment started in October 2013; contracts for the second round were not completed until late November 2013.

people in insurance using MNsure, which was 211 percent of its goal.³⁸ Portico Healthnet enrolled by far the most people for a single organization (6,162). Some organizations, like Minnesota Community Action Partnership, enrolled a large number of people (2,786), but still fell far short of their goals—perhaps indicating the challenge organizations had setting goals during the first year of the Navigator Program. Grantees enrolled about 70 percent of the consumers that received assistance from a navigator between October 2013 and September 2014.

Some grantees simply did not enroll many people. For example, the National Association of Mental Illness (NAMI Minnesota), the Confederation of Somali Community in Minnesota, Springboard for the Arts, and the Minnesota Chippewa Tribe together received more than \$400,000 but together enrolled only 175 people, according to MNsure records. Each of these organizations enrolled fewer than 10 percent of its individual goal. For the second year of open enrollment, MNsure awarded another \$4.6 million in grants to 28 organizations. Several organizations that performed poorly during the first year were awarded funds again for the second year, as seen in the first table in Appendix F.

Grantees' contracts also included **outreach goals**. Grantees used a variety of methods to achieve their outreach goals. For example, Springboard for the Arts produced a series of informational videos which were distributed to its members. Other organizations staffed booths at community events, gave presentations to organizations, visited food shelves, sent out mailings, wrote articles for newsletters, and performed door-to-door canvassing. Grantees submitted monthly and final reports listing the outreach events they held, the number of people reached, and the number of people they helped to enroll.

MNsure provided insufficient oversight of its consumer assister grants.

Even though 30 grantees failed to meet their outreach or enrollment goals, MNsure did not withhold any grant payments for performance reasons.³⁹ Staff told us that when MNsure made final payments to grantees at the end of 2014, they did not take into account grantees' contracted enrollment goals or their enrollment performance. Staff said they did consider organizations' outreach performance when making final grantee payments. But even grantees that did not meet their outreach goals received their full award by the end of the grant period.

In addition, the grantee data related to outreach activities were self-reported and, during the first year of operations, MNsure did not verify the occurrence of the outreach events listed in grantees' reports, the actual number of people "reached"

³⁸ As noted earlier in this chapter, problems with MNsure's enrollment and assister records prevented us from independently verifying the exact amounts earned by navigator organizations. The figures cited in this section represent our best estimates.

³⁹ MNsure and one grantee (Small Business Minnesota) mutually agreed to terminate the grantee's contract in June 2014 because problems with the functionality of MNsure's small business application would have made it difficult for the organization to fulfill its grant duties. Small Business Minnesota returned all of the funds it was awarded.

by the events, or the quality of such efforts. Some of the grantees' self-reported data, which is shown in Appendix F, seemed implausible. For instance, Minnesota Community Action Partnership, whose contract included 15 partners, estimated that it reached 2.8 million people through its outreach events—which is over half of the state's population. This figure also represented 28,000 percent of the organization's contracted outreach goal. Women Venture, which did not have any grant partners, reported that it reached 674,000 people, or 48,000 percent of its outreach goal.

We think MNSure should have provided more oversight of grantees' outreach activities. MNSure staff told us they acknowledged this shortcoming and for the second year of operations, MNSure hired three additional staff to oversee grant activities and provide grantees with greater support services. We also think MNSure should have considered grantees' performance in relation to both their contracted outreach goals and their contracted enrollment goals when evaluating grantees' final performance.

CONTACT CENTER

According to federal rules, MNSure must provide a toll-free call center to address the needs of consumers requesting assistance.⁴⁰ In this section, we review the development and performance of the MNSure contact center and the various problems it has faced since opening on September 3, 2013. We also review how the contact center functions within the state's existing network of customer service resources.

Customer Service Standards

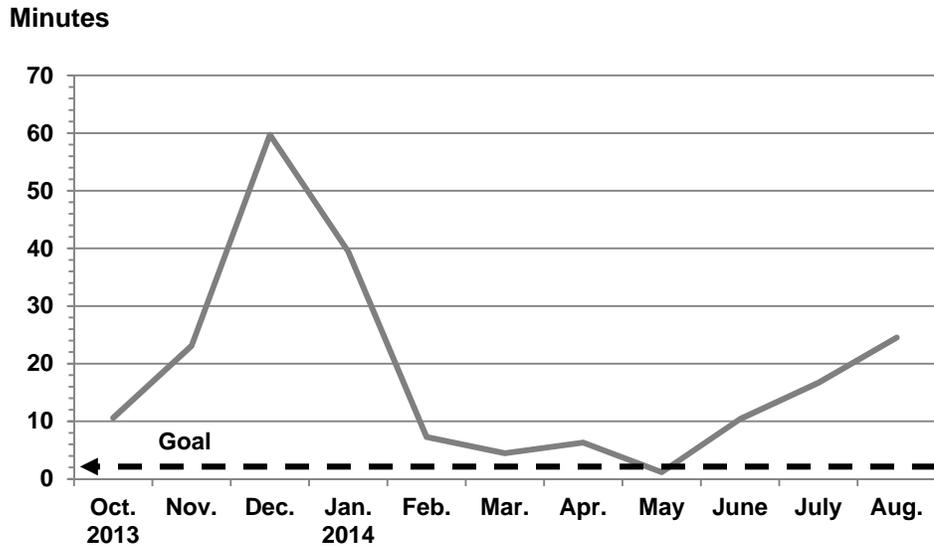
In the first year of operation, MNSure staff established two primary customer service goals and tracked the contact center's performance related to those goals. First, the contact center sought to answer more than 85 percent of calls in less than two minutes.

MNSure's contact center failed to answer calls within an acceptable amount of time.

Exhibit 6.2 shows the average wait time callers experienced each month, from October 2013 to August 2014. As shown in the exhibit, the contact center's average wait times were extremely high in November (23 minutes), December (60 minutes), and January (40 minutes). Wait times declined in the spring, and even fell below the contact center's two minute goal in May; but they rose again in the summer months, nearing 25 minutes in August. Across MNSure's first open enrollment period (October 2013 through March 2014), the average amount

⁴⁰ 45 CFR, sec. 155.205(a) (2014).

Exhibit 6.2: Average Amount of Time Consumers Spent Waiting on Hold, October 2013 to August 2014



NOTES: These figures include wait times for both MNsure’s contact center agents and contracted agents. They do not include the amount of time consumers spent waiting on hold after their calls were answered. The contact center’s goal was to answer 85 percent of calls within 2 minutes. Contracted customer service agents were supposed to answer 85 percent of calls within 30 seconds, according to the vendor’s contract with MNsure.

SOURCE: Office of the Legislative Auditor.

of time consumers waited on hold was 24 minutes. Some consumers had especially long waits. For example:

- On December 20, 2013, the average wait time was 1 hour and 49 minutes, the longest average over the course of a single day.
- The longest wait for an individual caller, which occurred on December 18, 2013, was 2 hours and 39 minutes.

On 78 percent of the days the contact center was open between October 1, 2013, and August 29, 2014, the average daily wait time exceeded MNsure’s two-minute goal. Not

Assister Responses to the Following Survey Statement: “Wait times to speak with a call center representative were reasonable.”			
	Navigators	CACs	Brokers
Always or almost always	2%	6%	3%
Often	7	10	2
Sometimes	35	30	14
Rarely or never	52	47	77

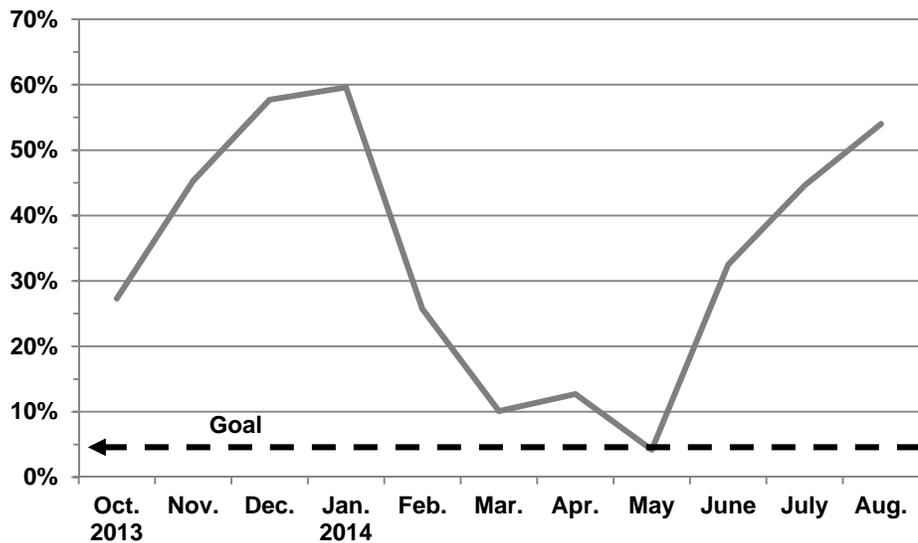
surprisingly, MNsure users were overwhelmingly dissatisfied with wait times. A majority of brokers and navigators we surveyed said wait times were “rarely or never” reasonable.

MNsure’s second customer service goal was to have less than 5 percent of callers hang up before speaking to a customer service agent. MNsure failed to achieve this goal for abandoned calls.

Many people abandoned their calls before speaking to a customer service representative.

With such long wait times, many people hung up before speaking to a contact center agent. Between October 2013 and August 2014, about one-third of callers abandoned their calls. Exhibit 6.3 shows the percent of calls abandoned each month, compared with MNsure’s goal during that time period. Only in May 2014 did the call abandonment rate fall below 5 percent. In January 2014, 35,000 calls (60 percent) were abandoned. The highest rate of abandoned calls for a single day occurred on January 3, 2014, when 81 percent of calls were abandoned. On the last day of open enrollment (March 31, 2014), 4,063 calls were abandoned—the most calls for a single day.⁴¹

Exhibit 6.3: Percentage of Phone Calls to the MNsure Contact Center Abandoned by Callers, October 2013 to August 2014



NOTES: MNsure’s goal was to have less than 5 percent of callers hang up before their calls were answered.

SOURCE: Office of the Legislative Auditor.

⁴¹ The data we reviewed did not capture the number of calls that were disconnected because the contact center was too overloaded to handle them.

Design

A number of factors contributed to the contact center’s customer service failures during its first year of operation. One factor was that state officials did not accurately predict the number of staff the contact center would need when designing MNsure’s customer service strategy.

In February 2013, the Department of Human Services (DHS) assigned three staff (which it called the “Customer Service Team”) to develop a customer service strategy for the exchange that could be ready by September 2013.⁴² One of the team’s “guiding principles” was to design a customer service system that provided the same level of service to all consumers, whether they purchased commercial health insurance products through MNsure or enrolled in public programs.⁴³ The team reviewed existing state and county call centers and technologies and found systemic problems that often result in poor service for program participants. In response, they recommended that MNsure build a state-operated call center that could serve as a “front door” and “one-stop shop” for all of the exchange’s health insurance options. In this model, they recommended that MNsure and DHS collaborate to provide seamless service between the contact center and existing customer service resources at DHS.

The Customer Service Team also designed the contact center’s staffing structure. They recommended that the contact center transfer a portion of its calls using an interactive voice response (IVR), which routes calls based on a consumer’s selection from a menu of options. The rest of the calls would be handled or transferred by customer

service agents, separated into two tiers. According to the team’s design, Tier I agents were supposed to answer basic questions and refer callers to consumer assisters or other call centers. Tier II specialists were supposed to handle more complicated cases and complaints and be trained in specific areas, like tax credits or children’s benefits.

The team recommended that MNsure hire a total of 22 customer service agents, with up to 7 specialists. They based this number on: historical call data from

Initial Plan for Contact Center Staffing, 2013

Tier I

15 basic contact center agents

Tier II (specialists)

2 Tribal enrollment specialists

1 Medical Assistance enrollment specialist

1 Tax credits, brokers, and small employers specialist

1 Public programs and children’s benefits specialist

1 Complaints, grievances, and appeals specialist

1 Pharmacy and carrier network specialist

Total

22 contact center agents

⁴² According to their report, *MNsure Customer Service Recommendations Focused on Contact Center* (St. Paul, April 2013), the three staff assigned to the Customer Service Team were temporarily reassigned from the Minnesota Department of Human Services’ Continuing Care Administration and had experience implementing and managing the Senior LinkAge Line® and the Minnesotahelp Network™, which are Minnesota’s aging and disability resource centers.

⁴³ These “guiding principles” were laid out in *Minnesota Health Insurance Blueprint Application: 2.0 Consumer and Stakeholder Engagement and Support* (St. Paul, November 2012), 2. *MNsure Customer Service Recommendations Focused on Contact Center* (St. Paul, April 2013), 3.

DHS call centers; assumptions about MNSure's usage rates; and standard forecasting methods, which assumed calls would be answered in two minutes or less, on average. Overall, the team projected that the call center would receive around 1,060 calls per day during the open enrollment period.

State officials underestimated contact center call volumes and staffing needs during the first year of the exchange.

In June 2013, MNSure hired a contact center manager to implement the Customer Service Team's plans and recommendations. Early on, contact center staff were concerned about the accuracy of the team's call volume and staffing projections. Staff noted, for example, that MNSure's contact center was slated to handle calls from a wider variety of programs, with more complex cases, than the DHS call centers the Customer Service Team used as points of comparison. The team's plan also did not consider how staffing might be affected if the exchange experienced any technical problems, which, by this point, MNSure staff knew was a possibility. When contact center staff expressed their concerns to MNSure's leadership, they were given authority to hire five additional customer service agents. But contact center staff told us that even if the online application had worked perfectly, MNSure probably would have needed more than the number of customer service agents it initially hired.

Exhibit 6.4 shows the call volume and staffing levels the Customer Service Team projected for MNSure's first open enrollment period and for the remainder of the year, compared with actual levels. It also shows the contact center's actual customer service performance (in terms of wait times and abandoned calls) compared with the Customer Service Team's projections. As shown in the exhibit, the contact center's actual call volumes and staffing needs were much higher than the Customer Service Team projected. Over the course of open enrollment, for example, MNSure received more than twice as many calls per month, on average, as it anticipated. Actual wait times and call abandonment rates were also much higher than the team predicted.

MNSure waited until well into the first open enrollment period to contract with a vendor to provide extra customer service staff.

The Customer Service Team developed its staffing recommendations under the assumption that MNSure would hire a vendor to provide extra agents during the initial open enrollment period, and as needed thereafter. MNSure staff considered one vendor's proposal before October 2013, but they deemed it too expensive. The agency did not hire a vendor to provide extra customer service staff until February 2014, less than two months before the end of the first open enrollment period.⁴⁴

⁴⁴ The vendor's customer service agents began training on February 5 and answering calls on February 13. However, MNSure's contract with the vendor was not officially signed until February 21, 2014. All of these agents were trained at the Tier I level and answered calls at a separate site.

Exhibit 6.4: Projected and Actual Contact Center Staffing and Performance, October 2013 to August 2014

	(Open Enrollment Period)			
	Oct. 2013 to Mar. 2014		Apr. to Aug. 2014	
	Projected	Actual	Projected	Actual
Average monthly call volume	27,560	58,143	3,782	37,269
Average number of agents	22	80 ^a	6	76 ^a
Average number of minutes on hold	0.5	24.3	0.6	11.3
Average percentage of calls abandoned	8.8%	37.5%	9.3%	25.8%

NOTES: MNsure projected the contact center would receive 1,060 calls per day during open enrollment and 163 calls per day during the remainder of the year. Between October 1, 2013, and March 31, 2014, the contact center was open on 156 days; between April 1 and August 29, 2014, the contact center was open on 116 days. We did not include September 2013 data in these figures since the exchange had not yet opened.

^a This figure includes both MNsure contact center agents and vendor agents.

SOURCES: Projection figures by *MNsure Customer Service Recommendations Focused on Contact Center* (St. Paul, April 2013). Actual 2014 data was provided by MNsure with analysis by the Office of the Legislative Auditor.

The month before the back-up vendor was put in place, callers were waiting on hold an average of 40 minutes, and nearly 60 percent gave up before ever talking to a customer service agent. As seen in Exhibit 6.5, the new vendor added over 100 agents at the end of February and in March 2014, and fewer in April, May, and June. Although wait times and abandon rates greatly improved in these months, as seen in Exhibits 6.2 and 6.3, the contact center still failed to achieve its customer service goals for most of this period.

Knowledge and Training

The quality of the contact center's staff and training also contributed to MNsure's customer service failures during the first year of operation.

The contact center's training was insufficient, and most callers were dissatisfied with the quality of information they received from customer service agents.

When MNsure's contact center manager was hired in June 2013, staff had three months to develop curriculum and hire and train customer service agents. Staff told us the recruitment process was rushed, resulting in a limited number of qualified candidates. They also said the contact center's training was inadequate. This was in part because contact center agents, like MNsure's consumer assisters, did not have access to MNsure's online application during their training. Most

Exhibit 6.5: Contact Center Staffing Levels, September 2013 to August 2014

Month	Estimated Number of Staff Needed	Actual Number of Staff (Monthly Average)		
		MNsure	Vendor	Total
September 2013	6	27	-	27
October	22	30	-	30
November	22	29	-	29
December	22	42	-	42
January 2014	22	58	-	58
February	22	54	108 ^a	162
March	22	58	102	160
April	6	55	69	124
May	6	48	49	97
June	6	45	31	76
July	6	43	-	43
August	6	42	-	42

NOTE: MNsure’s contact center opened on September 3, 2013, in advance of the first day of the exchange, October 1, 2013.

^a Vendor staff did not begin taking calls until February 13, 2014.

SOURCES: “Estimated Number of Staff Needed” was taken from *Customer Service Recommendations focused on Contact Center* (St. Paul, April 2013). Actual staffing data were provided by MNsure.

contact center agents accessed MNsure’s system for the first time when the exchange opened on October 1, 2013.⁴⁵

In our surveys of consumers and consumer assisters, we asked them about their experiences with MNsure’s over-the-phone help.⁴⁶ While most navigators and brokers we surveyed

Assister Responses to the Following Survey Statement: “Call center representatives were knowledgeable.”			
	Navigators	CACs	Brokers
Always or almost always	8%	9%	2%
Often	27	25	13
Sometimes	49	40	48
Rarely or never	11	19	31

said customer service representatives were courteous, a majority said they were “sometimes” or “rarely or never” knowledgeable.⁴⁷ As one certified application counselor said, “Call center representatives [were] polite but initially only able to

⁴⁵ As of mid-September 2014, contact center agents still did not have access to a training version of MNsure’s online application.

⁴⁶ As we discuss later in this chapter, some navigators and certified application counselors did not understand the difference between the MNsure contact center and the Assister Resource Center (a phone support line for navigators and CACs). So, in our surveys, we asked them to evaluate their experiences with any of the phone support they received. We asked brokers to evaluate their experiences with the “Broker Line” at the MNsure contact center.

⁴⁷ Seventy-one percent of navigators, 70 percent of CACs, and 63 percent of brokers said customer service representatives “always or almost always” or “often” provided courteous service.

offer empathy rather than answers.” The majority of consumer assisters also said customer service representatives “sometimes” or “rarely or never” resolved their questions or concerns the first time they called.⁴⁸

In addition, more consumers rated the help they received from the contact center as “poor” or “very poor” than “good” or “very good.”⁴⁹ Many people also told us they received conflicting information from various customer service agents. As one consumer described, “[Each representative] told me a different answer and often passed me along with no direct answers or, worse yet, inaccurate information.” Contact center agents struggled to provide callers with helpful information, at least in part, because MNsure leadership did not provide agents with talking points or solutions related to callers’ technical problems.

Surveyed Consumers’ Ratings of the Help They Received from the Contact Center

Very good	6%
Good	12
Fair	14
Poor	11
Very poor	25
Did not use/no opinion	31

Technical Calls

During the first year of operations, MNsure did not have an adequate strategy for handling callers’ technical questions.

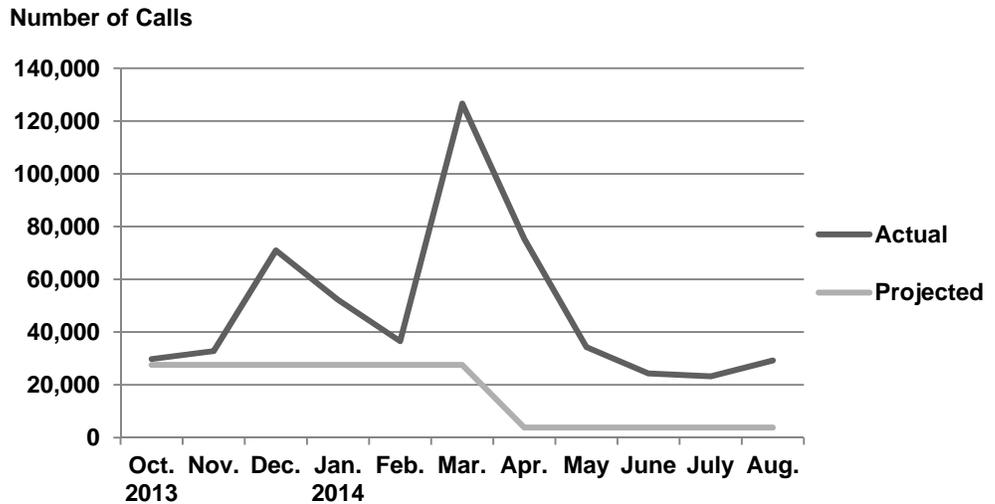
When consumers began experiencing major technical problems with MNsure’s online application in the fall of 2013, the contact center became inundated with calls. Exhibit 6.6 shows the volume of calls MNsure expected compared with the actual number of calls it received from October 2013 to August 2014. When call volume skyrocketed, the contact center’s two-tiered staffing structure dissolved and all available staff began handling as many calls as possible.

Even if the contact center had more agents, they would not have been able to resolve callers’ technical questions because none of the Tier II specialists were trained to handle them. In fact, MNsure had no available technical staff to which contact center agents could refer technical calls. As a result, contact center agents with no technical training were left helping consumers with technical problems—which, from October 2013 to April 2014, was the contact center’s second most common type of call.

⁴⁸ Sixty-one percent of CACs, 67 percent of navigators, and 85 percent of brokers we surveyed said call center representatives “sometimes” or “rarely or never” resolved their concerns so they did not have to make a second call.

⁴⁹ Thirty-one percent of consumers said they did not use the contact center or had no opinion about it in their survey responses.

Exhibit 6.6: Contact Center Call Volume, October 2013 to August 2014



SOURCES: Projection figures by *MNsure Customer Service Recommendations Focused on Contact Center* (St. Paul, April 2013), 11. Actual 2014 data was provided by MNsure with analysis by the Office of the Legislative Auditor.

Contact center staff were not satisfied with the temporary strategies MNsure leadership employed over the course of the first year to deal with these types of calls.⁵⁰ Starting in November 2013, contact center agents could notify a technical team of DHS, Office of MN.IT Services, and Maximus staff about callers’ technical issues.⁵¹ If a consumer called in after receiving an error message or getting “stuck,” contact center agents recorded the issue (which they called “creating a ticket”) and sent the ticket to the team. But contact center staff said this arrangement did not work well because the technical team did not directly take calls. In addition, when the team resolved issues, they did not inform the contact center or the callers. Contact center staff said they struggled throughout the first open enrollment period to get information from technical staff about “fixes” that had been developed. At one point, contact center agents were instructed to simply tell callers to “call back in two weeks” in the hopes that their technical issues had been resolved.

By December 2013, MNsure relocated some technical team members to the contact center to help track technical issues and improve communication about solutions that were available. But the technical team members still did not

⁵⁰ MNsure hosted a temporary conference call (called a “bridge”) that contact center leadership could call during the first week of the exchange to get answers to technical questions. When the exchange opened, this was the only support system the contact center had for handling callers’ technical questions.

⁵¹ Maximus was one of the firms in charge of building MNsure’s technical infrastructure.

handle calls directly, and contact center staff said this was not very effective. By April 2014, the technical team left the contact center, and customer service agents remained without adequate technical support during the summer of 2014.

Contact center staff told us that establishing an adequate mechanism for handling callers' technical issues was their biggest priority for MNsure's second year. Shortly before the second open enrollment period began, MNsure made available two e-mail addresses the contact center leadership could use to get answers about callers' technical issues. But contact center staff told us in January 2015 that this strategy was still insufficient—describing it as a “last minute Band-Aid again this year.”

Coordination with Other Resources

Another reason customer service was inadequate during MNsure's first year was callers did not receive seamless referrals from the contact center or experience consistent customer service from the state's various customer service resources. State officials established several “guiding principles” for the state to follow when developing the exchange's customer service approach.⁵² The guiding principles included:

- “Simplify[ing] the consumer experience” by providing “seamless” customer service and referrals between the contact center and other customer service resources.
- “Ensur[ing] that all consumers have the same service experience,” whether they seek coverage in a public program or a commercial health insurance plan.

MNsure's contact center was not well coordinated with other customer service resources.

Minnesota's health insurance exchange is connected to several public programs as well as private health insurers, so the contact center's referral protocols are complex. For example, the contact center refers calls about Medical Assistance to DHS's Minnesota Health Care Programs Member Help Desk, calls about MinnesotaCare to the DHS MinnesotaCare Operations call center, and calls about specific health insurance products to insurers.⁵³ It also refers consumers to hundreds of individual brokers and navigators and to many other state and county resources—all of which adhere to different hours, policies, and customer service

⁵² *Minnesota Health Insurance Exchange Blueprint Application Documentation, 2.0 Consumer and Stakeholder Engagement and Support: Contact Center* (St. Paul, November 2012), 2; and *MNsure Customer Service Recommendations Focused on Contact Center* (St. Paul, April 2013), 3.

⁵³ Contact center agents transfer and refer callers to many different customer service resources, including: all of the health and dental plans sold on MNsure; health care providers; hundreds of brokers, CACs, and navigators; the County Line (which refers callers to county human service agencies); tribal agencies; the Disability Linkage Line; the Senior LinkAge Line®; LinkVet; the Assister Resource Center; the Minnesota Health Care Programs Member Help Desk; MinnesotaCare Operations; the Provider Help Desk; the Managed Care Ombudsman; the MMIS Resource Center; the Minnesota Family Planning Program; and the State Medical Review Team.

standards. This makes it challenging for the contact center to provide seamless referrals and to ensure that all callers received the same level of service.

Many consumer assisters we surveyed said there was not enough coordination between the contact center and other customer service resources. As one broker explained, “The disconnect between the carriers, MNsure, and the county was very painful.” Similarly, a navigator said, “DHS would tell us one thing and MNsure another.” For example, when consumers went through the application process, were determined eligible for a DHS-administered public program, and then got “stuck” in the online system, DHS often referred them back to MNsure’s contact center for help. But MNsure staff told us that once consumers were deemed eligible for a public program, they were sent to DHS. Thus, there was a lack of clarity about which agency was responsible for handling these issues.

The majority of navigators and brokers said customer service representatives only “sometimes” or “rarely or never” provided appropriate referrals when they did not know the answer to a question.⁵⁴ Some navigators and brokers said call center representatives from various agencies referred consumers to them when representatives did not know the answer to a question. One navigator said, “Call centers often just passed the buck. [They] would refer clients to navigators when they should have answered clients’ questions.”

One source of the confusion between MNsure’s contact center and other call centers was that each had different degrees of access to consumers’ information. For example, although DHS and MNsure have an agreement to share consumers’ data, DHS had not—as of January 2015—granted contact center agents access to the DHS public program information systems that contained the data. This access would make it easier for MNsure contact center staff to identify and resolve some callers’ issues without transferring them to another call center.⁵⁵ Counties also had a different degree of access to consumers’ case information. As one certified application counselor explained, “The county...can’t see what MNsure sees [on an application].”

RECOMMENDATION

MNsure should improve its referral guidance for customer service staff in its contact center and in DHS and county call centers.

Over the course of the contact center’s first year, staff developed dozens of protocols diagramming when, where, and in what manner calls should be transferred to and from the contact center. They also developed some guidance about the kinds of calls other call centers could handle. But, judging from concerns we heard from users, these efforts were insufficient.

⁵⁴ Forty-nine percent of certified application counselors, 57 percent of navigators, and 75 percent of brokers said customer service representatives “sometimes” or “rarely or never” made appropriate referrals when consumers asked questions for which they did not have answers.

⁵⁵ Also, when MNsure contact center staff have called DHS for information on specific cases, DHS has not provided this information verbally.

Phone Support for Assisters

MNsure’s consumer assisters often called the contact center when they needed help assisting a consumer with an application, but they also got help from MNsure’s assister support lines—the “Broker Line” and the Assister Resource Center (ARC).⁵⁶ Originally, only one of the contact center’s Tier II specialists was trained to assist brokers, but this eventually increased to about five agents. ARC was a separate call center dedicated to answering calls from navigators and CACs. During the first year of MNsure operations, ARC was located within DHS and run jointly by MNsure and DHS.⁵⁷ By July 2014, ARC customer service staff were handling around 175 calls per day. A number of navigators and CACs we surveyed said they were more satisfied with the help they received from the Assister Resource Center than with the contact center.

To access ARC or the Broker Line, consumer assisters called MNsure’s toll-free number and selected an unlisted (or hidden) option from the menu. However, some assisters did not dial in correctly and waited in the contact center’s long lines rather than being directed to ARC or the Broker Line. Others were not aware that MNsure provided specialized phone support for them.⁵⁸

For the second year of operations, MNsure reorganized the way it provided phone support to its consumer assisters. The agency installed dedicated phone lines for ARC and the Broker Line, so assisters no longer have to dial into MNsure’s main line. This may eliminate some of the confusion assisters experienced. MNsure also trained more staff to support the Broker Line and relocated ARC to the MNsure contact center.⁵⁹ This move allowed MNsure to align the hours of operation for the two groups of customer service representatives. It may also make training more uniform for representatives helping consumer assisters and make customer service more consistent.

Changes

The contact center failed to provide adequate customer service to callers during the first year of the exchange, but MNsure made changes to address some of its problems for the second year. For example, by November 15, 2014, the first day of the second open enrollment period, MNsure had a total of 239 customer service agents taking calls—a dramatic increase from the 27 agents that started in the fall of 2013. A majority of the customer service agents answering calls in the

⁵⁶ The Broker Line was staffed by MNsure contact center agents and was a part of the contact center.

⁵⁷ Before the exchange was implemented, the Assister Resource Center supported the Department of Human Services’ Minnesota Community Application Agent Program, the precursor to MNsure’s Navigator Program.

⁵⁸ Also, some assisters unwittingly dialed into the Broker Line or ARC and incorrectly thought they were speaking to regular contact center agents.

⁵⁹ As of January 2015, MNsure considered ARC’s relocation to the contact center a pilot project.

second open enrollment period were employed by a vendor.⁶⁰ According to MNsure staff, the average wait time in November 2015 was 3 minutes and 30 seconds; in December it was 5 minutes and 45 seconds.⁶¹ We did not review in detail the impact of MNsure's changes on the contact center services provided to consumers and assisters during MNsure's second enrollment period.

ADVERTISING

MNsure was created to help enroll uninsured people and, more generally, to help Minnesotans make informed choices about health insurance. Consequently, MNsure leaders tried to find ways to convey their messages to a wide array of Minnesotans. During planning for the exchange, a work group offered advice on possible approaches:

The Outreach Work Group acknowledges the value of utilizing all marketing tactics to ensure an effective marketing campaign across the entire audience. The group strongly feels a larger effort should be expended on grassroots outreach through organizations that already serve their community rather than mass advertising.⁶²

Earlier, we discussed MNsure's consumer assistance grants, which provided some of the "grassroots outreach" referenced above.

In addition, exchange officials entered into other contracts for marketing and outreach in preparation for the first open enrollment period. The main contracts are shown in Exhibit 6.7. For example, the exchange spent more than \$200,000 to research, test, and develop a "brand." As stated in law, a purpose of the exchange is to "establish and modify as necessary a name and brand for [the exchange] based on market studies that show maximum effectiveness in attracting the uninsured and motivating them to take action."⁶³ Exchange officials hired a vendor that developed options for the exchange's name and designed possible logos.⁶⁴

⁶⁰ According to MNsure staff, about 75 MNsure contact center agents and 164 vendor agents were taking calls when the second open enrollment period began on November 15, 2014. At that time, the contact center also had about 23 permanent staff performing work other than answering calls.

⁶¹ In the second open enrollment period, the contact center's automated voice recordings no longer provided callers with estimated wait times, in contrast to contact center practice during much of the first period. Also, the contact center's prerecorded messages in the second period gave some inaccurate information. For example, on December 13, 2014, a recorded call center message said that "over 3,000" assisters were available to help consumers. But on that date, according to MNsure's online assister directory, MNsure only had 1,335 certified assisters.

⁶² Outreach, Communications and Marketing Work Group, *Report to the Health Insurance Exchange Advisory Task Force* (St. Paul, December 11, 2012), 29.

⁶³ *Minnesota Statutes* 2014, 62V.03, subd. 1.

⁶⁴ The 2013 law that created the exchange called it the "Minnesota Insurance Marketplace." The Legislature adopted the MNsure name into law later in the 2013 session.

Exhibit 6.7: MNsure’s Key Marketing and Outreach Contracts for First Open Enrollment Period

Vendor	Contract Dates	Key Focus	Amount
Salter Mitchell	April 2012-July 2012	Research on potential audiences and messages	\$ 165,901
Himle Rapp	October 2012-December 2012	Public relations plan	34,000
Haberman	November 2012-October 2013	“Branding” the exchange	210,000
BBDO	April 2013-March 2014	Outreach, especially the advertising campaign	1,592,047
SideDish	January 2014-March 2014	Testimonial radio/TV ads	112,900
Total			\$2,114,848

SOURCE: Office of the Legislative Auditor, based on review of MNsure documents.

The largest contract shown in Exhibit 6.7 (about \$1.6 million) was primarily for development and purchase of advertising.⁶⁵ Shortly before open enrollment began in October 2013, MNsure began publicizing itself through television, radio, and other ads featuring state icons Paul Bunyan and Babe the Blue Ox. The ads showed Paul sustaining injuries, with the message: “Minnesota: Land of 10,000 Reasons to Get Health Insurance.” Because MNsure was completely new, the ads were intended to create a general awareness of MNsure. The original plan was to run the Paul and Babe ads through the entire open enrollment period (ending in March 2014). But, in late 2013, MNsure management decided to discontinue the ads. Some testimonial ads—featuring consumers who had enrolled in MNsure—aired during the final two months of open enrollment.

MNsure’s advertising campaign during the first open enrollment period helped to increase awareness of the exchange, but the campaign’s effectiveness was undermined by MNsure’s technical problems.

The contractor that developed the original advertising campaign hired a firm to conduct an evaluation of the campaign; this evaluation did not examine the testimonial ads. The evaluation was based on surveys given to samples of Minnesotans before and after the ad campaign. The evaluation showed that 75 percent of respondents were aware of MNsure after the ad campaign (compared with 20 percent before the campaign), and more than half the respondents said they had seen a MNsure ad multiple times. But, the evaluation

⁶⁵ The original BBDO contract (for \$666,590) was increased to about \$1.6 million, but this amendment occurred after the additional work was completed. This resulted in an audit finding in: Office of the Legislative Auditor, *Minnesota Health Insurance Exchange: MNsure, Internal Controls and Compliance Audit, July 2011 through December 2013* (St. Paul, October 28, 2014), 11-13. Also, one component of the BBDO contract was a \$70,000 subcontract for an outreach plan. This plan was issued in May 2013, but many of its recommended strategies were not used in the first year of enrollment.

said, “The enormous gains in awareness did not translate into intention to enroll in MNsure.”⁶⁶ This suggested that the ads probably did not have much impact on enrollment.

The Paul and Babe ads were memorable, but they provided little information about MNsure. The evaluation of the ads reported that the commercials “lacked the educational value.”⁶⁷ In addition, only 28 percent of survey respondents who were shown a Paul and Babe commercial said they could “relate to the ad.”⁶⁸ The evaluation said that the ad campaign also showed an increase in negative impressions of MNsure. It said that problems with the website’s functionality and related media coverage contributed to the negative impressions.

DATA SECURITY

Information that MNsure collects, creates, or maintains regarding individuals who apply for health coverage is classified by law as not public.⁶⁹ During the application process, individuals may be required to provide sensitive information, such as birthdates, Social Security numbers, and income. An applicant may also be asked to provide information about which, if any, family members have communicable diseases, terminal illnesses, or mental illnesses. Because there is considerable legislative interest in the protection of these data, we examined some issues related to data security.

In 2013, as the Legislature discussed bills to establish MNsure, legislators asked many questions about the security and privacy of data that would be provided to the exchange. MNsure’s 2013 enabling legislation contained a section that specified how MNsure should handle the data it collected.⁷⁰ For example, the law makes MNsure subject to the Minnesota Government Data Practices Act, which defines various types of data and specifies who has access to each type of data.⁷¹ State law says MNsure may share data with other state or federal agencies to help verify individual identities, determine eligibility, process enrollments, process premiums, or investigate fraud, but it must have data-sharing agreements with those agencies before this occurs.⁷²

The Affordable Care Act required the U.S. Department of Health and Human Services to develop standards and protocols to ensure security and privacy when individuals enroll in federal and state health care programs. The department

⁶⁶ Persuadable Research Corporation, *Evaluating Advertising Campaign: MNsure* (Overland Park, KS, March 2014), 7.

⁶⁷ *Ibid.*, 20.

⁶⁸ *Ibid.*

⁶⁹ *Minnesota Statutes* 2014, 62V.06, subd. 3.

⁷⁰ *Minnesota Statutes* 2014, 62V.06.

⁷¹ *Ibid.*, subd. 1.

⁷² *Ibid.*, subd. 5(a). State law also authorizes MNsure to share information with nongovernmental entities for these purposes, provided that MNsure has contracts with these entities that comply with the state’s government data practices provisions.

developed Minimum Acceptable Risk Standards for [Health Insurance] Exchanges, commonly referred to as MARS-E. These standards “provide a starting point for security guidance that exchanges can use in implementing and operating their [information technology] systems in support of the Affordable Care Act.”⁷³

State information technology experts consider MNsure’s data security structure to be sophisticated and effective, even though the system does not yet meet all of the federal government’s security requirements.

An independent contractor issued a security assessment of MNsure in late August 2013, about one month before MNsure’s first open enrollment began.⁷⁴ That report assessed 282 security controls and found that 145 (51 percent) had been fully implemented. The remaining controls were either partially implemented or planned. The report identified 40 system risks, and it categorized none as high risks, 7 as moderate risks, and 33 as low risks. The report concluded that MNsure’s system was “substantially compliant” with the MARS-E standards.

Minnesota’s Office of MN.IT Services helped to build and implement security practices for Minnesota’s exchange. Shortly before open enrollment began, an official from that office testified to legislators that the low and moderate risks identified by the August 2013 external review had been addressed.⁷⁵ When asked by a legislator whether there were any security issues that should cause MNsure to delay open enrollment, the official said: “That’s a difficult question to answer.... We still have some final security work to do.... At this point in time, we don’t see a list of those show-stopper issues from a security perspective....”

The federal government gave Minnesota’s health insurance exchange “authority to connect” to the Federal Data Services Hub on September 27, 2013. Curiously, a federal document from the following day said that the Centers for Medicare and Medicaid Services’ chief information security officer “rates the risk associated with the Minnesota MNsure Application [Authority to Connect] as High.”⁷⁶ An Office of MN.IT Services official told us his agency never saw this federal document at the time, and he does not understand the basis for its conclusion.

⁷³ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Minimum Acceptable Risk Standards for Exchanges—Exchange Reference Architecture Supplement*, Version 1.0 (Washington, DC, August 1, 2012), 2.

⁷⁴ WIPFLi, *MNsure Security Assessment Report*, August 29, 2013. The report is not a public document.

⁷⁵ MNsure Legislative Oversight Committee, September 24, 2013.

⁷⁶ Jane Kim, Center for Medicare and Medicaid Services, “[Chief Information Security Officer] Reviewer Overall Comments & Recommendations,” September 28, 2013. The document said this was based on various considerations, including 110 security controls “not documented or incomplete.”

A second independent security assessment of MNsure's system was issued in June 2014.⁷⁷ It said that 82 percent of the security controls it assessed had been fully implemented. The assessment identified 3 security issues it categorized as high risks; there were also 9 moderate risks and 23 low risks. We asked the Office of MN.IT Services for an update on the status of the issues identified in this security audit. As of October 2014, seven moderate and eight low risk issues remained, according to the office.

Despite these outstanding issues, officials from the Office of MN.IT Services told us that MNsure's security controls may be the best that Minnesota state government has ever built. They said there is room for improvement, and they expressed confidence that officials from MNsure, the Department of Human Services, and the Office of MN.IT Services will jointly give attention to the remaining security issues.

To our knowledge, there have been no instances of large-scale security breaches involving data supplied to MNsure by applicants or enrollees.⁷⁸ There have been a few instances in which personal information submitted to MNsure has been unintentionally shared with others. For example, a consumer asked MNsure to reset an account password but gave MNsure an incorrect application number; the consumer used the incorrect application number and new password to view an online application and recognized that it contained information about another person. MNsure disabled the account.

Ability to Detect Improper Data Access

State law says: "Only individuals with explicit authorization from the [MNsure Board] may enter, update, or access not public data collected, created, or maintained by MNsure."⁷⁹ The law also says: "All queries and responses, and all actions in which data are entered, updated, accessed, or shared or disseminated outside of MNsure, must be recorded in a data audit trail."⁸⁰

MNsure has some—but not complete—ability to identify inappropriate access to individuals' not-public records.

⁷⁷ WIPFLi, *MNsure Security Assessment Report*, June 6, 2014. The report is not a public document. The report said: "Due to the limited nature of this assessment, and the fact that it is a point in time assessment, we cannot provide an opinion as to the overall security posture of the MNsure system and organizational environment" (p. 2). This assessment excluded review of (1) security controls that had been implemented before the first review and did not have moderate or high risks at that time; and (2) security controls deemed "not critical."

⁷⁸ However, there was an incident in September 2013 in which a MNsure employee inadvertently sent not-public information about a large number of insurance brokers to a broker. See Office of the Legislative Auditor, *MNsure: An Unauthorized Disclosure of Private Data, Special Review* (St. Paul, November 7, 2013).

⁷⁹ *Minnesota Statutes* 2014, 62V.06, subd. 8(a).

⁸⁰ *Ibid.*

At a September 2013 legislative hearing, MNsure was asked about the status of its “audit trail” capabilities.⁸¹ A MNsure official described how MNsure intended to analyze “a large volume of data” for the purpose of “tracking every single view or modification to any piece of personally identifiable data within [the] system.” The official seemed to indicate that this capability was still under development, so a legislator asked if there was a timeline for putting this in place. The MNsure official responded, in part: “The audit trail is fully functional within the system.”

To better understand the functionality of MNsure’s audit trail system, we talked with Office of MN.IT Services staff. We learned that, prior to October 1, 2013, the plan to install a system-wide, integrated analytics system to help MNsure monitor access to data and identify possible privacy breaches was postponed indefinitely. We were told in late 2014 that action on this system has been postponed until at least 2015.

Without such a system, MNsure still has the ability to review who has accessed not-public data, but in limited ways. For example, if an individual wants to know who has accessed his or her private data, MNsure can look at its records to determine this. However, MNsure does not currently have the ability to do large-scale reviews of its entire enrollee database to identify “red flags” that might indicate inappropriate access.

In our view, MNsure’s response to a 2013 legislative question on this topic did not provide a sufficiently clear picture of MNsure’s audit trail capabilities. We have no reason to think that MNsure’s response was intentionally misleading. Nevertheless, we think it is important to clarify that while MNsure has established the “data audit trail” required by state law, MNsure’s ability to identify and investigate possible cases of inappropriate access is, at this time, somewhat limited.

⁸¹ MNsure Legislative Oversight Committee, September 24, 2013.

List of Recommendations

- The Legislature should amend *Minnesota Statutes* 2014, chapter 62V, to ensure that MNsure’s future information technology work is subject to oversight from the Office of MN.IT Services. (p. 36)
- The MNsure Board should ensure implementation of its policies or, if necessary, revise policies that are not realistic to implement. (p. 50)
- The MNsure Board should:
 - Adopt consumer assister compensation rates annually and ensure that changes in the rates are published in a timely manner in the *State Register*; and
 - Adopt navigator, call center, and customer service policies in 2015. (p. 51)
- The Legislature should establish in state law a structure for governing MNsure’s online enrollment system. (p. 52)
- The Legislature should amend state law to give the governor, rather than the MNsure Board, authority to appoint the MNsure chief executive officer. (p. 55)
- The Legislature should consider whether to retain the MNsure Board as a governing body or to make it advisory. (p. 55)
- MNsure should develop ways to improve its access to the applicant and enrollee data it collects—for the purpose of assessing MNsure performance, generating management reports, and responding to public inquiries. (p. 62)
- MNsure and DHS should ensure that brokers are fairly compensated for enrolling consumers in insurance through MNsure. (p. 109)
- MNsure should improve its referral guidance for customer service staff in its contact center and in DHS and county call centers. (p. 123)

Appendix A: Glossary of Terms

Actuarial Value: The estimated percentage of total expenditures for “essential health benefits” (see below) that would be covered by an insurance product for a standard population of insured individuals. For example, an insurance product with an actuarial value of 70 percent would cover 70 percent of the costs for essential health benefits that are provided to individuals covered by that insurance. An insurance product’s “metal level” (see below) indicates the actuarial value of that product.

Advanced Premium Tax Credit (APTC): A type of federal tax credit available to people who purchase health insurance through an exchange, depending on their income and household size. The credit may be claimed by eligible people when they file income taxes. Alternatively, qualified individuals may use the tax credit right away to lower their monthly health insurance premium costs; in this case, the U.S. Treasury Department sends monthly payments to the person’s insurer to cover all or part of the premium.

Adverse Selection: The tendency for people to avoid buying insurance until they think they will benefit from it. As a result of adverse selection, people who are sicker tend to be more likely to obtain insurance coverage than healthier people.

Affordable Care Act (ACA): The common name for the federal legislation signed into law in March 2010 that aimed to reduce the number of people without insurance, increase the quality and affordability of coverage, and reduce the costs of health care. The full title of the act is the Patient Protection and Affordable Care Act.

Assister Resource Center (ARC): A MNsure call center—separate from MNsure’s contact center—dedicated to answering questions from MNsure-certified navigators and certified application counselors.

Basic Health Program (BHP): A federal option under the Affordable Care Act that allows states to receive federal assistance if they offer insurance to certain low-income people with incomes too high to be eligible for Medicaid. For states implementing a Basic Health Program, the federal government pays 95 percent of the advanced premium tax credit and cost-sharing reductions for which participating individuals would have qualified if they had enrolled through a health insurance exchange in a qualified health plan. In 2015, Minnesota is the only state offering a Basic Health Program. Minnesota’s Basic Health Program is called MinnesotaCare.

Broker: A state-licensed seller of health insurance who helps individuals or businesses purchase insurance. Brokers (also called insurance agents or producers) are licensed and regulated by the Minnesota Department of Commerce. Brokers receive payments from a health insurer for enrolling an individual in that insurer’s products, assuming the insurer has authorized the

broker to sell insurance on its behalf. Brokers must be certified by MNsure to provide assistance to individuals seeking to obtain insurance through MNsure.

Certified Application Counselor (CAC): A person—typically a hospital employee—who helps individuals applying for insurance through MNsure. CACs do not receive compensation for this assistance from MNsure or insurers.

Children’s Health Insurance Program (CHIP): A federal program that provides health insurance coverage to uninsured children under age two from low-income families and to uninsured, low-income, pregnant women.

Coinsurance: A type of out-of-pocket cost required by some insurance products. Specifically, health insurance products may require that an insured individual who is making an insurance claim pay a percentage of the bill that remains after any required deductible amount has been paid.

Consumer Assister: A general term that we use in this report to refer to several categories of people who provide application and enrollment assistance to individuals seeking to enroll through MNsure. As used here, a consumer assister may be a navigator, certified application counselor, or broker; all of these terms are separately defined in this glossary.

Contact Center: A customer service call center operated by MNsure. Federal law requires health insurance exchanges to have toll-free phone lines that individuals can call to get help when enrolling in insurance through the exchange.

Copayment: A type of out-of-pocket cost usually paid at the time an insured person receives a service. For example, an insurance product may require that a covered individual pay \$20 each time the individual has a health care appointment.

Cost-Sharing Reduction (CSR): A discount available to certain individuals who buy health insurance through an exchange. The Affordable Care Act authorizes cost-sharing reductions for people with incomes between 139 and 250 percent of the federal poverty level who purchase a “silver plan” (see the definition of “metal level” below). In Minnesota, only individuals with incomes between 201 and 250 percent of the federal poverty level are eligible for cost-sharing reductions, due to Minnesota’s implementation of a Basic Health Program for people with incomes between 139 and 200 percent of the federal poverty level. With a cost-sharing reduction, a person’s health insurance product has lower out-of-pocket health care expenses—copayments, deductibles, and coinsurance—than it would otherwise have. A silver plan would generally cover 70 percent of the costs of covered individuals’ essential health benefits, but a cost-sharing reduction effectively increases this coverage to 73 percent.

Deductible: The amount people pay for health care services before their insurer begins to pay. For example, if someone buys an individual insurance product with a \$2,000 deductible, insurance will generally not cover the person’s claims until the bills submitted for health care services in that year exceed the amount of the deductible.

Essential Health Benefits: A comprehensive set of services that “qualified health plans” (see below) must offer under the Affordable Care Act. The plans must offer services in ten categories, including doctor visits, hospitalization, mental health services, prescription drugs, and others. In Minnesota, the “small group” insurance plan (that is, an insurance product sold to businesses with 2 to 50 full-time-equivalent employees) with the largest enrollment statewide provides the benchmark for evaluating the benefits in other plans. This means that all qualified health plans in Minnesota must offer benefits similar to those offered by the benchmark plan.

Exchange: A resource where individuals, families, and small businesses can learn about their health coverage options, compare health insurance products, and enroll in coverage. Exchanges are sometimes called health insurance “marketplaces.” In this report, we use the term “exchanges” to refer to exchanges authorized by the Affordable Care Act, although privately operated exchanges may have similar features. Individuals only qualify for federal advanced premium tax credits or cost-sharing reductions when they purchase insurance through an ACA-authorized exchange.

Individual Market (or “Nongroup” Insurance): Insurance that is sold to individual buyers, rather than to groups or employers. In Minnesota, such insurance may be purchased directly from an insurer or through MNsure.

Insurer (or “Health Plan”): A company that provides insurance coverage to individuals or businesses.

Large-Group Insurance: Health insurance that is provided to individuals or families through a group health plan by an employer with more than a certain number of employees. The Affordable Care Act defines large-group as 50 or more full-time-equivalent employees.

Life Event: A circumstance that allows a person to enroll in insurance or make a change to their existing insurance coverage outside of an open enrollment period. A qualifying life event might include a change of residence, a change in income, or a change in family size (for example, through a birth, death, marriage, divorce, or adoption).

Medical Assistance (MA)/Medicaid: A program—funded roughly equally by federal and state dollars—that pays for health insurance for low-income people. The federal program is called Medicaid, and Minnesota’s version of the Medicaid program is called Medical Assistance.

Metal Level: A designation—bronze, silver, gold, or platinum—that is given to “qualified health plans” (see below) to help consumers compare plans offering similar coverage. Metal levels reflect the percentage of total “essential health benefits” costs (see above) the plan will cover, based on actuarial assessments. For example, a bronze plan would cover 60 percent of the expected value of the essential health benefits; a silver plan would cover 70 percent; a gold plan would cover 80 percent; and a platinum plan would cover 90 percent.

MinnesotaCare: A Minnesota program, created in 1992, that provides health insurance to individuals who do not qualify for Medical Assistance. Starting in 2015, MinnesotaCare serves as Minnesota’s “Basic Health Program” under the Affordable Care Act. MinnesotaCare mostly provides coverage to adults with modified adjusted gross incomes between 139 and 200 percent of the federal poverty level. Most MinnesotaCare recipients pay a sliding-scale premium, ranging from \$4 to \$50 monthly.

MNsure: Minnesota’s health insurance exchange, as authorized in state law by the 2013 Legislature. “MNsure” is the name of the state agency, governed by a board, that has directed the development of the exchange, pursuant to the federal Affordable Care Act. MNsure is not an insurance company. However, individuals and businesses may purchase and enroll in commercial insurance or public health care programs through MNsure—or, more accurately, through MNsure’s online enrollment and eligibility determination system. People purchasing commercial insurance may access through MNsure any Affordable Care Act tax credits or subsidies for which they qualify.

Modified Adjusted Gross Income (MAGI): A definition of income that is used to determine eligibility for most recipients of Medical Assistance, MinnesotaCare, advanced premium tax credits, and cost-sharing reductions. As defined for federal tax purposes, modified adjusted gross income is a household’s adjusted gross income plus any tax-exempt Social Security, interest, or foreign income.

Navigator: A type of consumer assister, typically employed by a community-based organization, that helps people enroll in public health insurance programs or commercial products offered through MNsure. Navigators must help any MNsure user that requests their assistance and provide information in a fair, accurate, and impartial manner. Navigators receive state compensation for each person they help enroll through MNsure; they do not receive compensation from insurance companies. Navigators must help consumers understand the differences between their health insurance options, but they may not advise people about which specific commercial product to select.

Network: The group of health care providers that an insured person is authorized to use, under the terms of the insurance they have obtained.

Open Enrollment: The period of time when individuals may obtain or change commercial insurance through MNsure. For example, individuals purchasing commercial insurance for calendar year 2015 could enroll or re-enroll through MNsure between November 15, 2014, and February 15, 2015. During other parts of the year, individuals may only make changes in their commercial insurance coverage if they have a qualifying “life event” (see above) or are members of an American Indian tribe.

Out-of-Pocket Costs: Costs for health care services that are the responsibility of the insured person. These costs may include deductible amounts, coinsurance, and copayments.

Portal: A point of access to a health insurance exchange’s online enrollment system. MNsure was intended to have separate portals for use by navigators/brokers, health insurers, county and state human services caseworkers, and MNsure financial staff. However, these portals were not all fully functional during MNsure’s first two enrollment years.

Premium: The monthly amount paid by an individual to an insurance company for providing health care coverage.

Premium Withhold: The portion of paid premiums that MNsure uses to cover part of its operating expenses. Under state law, MNsure is authorized to retain up to 3.5 percent of premiums paid by individuals who have enrolled in qualified health plans through MNsure.

Qualified Health Plan: Insurance products that have been certified, in accordance with the Affordable Care Act, to be sold through health insurance exchanges. Insurers may apply to MNsure to have their commercial insurance products sold through the state exchange. The Affordable Care Act requires qualified health plans to offer “essential health benefits” (see above) and have designated “metal levels” (see above). Minnesota law also requires certain products sold in the small-group and nongroup markets outside of MNsure to be certified as qualified health plans.

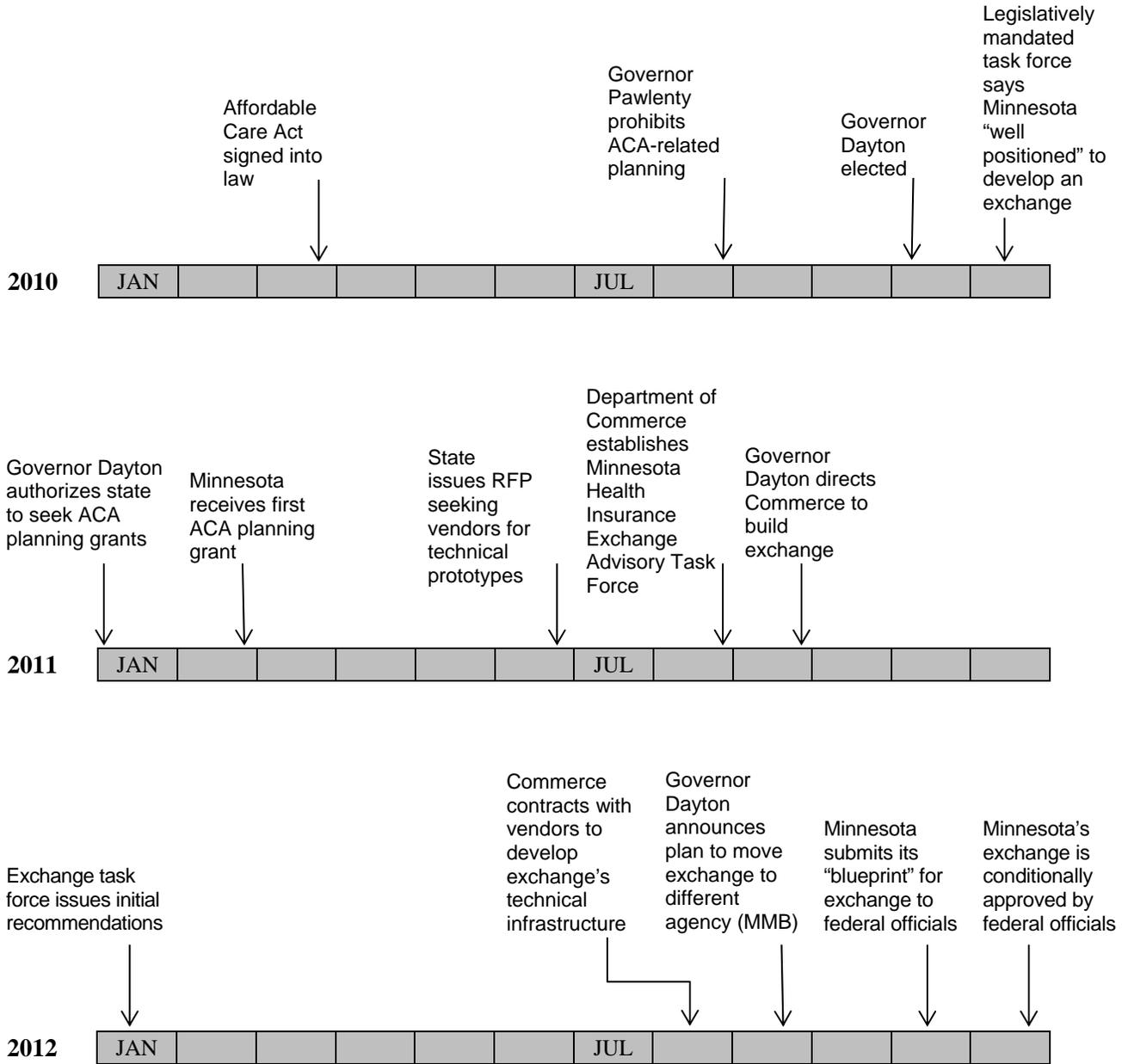
Small-Group Insurance: Health insurance that is provided to individuals or families through a group health plan by an employer with fewer than a certain number of employees. The Affordable Care Act defines small-group as fewer than 50 full-time-equivalent employees.

SOURCE: Office of the Legislative Auditor.

Appendix B: Key Events in MNsure's Development and Implementation

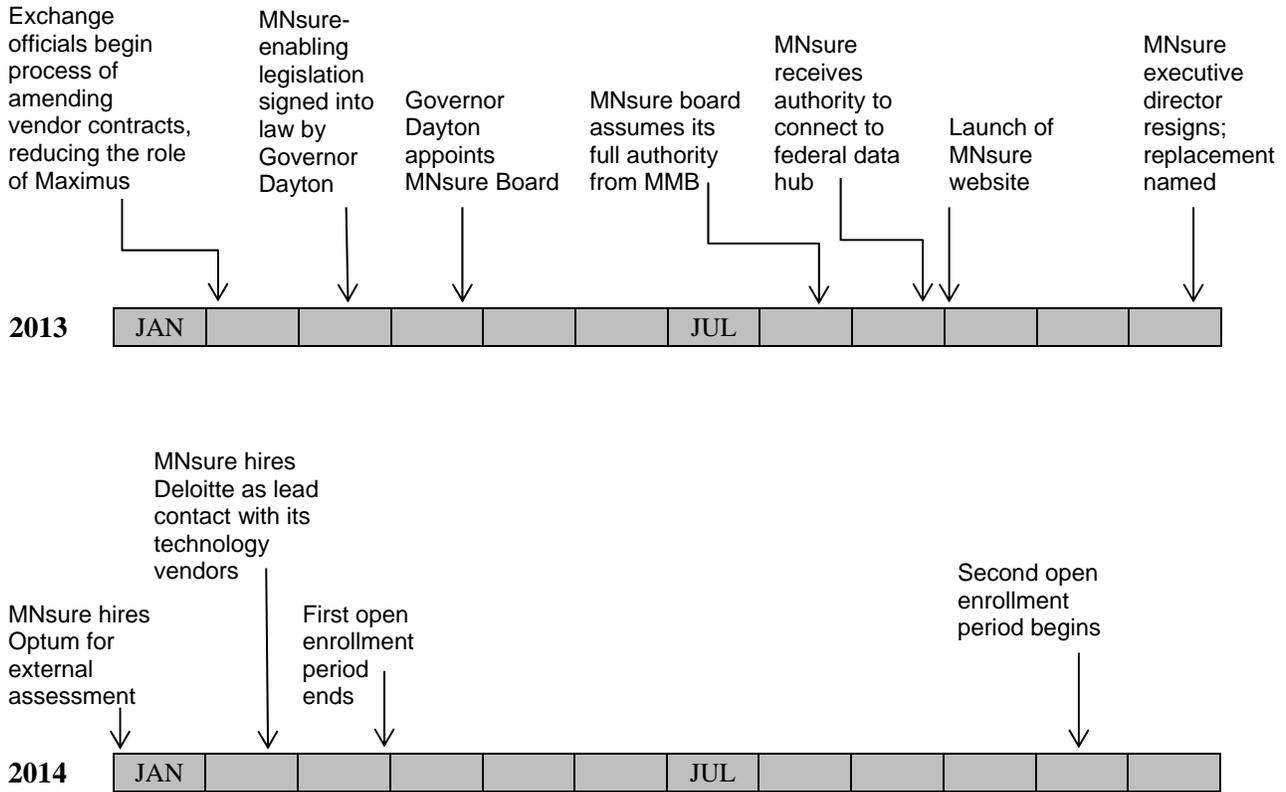
The following pages show selected events in the development and implementation of MNsure. This timeline is not intended to be comprehensive, but it provides context for understanding MNsure's relatively short history.

Timeline of Key Events



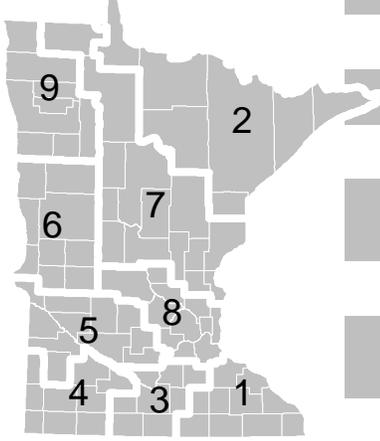
(continued on next page)

Timeline of Key Events (continued)



SOURCE: Office of the Legislative Auditor.

Appendix C: Health Insurance Rating Areas in Minnesota



Rating Area Number	Region	Counties
1	South East	Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Steele, Wabasha, Winona
2	North East	Carlton, Cook, Itasca, Koochiching, Lake, Lake of the Woods, Saint Louis
3	South Central	Blue Earth, Faribault, Le Sueur, Martin, Nicollet, Rice, Waseca, Watonwan
4	South West	Brown, Cottonwood, Jackson, Lincoln, Murray, Nobles, Pipestone, Redwood, Rock
5	Mid Central	Big Stone, Chippewa, Kandiyohi, Lac qui Parle, Lyon, McLeod, Meeker, Renville, Sibley, Swift, Yellow Medicine
6	West Central	Becker, Clay, Douglas, Grant, Otter Tail, Pope, Stevens, Traverse, Wilkin
7	North Central	Aitkin, Beltrami, Cass, Chisago, Crow Wing, Hubbard, Isanti, Kanabec, Mille Lacs, Morrison, Pine, Roseau, Todd, Wadena
8	Twin Cities	Anoka, Benton, Carver, Dakota, Hennepin, Ramsey, Scott, Sherburne, Stearns, Washington, Wright
9	North West	Clearwater, Kittson, Mahnomon, Marshall, Norman, Pennington, Polk, Red Lake

SOURCE: Minnesota Department of Commerce.

The federal Public Health Service Act, as amended by the Affordable Care Act, requires states to establish geographic divisions known as “rating areas.”¹ A health insurance enrollee’s rating area of residence is one of four factors that may be considered by health insurers when varying the premium to be paid by the enrollee for any given insurance product sold in the individual or small-group market, whether through MNsure or not.² To be presumed adequate by the U.S. Department of Health and Human Services (HHS), the number of rating areas in a state must not exceed one more than the number of metropolitan statistical areas in that state.³ State law requires that geographic rating areas contain no fewer than seven counties that create a contiguous region.⁴ Minnesota’s rating areas were defined by the state’s departments of Commerce and Health.

¹ 42 U.S. Code, sec. 300gg (2013).

² The other factors that may affect the premium are the age of the enrollee, whether the enrollee uses tobacco products, and whether the insurance product covers an individual or a family.

³ Metropolitan statistical areas (MSAs) are defined by the U.S. Office of Management and Budget as having at least one urbanized area of 50,000 or more inhabitants. Portions of Minnesota are included in eight MSAs, some of which have their principal cities in North Dakota or Wisconsin. Therefore, Minnesota could have a maximum of nine rating areas.

⁴ Minnesota Statutes 2014, 62A.65, subd. 3(b).

Appendix D: 2014 Federal Poverty Guidelines

For the 48 Contiguous States and the District of Columbia

Family/Household Size	100%	138%	200%	250%	275%	400%
1	\$11,670	\$16,105	\$23,340	\$ 29,175	\$ 32,093	\$ 46,680
2	15,730	21,707	31,460	39,325	43,258	62,920
3	19,790	27,310	39,580	49,475	54,423	79,160
4	23,850	32,913	47,700	59,625	65,588	95,400
5	27,910	38,516	55,820	69,775	76,753	111,640
6	31,970	44,119	63,940	79,925	87,918	127,880
7	36,030	49,721	72,060	90,075	99,083	144,120
8 ^a	40,090	55,324	80,180	100,225	110,248	160,360

NOTE: The 2014 Federal Poverty Guidelines are used to make eligibility determinations for coverage year 2015.

^a For families/households with more than 8 persons, add \$4,060 to the 100 percent column for each additional person.

SOURCE: Poverty Guidelines, 79 *Fed. Reg.* 3,593 (2014).

Appendix E: Current Assessment of Gruber-Gorman Projections

In 2011, the Minnesota Department of Commerce hired Jonathan Gruber, professor of economics at the Massachusetts Institute of Technology, and Gorman Actuarial to estimate the impact of the Affordable Care Act (ACA) and a state-based health insurance exchange on Minnesota. The initial Gruber-Gorman economic and actuarial analysis was released in April 2012. A second Gruber-Gorman report updated the earlier analysis and was released in February 2013, when the enabling legislation for Minnesota's exchange was moving through the Legislature. Both reports made projections of the ACA's impacts for 2016.

The February 2013 report consistently assumed that public health insurance would be available for children up to 275 percent of the federal poverty guidelines (about \$65,588 for a family of four) and sometimes assumed that Minnesota would adopt a Basic Health Program. This report made four key projections regarding the impact of the ACA. Below, we compare the 2013 Gruber-Gorman projections for 2016 with what is known as of early 2015.

Projection 1

The 2013 Gruber-Gorman report projected that if MinnesotaCare were implemented as the Basic Health Program, the number of uninsured people in Minnesota under the ACA would drop by between 298,000 and 340,000 people (up to 68 percent) in 2016 from the projected uninsurance rate without the ACA (10.9 percent). This would mean that there would be as few as 159,000 uninsured Minnesotans in 2016.

In fact, a 2014 study estimated that the number of uninsured people in Minnesota fell by 180,520 people (40 percent) from the Fall 2013 uninsurance rate of 8.2 percent.¹ As of May 1, 2014, there were an estimated 264,480 uninsured Minnesotans. Thus, as of mid-2014, Minnesota's number of uninsured people was greater than the number that Gruber-Gorman projected for 2016.

Projection 2

The Gruber-Gorman report projected that the individual insurance market would cover 530,000 individuals in 2016. It said there would be little change in the number of people covered by employer-sponsored insurance. Projection 2 did not contemplate the availability of MinnesotaCare as the Basic Health Program.

¹ 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, University of Minnesota, June 2014).

In fact, the individual insurance market covered 324,510 individuals as of May 1, 2014.² As projected, between September 30, 2013, and May 1, 2014, there was little change in the number of people covered by employer-sponsored insurance.

Projection 3

The 2013 Gruber-Gorman report projected that Minnesota's health insurance exchange would enroll 1.3 million people in 2016. The report estimated that qualified health plans would account for 35 percent of total enrollments through the exchange, assuming that the state retained MinnesotaCare as the Basic Health Program. In fact, the exchange enrolled approximately 371,000 people as of November 11, 2014. About 15 percent of these enrollments were in qualified health plans.

Projection 4

The Gruber-Gorman report projected that overall premium costs in the individual market—inside and outside the exchange—would fall by 34 percent on average after accounting for subsidies, relative to what premiums in that market would have been in 2016 had the ACA not been implemented. The report estimated that 70 percent of the individual market would experience no change or a decrease in premiums. Projection 4 did not contemplate the availability of MinnesotaCare as the Basic Health Program.

In fact, an analysis by Yale University economist Amanda Kowalski, supplemented by our own research, showed that, as of mid-2014, premium costs in the overall individual market in Minnesota averaged 5 percent higher, accounting for tax credits received through MNsure, than what premiums in that market would have been in mid-2014 if the Affordable Care Act had not been implemented and there were no changes in plan characteristics.³

Specifically, the Kowalski study projected that, without the ACA, average premiums in the individual market in Minnesota would have been \$230 per month if trends since 2008 had persisted into the second quarter of 2014. Actual average premiums in Minnesota's overall individual market—both inside and outside of MNsure—as of mid-2014 were \$256 per month, not accounting for subsidies. This represented an increase of 11 percent over Kowalski's estimate of average premiums without the ACA.

We extended Kowalski's analysis using enrollment data from the Office of MN.IT Services to account for the average advanced premium tax credit taken by qualified health plan enrollees who received it, which amounted to around \$203. That tax credit was only taken by about 7 percent of the overall individual market. After weighting to account for that, the average monthly premium paid in the overall individual market was \$242 as of mid-2014, a 5 percent increase

² *Ibid.*, 6.

³ Amanda Kowalski, *The Early Impact of the Affordable Care Act State-by-State* (Washington, DC: Economic Studies at Brookings, September 2014).

over what Kowalski estimated individual market premiums would have been without the ACA.

It is not currently known what percentage of the overall individual market experienced no change or a decrease in premiums. Our survey of MNsure qualified health plan enrollees found that 69 percent of those who had previously purchased insurance directly from an insurer said that their MNsure premiums, after subsidies, are “better” than or “about the same” as their previous insurance premiums.

Appendix F: MNsure Grants to Promote Enrollment and Consumer Outreach, October 2013 to September 2014

As discussed in Chapter 6, MNsure awarded \$4.75 million in competitive grant funds to 41 community organizations in the fall of 2013. The grants supported organizations that provided application and enrollment assistance to consumers via navigators, and organizations that conducted outreach and education about MNsure to targeted populations across the state.

The following tables show the performance of MNsure grantees in enrolling individuals and holding outreach events. The grantees' contracts established goals in each of these areas. We analyzed MNsure enrollment data to estimate each grantee's achievement of its enrollment goal during MNsure's first year. For goals related to the number of outreach events and people "reached" through these events, the only performance data available were those self-reported by grantees. The outreach data were not verified by MNsure or the Office of the Legislative Auditor.

MNsure and one grantee (Small Business Minnesota) mutually agreed to terminate the grantee's contract in June 2014 because problems with the functionality of MNsure's small business application would have made it difficult for the organization to fulfill its grant duties. Small Business Minnesota returned all of the funds it was awarded.

Exhibit F.1: Number of People that MNSure Grantees Enrolled through MNSure

Grantee	Grant Award	Number of People Enrolled	People Enrolled, as a Percentage of Enrollment Goal in Contract
Arrowhead Economic Opportunity Agency ^a	\$128,000	864	229%
C.A.R.E. Clinic	20,000	142	29
Central MN Jobs and Training Services	118,836	1,080	63
Centro Cultural Chicano	47,293	124	41
Children's Dental Services	35,000	18	18
Communicating for America ^a	38,836	221	44
Community Resource Connections ^a	141,600	337	65
Comunidades Latinas Unidas en Servicio (CLUES) ^a	99,120	350	101
Confederation of Somali Community in MN	50,000	47	3
Dakota County	190,367	0	0
Family Tree Clinic	30,000	142	142
Generations Healthcare Initiatives ^a	230,369	2,024	174
Health Access MN ^a	326,606	1,729	29
HealthFinders Collaborative	31,662	516	172
Hmong American Partnership ^a	153,552	2,196	211
International Institute of MN	128,560	1,419	71
McDonough Organization with Respect and Equality for People (MORE)	2,407	75	33
Minneapolis Urban League ^a	100,000	118	59
MN Adult and Teen Challenge	56,640	379	24
MN AIDS Project ^a	192,576	649	43
MN Chippewa Tribe ^a	192,573	66	7
MN Community Action Partnership	424,150	2,786	70
MN Council of Churches	159,830	240	75
MN Recovery Connection	45,000	166	66
National Alliance on Mental Illness ^a	125,000	31	6
NorthPoint Health and Wellness Center ^a	138,052	1,992	203
Pillsbury United Communities ^a	100,000	375	94
Planned Parenthood MN, ND, SD ^a	150,333	572	11
Portico Healthnet ^a	377,592	6,162	103
ResourceWest	45,974	133	76
Somali Health Solutions ^a	149,421	1,721	143
Southside Community Health Services ^a	94,400	946	20
Springboard for the Arts	50,032	31	9
Stairstep Foundation ^a	100,000	173	58
Sub-Saharan African Youth and Family Services in MN	25,000	83	55
West Side Community Health Services ^a	75,000	493	66
Western Community Action ^a	257,183	1,183	59
Women's Health Center of Duluth, P.A.	21,385	191	76
Total		29,774	58%

NOTES: This exhibit only includes the 28 grantees that set enrollment goals in their contracts with the state. The enrollment figures presented here represent our best estimates of the number of consumers successfully enrolled with the help of a navigator, based on our analysis of MNSure's payment reports. Because of MNSure's weak recordkeeping and problems with MNSure's enrollment system, we could not independently verify the exact number of navigator-aided enrollments, as explained in Chapter 6. Enrollments facilitated by navigator organizations that did not receive grant funds were not included in this table. Enrollments facilitated by subcontractor organizations were included in the primary grantees' total enrollments.

^a Grantee received additional funds for outreach and enrollment activities in the 2014-15 enrollment year through another round of MNSure grant awards.

SOURCES: MNSure's grant contracts and Office of the Legislative Auditor's analysis of MNSure's enrollment payment reports.

Exhibit F.2: Extent of MNsure-Related Outreach Reported by MNsure Grantees

Grantee	Grant Award	Number of Outreach "Events," as Reported by Grantee	Reported Outreach "Events", as a Percentage of Goal in Contract	Number of People "Reached," as Reported by Grantee	Reported People "Reached," as a Percentage of Goal in Contract
Accountability MN	\$ 41,337	526	1,052%	24,195	144%
Arrowhead Economic Opportunity Agency	128,000	114	146	333,398	1,334
C.A.R.E. Clinic	20,000	52	325	42,043	210
Central MN Jobs and Training Services	118,836	150	313	6,071	467
Centro Cultural Chicano	47,293	93	2,325	4,478	110
Children's Dental Services	35,000	42	420	1,562	312
Communicating for America	38,836	26	130	5,000	100
Community Resource Connections	141,600	22	92	1,322	26
Comunidades Latinas Unidas en Servicio	99,120	56	193	5,656	377
Confederation of Somali Community in MN	50,000	15	125	3,500	58
Dakota County	190,367	23	192	63,228	315
Family Tree Clinic	30,000	550	4,583	5,000	100
Generations Healthcare Initiatives	230,369	204	1,569	97,721	244
Health Access MN	326,606	294	74	11,034	46
HealthFinders Collaborative	31,662	60	120	1,500	107
Hmong American Partnership	153,552	161	847	15,528	2,724
International Institute of MN	128,560	349	241	4,460	1,025
Minneapolis Urban League	100,000	42	700	37,036	7,407
MN Adult and Teen Challenge	56,640	119	66	1,187	37
MN AIDS Project	192,576	208	114	115,571	770
MN Chippewa Tribe	192,573	125	179	5,489	253
MN Community Action Partnership	424,150	1369	1,521	2,769,505	27,695
MN Council of Churches	159,830	158	93	3,287	1,027
MN Recovery Connection	45,000	68	1,700	10,219	204
National Alliance on Mental Illness	125,000	76	117	71,437	1,587
NorthPoint Health and Wellness Center	138,052	129	33	1,849	66
Pillsbury United Communities	100,000	109	95	28,370	142
Planned Parenthood MN, ND, SD	150,333	560	1,120	37,755	95
Portico Healthnet	377,592	413	^a	30,814	^a
ResourceWest	45,974	45	346	465	116
Somali Health Solutions	149,421	140	280	51,000	173
Southside Community Health Services	94,400	121	242	2,272	45
Springboard for the Arts	50,032	108	360	46,102	115
Stairstep Foundation	100,000	25	417	200,000	4,000
Sub-Saharan African Youth and Family Services in MN	25,000	63	252	2,143	11
West Side Community Health Services	75,000	65	^a	10,212	101
Western Community Action	257,183	950	7,917	9,869	164
Women Venture	45,746	24	104	673,647	48,118
Women's Health Center of Duluth, P.A.	21,385	19	127	876	219

NOTES: The performance data listed in this table were self-reported by grantees at the end of the grant period and were not independently verified by MNsure or the Office of the Legislative Auditor. MNsure and its grantees defined an outreach or education "event" broadly. For example, grantees considered radio or Internet-based ads and direct mailings to be outreach "events." Also, the McDonough Organization with Respect and Equality for People (MORE) is not included in this exhibit because it neither set outreach goals with the state nor reported on any outreach activities at the end of the grant period.

^a The grantee's contract did not include a goal in this area.

SOURCES: Office of the Legislative Auditor's review of MNsure's grant contracts and grantee's final reports to MNsure.



February 9, 2015

James Nobles
Legislative Auditor
Centennial Office Building, Room 140
658 Cedar Street
St. Paul, Minnesota 55101

Dear Mr. Nobles:

Thank you for conducting a program evaluation of MNSure. We appreciate the professionalism shown by you and your staff throughout this process. As you know, we welcome your review and view it as part of an ongoing process of improvement for the organization. MNSure's response to the specific findings is attached.

First, we measure success thus far in several distinct ways. Since October 1, 2013, the uninsured rate in Minnesota has dropped by 40 percent to less than five percent. Now, 95 percent of Minnesotans have comprehensive, affordable health insurance coverage.

Second, MNSure has been instrumental in the enrollment of hundreds of thousands of Minnesotans in comprehensive, affordable health coverage. Many of those who enrolled had previously not had health insurance coverage. MNSure has added competition to the insurance market and transparency to price comparison which, combined, drive down costs for Minnesotans. This is evidence of success.

Furthermore, MNSure has made dramatic improvements to the consumer experience in less than 24 months of operation. MNSure has completed its second open enrollment period and in contrast to year one—

- Consumers are enrolling through the website with relative ease.
- Call volume is high and call wait times are on average less than five minutes.
- A robust statewide network of navigators, brokers and other assisters is in place to help consumers enroll.
- Consumers are saving money. Minnesotans who enrolled in qualified health plans saved over \$30 million as a result of tax credits on health insurance plans sold through MNSure.
- We have a strong, multi-agency project management team and decision-making process in place to set priorities.
- We have a deep commitment to transparency and accountability.
- We are listening, and our partners and stakeholders are informed and engaged with us as we continue to grow and improve.

I appreciate your frequent mention of the hard work of the MNSure team in your report. Our entire team—including our partners at MN.IT Services and the Department of Human Services—is extraordinarily dedicated to the mission and success of MNSure.

We continue to take our responsibility to be an accountable and transparent organization extremely seriously. We have been working as an organization since early 2014 to proactively identify and make improvements to all areas of MNsure.

Reviews and audits such as this one are important tools for us to improve. In the interest of transparency and accountability, we will continue to make necessary adjustments to the organization while maintaining our focus on improving the consumer experience. Again, thank you for the work that you and your staff have done on this review.

Sincerely,

A handwritten signature in black ink that reads "Scott Leitz". The signature is written in a cursive, flowing style.

Scott Leitz
Chief Executive Officer

Attachments

OLA Summary Conclusion: In its first year of operations, MNsure's failures outweighed its achievements.

MNsure Response

To the extent this statement was intended to be the overall conclusion of this report, MNsure strongly disagrees with this conclusion. Since October 1, 2013, the uninsured rate in Minnesota has dropped by 40 percent with 95 percent of Minnesotans having comprehensive, affordable health insurance coverage. To date, the MNsure IT system has been instrumental in enrolling hundreds of thousands of Minnesotans in affordable health coverage. Many of those enrolled did not previously have coverage. Minnesotans who enrolled in qualified health plans through MNsure saved over \$30 million as a result of tax credits on health insurance plans sold through the Exchange.

For further context, all of this was accomplished as MNsure worked to stand up, from scratch, a brand new state agency-developing and improving all of the business functions necessary to support its mission outlined in Minnesota Statutes, Chapter 62V.

Significant improvements have been made to the enrollment process and customer service. Minnesotans have received and continue to receive considerable benefits from the existence of MNsure. For all of these reasons, MNsure cannot agree with the statement that its failures outweighed its achievements.

MNsure General Comments

1. The use of the term “MNsure” in this report

While MNsure appreciates that the definition of the term “MNsure” is included in Appendix A: Glossary of Terms, and that, in certain sections of the report the phrase “MNsure enrollment system” or MNsure’s enrollment system” is used, this definition does not provide sufficient clarity regarding the difference between MNsure (the state agency) and MNsure (the IT system). MNsure is concerned that instead of resolving any confusion regarding this differentiation, this confusion will only be perpetuated amongst the public at large as they read this report. It is MNsure’s understanding that the Office of the Legislative Auditor views certain statutory provisions in Minnesota Statutes, Chapter 62V to require MNsure to solely operate the MNsure IT system, and thus, that MNsure (the state agency) is solely responsible for allowing other agencies to use this system and responsible for providing them with output from the system’s various functions (eligibility determinations, billing, etc.). MNsure does not agree that Chapter 62V contains this requirement, and believes this view misconstrues the legal framework that governs use of the MNsure IT system. In an effort to further explain, the following paragraphs provide some additional background on the development of the legal framework for the MNsure IT system.

As noted in this report, early on in the planning and development of the MNsure IT system there was keen interest on the part of the state agencies to assuring that this system would provide a single, streamlined access point for individuals to receive eligibility determinations for and enroll in public health care programs and private health coverage. In fact, the Patient Protection and Affordable Care Act (“ACA”) itself, as well as federal regulations and guidance, have identified this as an important role for Exchanges.

However, the early, proposed regulation and high-level guidance relating to how Exchanges and State Medicaid agencies should interact on the responsibilities and authorities for eligibility determinations only appeared to provide a “binary” approach: 1) an Exchange performs an “assessment” of Medicaid eligibility and “hands-off” to the State Medicaid Agency for the final determination; or 2) an Exchange “directly” makes the Medicaid eligibility determination. While the proposed regulation identified an option for “a combination” of these approaches, of particular note was that neither the term “assessment” nor “directly” were defined. As legislation for the creation of MNsure as a separate state agency was preceding, there was not clarity on the scope of regulatory requirements for Exchanges and State Medicaid agencies regarding specific authority and responsibilities for eligibility determination, and thus, the legislation was drafted to allow for flexibility to meet these possible requirements while retaining specific provisions to identify this commitment to providing consumers a single, streamlined application process to access public programs and private health insurance coverage.

Subsequent to the enactment of MNsure’s enabling legislation, MNsure and Minnesota Department of Human Services (“DHS”) had many joint communications with federal officials from both the Consumer Information and Insurance Oversight (“CCIO”) and Centers for

Medicare and Medicaid Service (“CMS”) in which the agencies presented Minnesota’s approach to Medicaid eligibility determinations going through the MNsure IT system. Specifically, the agencies described the approach that the MNsure IT system would simultaneously serve as the automated eligibility system for both the DHS (the state Medicaid agency) and MNsure (the Exchange), and thus, would not fit neatly into the binary framework suggested by the regulations and guidance which presumed one automated eligibility system maintained by a State Medicaid agency and another – separate – automated eligibility system maintained by an Exchange. Both MNsure and DHS explained that the approach being built into the MNsure IT system most likely complies with the “assess and hand-off” option for Medicaid eligibility, but the mechanics of the “assessment” and “hand-off” are unique in that the system doing the “assessment” and the “hand-off” is the same system that is being “handed-off” to.

Federal officials acknowledged that this approach appropriately met the regulatory requirements, and that even though MNsure and DHS would be working very closely and that the work of each agency could have benefits that accrue to the other (i.e. MNsure contact center staff would field calls from public program enrollees requesting status updates) the approach identified by the two agencies did not require a delegation of authority from DHS to MNsure to conduct eligibility determinations because it was clear that DHS was continuing to make the eligibility determinations for Medicaid, albeit on a shared IT system.

We believe that readers of this report would have a more accurate understanding of the unique relationship of MNsure (the state agency), DHS, and the MNsure IT system if those entities and terms were used in their correct context. In some cases an attempt has been made to use the term “MNsure enrollment system” but the term is undefined and used inconsistently throughout the report.

2. Scope of the time period being reviewed

MNsure appreciates that some mention was made of the time period being evaluated, but believes that this reference was insufficient to give readers proper context for the sweeping statements or findings made in this report. No mention is made of several key improvements put in place for the second open enrollment period, even though information on these improvements has been publicly disclosed and discussed. For example, functionality and experience testing occurred prior to the release of new system functionality for the open enrollment period; robust technical information and training was available to staff in advance of the open enrollment period; public website was updated to make specific information easier to access; and information about assisters and enrollment events was updated and provided in a searchable format.

Chapter 1: Background

OLA Key Finding 1: Minnesota’s health insurance exchange (MNsure) has some important differences from other executive branch state agencies.

MNsure Response

MNsure generally agrees with this finding, but it is more accurate to characterize MNsure as being a state agency subject to all the same requirements other state agencies with some key exemptions and some additional requirements not applicable to any other state agencies.

OLA Key Finding 2: In contrast to practices in many other states, Minnesota’s exchange provides a single website at which individuals’ eligibility for tax credits and public health care programs can be determined.

MNsure Response

As has been explained above in this response, it is important to distinguish between the roles played by MNsure (the state agency) and DHS and to clarify the co-development and co-ownership of the MNsure IT system by the two agencies. MNsure (the state agency) has no legal authority to determine eligibility for public programs. However, the two agencies share an automated eligibility system in the MNsure IT system.

Chapter 2: Exchange Development and Implementation

OLA Key Finding 1: Minnesota’s efforts to meet an ambitious federal deadline were hindered by late federal rules, delays in passing state legislation, and problems with vendor selection and performance.

MNsure Response

Aggressive timelines, delays in receiving federal regulations and guidance, delays in enactment of enabling legislation creating MNsure (the state agency), and delays in the selection of vendors significantly complicated the development of the MNsure IT system.

In addition to these factors identified in the report, it is important to note that at the time of vendor selection, Minnesota was competing with both the federal government and other state-based exchanges for a very limited pool of vendors with ability to perform an IT system build of this complexity, in the limited amount of time available. The project leadership and other agencies involved in the contract negotiations had to carefully balance pushing prospective vendors to agree to the best price for the State of Minnesota, and at the same time moving quickly to assure available vendors did not become separately engaged in exchange projects with other entities and moving quickly to assure the project could begin.

It is also important to note that significant changes in federal requirements in January 2013 (commonly referred to as “the fed 70”) forced a reevaluation of the project’s ability to meet

federal certification requirements for go-live on October 1, 2013. In response to these requirements, leadership at the exchange (then under direction of the Commissioner of MMB), DHS, and MN.IT services came to the conclusion that a reorganization of the then existing contractual roles was critical to meeting the milestones necessary to achieve go-live on October 1, 2013.

OLA Key Finding 2: Serious technical deficiencies plagued MNsure’s enrollment system throughout its first year of operations.

MNsure Response

The limited functionality of the MNsure IT system on October 1, 2013, resulted in a frustrating experience for many consumers who attempted to use the system. However, as the impact of the system limitations became evident to the MNsure Board, it authorized MNsure staff to quickly identify and implement solutions. There was an immediate focus on identifying system issues, bringing appropriate resources to bear to address the issues, and implementing fixes to address the issues.

In early 2014, MNsure leadership commissioned an end-to-end review of the MNsure IT system by Optum Health. Based on the recommendations of the review, MNsure hired Deloitte Consulting LLP as the “lead vendor” to assist the State in managing and implementing MNsure IT system improvements. State operations and IT staff from MNsure, DHS and MN.IT Services have worked tirelessly over the past year to make improvements to provide consumers a better experience. As a result, the MNsure IT system is more stable and is operating in a consumer-friendly manner for the 2015 open enrollment period.

OLA Key Finding 3: MNsure did too little testing of the technology it developed, and it did not make sufficient use of state government’s information technology experts.

MNsure Response

It is generally true that too little testing was performed on the MNsure IT system prior to go live in October 1, 2013, but this should also be understood in the context of a non-negotiable federal deadline of October 1, 2013, by which Minnesota was required to have the system “go live.” As the MNsure IT system project has continued, improving the management of the release schedule – which includes allocating sufficient time for testing- has been a focus of the project and significant improvements have been made. Initially vendor staff and consultants were brought on board to expand the quality assurance effort. Over the past few months, MN.IT Services has hired a state quality assurance manager and a team of quality assurance staff to coordinate quality assurance on the project.

MNsure takes no position on the opinion of certain MN.IT Services officials that state IT experts were not sufficiently involved in the development and implementation of the MNsure IT system. However, MNsure does want to address the suggestion that this report provides

that MN.IT Services staff had no involvement in the development and implementation of the MNsure IT System. To suggest this directly contradicts the facts of this project. While MN.IT Services project management and oversight expertise may not have been utilized in the early stages of this project, MN.IT Services staff have been deeply engaged in this project and MNsure's current coordination with MN.IT Services is robust. MNsure, MN.IT Services and DHS are all focused on improving the functionality of the MNsure IT system.

OLA Key Finding 4: Because of technical problems with MNsure's online enrollment system, many Medical Assistance recipients did not receive timely reviews of their eligibility.

MNsure Response

MNsure takes no position and defers to DHS (the state Medicaid agency) on this finding. However, it is important to note that the appropriate reference in this finding should be to "MNsure IT system" and not MNsure (the state agency).

OLA Recommendation: The Legislature should amend Minnesota Statutes chapter 62V to ensure that MNsure's future information technology work is subject to oversight from the Office of MN.IT Services.

MNsure Response

MNsure takes no position on this recommendation.

Chapter 3: Governance

OLA Key Finding 1: The MNsure Board had little influence over the exchange operations prior to the launch of the MNsure enrollment website.

MNsure Response

The MNsure enabling legislation directed an initial appointment of MNsure Board members but did not provide those Board members with the authority to direct the actions of MNsure until certain preconditions were met. These preconditions were fulfilled in late summer of 2013, and for this reason, MNsure generally agrees with this finding.

OLA Key Finding 2: MNsure staff withheld key information from the board and other state officials during 2013.

MNsure Response

Since early 2014, MNsure leadership has placed a great emphasis on keeping the MNsure Board and other key stakeholders informed of key developments related to agency operations and the development of the MNsure IT system.

OLA Key Finding 3: MNsure leadership has not implemented some internal policies and statutory requirements.

OLA Recommendation 1: The MNsure Board should ensure implementation of its policies or, if necessary, revise policies that are not realistic to implement.

OLA Recommendation 2: The MNsure Board should:

- **Adopt consumer assister compensation rates annually and ensure that changes in the rates are published in the State Register;**
- **Adopt navigator, call center, and customer services policies in 2015.**

MNsure Response

As described in the report and further elaborated in this document, the Board and MNsure staff took steps to address technical and operational issues during the first year of operations as they became evident. For this reason, MNsure generally agrees with the finding that it has not implemented some internal policies and statutory requirements, but MNsure disputes the finding that certain policies and procedures have not been established as required under Minnesota Statutes, section 62V.05, subdivision 4, paragraph a. The business operational units with responsibility for these functions have implemented policies and procedures to govern their day-to-day management of these functions as authorized by the MNsure Board's Delegation of Authority Policy, and the statute places no further requirements upon the establishment of these policies and procedures. Thus, the claim that the policies and procedures have not been implemented is inaccurate. MNsure has implemented this statutory requirement.

OLA Recommendation 3: The Legislature should amend state law to give the governor, rather than the MNsure Board, authority to appoint the MNsure chief executive officer.

MNsure Response

MNsure takes no position on this recommendation.

OLA Key Finding 4: The multi-agency governing structure for MNsure’s online enrollment system lacks formal authority.

OLA Recommendation: The Legislature should establish in state law a structure for governing MNsure’s online enrollment system.

MNsure Response

MNsure strongly supports the existing interagency governance structure for the MNsure IT system. MNsure takes no position on the establishment by statute of a formal governance structure for the MNsure IT system.

Chapter 4: Enrollment

OLA Key Finding 1: MNsure met its overall enrollment target for the first enrollment period, but this target was seriously flawed due to a Department of Human Services error that significantly underestimated Medical Assistance enrollment.

MNsure Response

MNsure agrees that its overall enrollment target was accurate, but that the actual “mix” of public and private consumers differed from the estimates.

OLA Key Finding 2: Survey results showed that 28 percent of individuals who enrolled in commercial insurance through MNsure were uninsured immediately before they enrolled.

MNsure Response

MNsure lacks the information to comment on the validity or accuracy of the survey results presented in this finding, but can comment that the survey results appear to be generally consistent with other third-party surveys showing a significant decrease in the rate of Minnesotans without health insurance coverage.

OLA Key Finding 3: MNsure’s data reporting capabilities are weak, limiting its ability to produce information for management and decision-making purposes.

MNsure Response

MNsure, along with other state agencies, are focusing significant efforts on the development and improvement of reporting capabilities. MNsure, DHS, and MN.IT Services are working to develop and implement a data warehouse for the MNsure IT system and MNsure has appointed a reporting manager within the Policy and Plan Management team to coordinate the development and implementation of reporting at MNsure. MNsure generally agrees with this finding.

OLA Recommendation: MNSure should develop ways to improve its access to the applicant and enrollee data it collects- for the purpose of assessing MNSure performance, generating management reports, and responding to public inquiries.

MNSure Response

In the past few months, MNSure has worked with MN.IT Services to develop and implement an Enrollment System of Record (ESOR) that will greatly improve MNSure’s ability to provide reports to management, insurance carriers, and regulators. Additionally, as described above, MNSure is collaborating with DHS and MN.IT Services on the development and implementation of a data warehouse for the MNSure IT System to address this issue. MNSure generally agrees with this finding.

Chapter 5: User Experiences

OLA Key Finding 1: Consumers and the people who helped them enroll encountered numerous technical problems during MNSure’s first year of enrollment.

MNSure Response

As the impact of the IT system limitations became evident to the MNSure Board, it authorized MNSure staff to quickly identify and implement solutions to the crisis. There was an immediate focus on working with vendors to bring additional functionality online on an accelerated schedule.

In the spring of 2014, MNSure leadership commissioned an end-to-end review of the MNSure IT system by Optum Health. Based on the recommendations of the review, MNSure hired Deloitte Consulting LLP as a “lead vendor” to assist the State in managing and implementing MNSure IT system improvements. Operations and IT staff have worked tirelessly over the past year to make improvements to provide consumers a better experience. As a result, the MNSure IT system is more stable and is operating in a more consumer-friendly manner for the 2015 open enrollment period.

In addition, beginning in October 2013, MNSure increased staffing levels in its contact center, beginning with a total head count of about 38 staff at the beginning of October 2013 and for the first open enrollment, peaking at about 75 staff at the end of March 2014. As noted in your report, MNSure has engaged vendors to provide overflow services. These vendors have provided access to over 100 additional staff, and including up to approximately 200 additional staff during certain peak periods. With all of this said, MNSure generally agrees that technical problems significantly impacted user experience in the first year of MNSure’s operation.

OLA Key Finding 2: Individuals who enrolled through MNsure generally reported more satisfaction than dissatisfaction with the products they purchased.

MNsure Response

MNsure lacks the information to comment on the validity or accuracy of the consumer survey results presented in this finding but can comment that the survey results appear to be generally consistent with other third-party surveys showing consumer satisfaction.

OLA Key Finding 3: Problems with MNsure's enrollment system had a significant impact on the ability of insurers and counties to manage individuals' cases.

MNsure Response

With respect to insurers, MNsure has continued to work on improving the process of enrollment data transmission. These efforts have included the construction of an Enrollment System of Record (ESOR) that will better meet MNsure's reporting needs, including the submission of enrollment data to insurers and regulators. In addition, it is anticipated that the current development and implementation of a data warehouse for the MNsure IT System will assist in addressing this issue. MNsure generally agrees with this finding.

Chapter 6: Operations

OLA Key Finding 1: Many consumers were referred back and forth between brokers and navigators, due to differences in the roles and compensation practices for these assisters.

MNsured Response

MNsured has improved and continues to improve the experience through new referral processes, enrollment tools, and communications with navigators, brokers, and counties. Our experience has been that most brokers will assist consumers regardless of whether the consumer obtains public or private insurance. Likewise, our experience has been that most consumers who sought assistance from navigators, were able to complete enrollment without consulting a broker. State law prohibits navigators from providing advice on the selection of insurance products and under federal law brokers cannot be navigators. Navigators may guide the consumer through the selection process and assist consumers in using the selection tools and information available through MnSured. Consumer questions on the merits of one insurance product over another must be referred to a licensed insurance broker. Due to this nuanced distinction, consumers occasionally must work with multiple assisters. For these reasons, MnSured does not dispute that some referrals occurred that were disruptive to a customer service experience, but it disagrees with the suggestion that these were common or widespread.

OLA Key Finding 2: MnSured's contact center failed to provide adequate customer service during the first open enrollment period.

MnSured Response

Call volume in the first open enrollment period was higher than expected. Many of the calls were in relation to technical issues. MnSured contact center staff rose to this unexpected challenge.

Since January 2014, MnSured has built out its customer service operations and now provides a number of ways consumers can receive assistance. For many customers, the MnSured Contact Center toll-free line is their first stop and their issue is usually resolved in the first call. The number of calls to the MnSured Contact Center has dramatically increased, while the average hold times have remained low. For example, for the week of December 14, 2014 (a high volume week because of a deadline), the MnSured Contact Center received 35,598 calls with the average hold times remaining under 10 minutes.

OLA Key Finding 3: MNsire has some -but not complete- ability to analyze who has accessed private data on enrollees.

MNsire Response

MNsire is providing no response to this finding because doing so would likely result in the disclosure of security information as defined by Minnesota Statutes, section 13.37, subdivision 1, paragraph a, and MNsire is prohibited from making such a disclosure under Minnesota law.

OLA Recommendation 1: MNsire and DHS should ensure that brokers are fairly compensated for enrolling consumers in insurance through MNsire.

MNsire Response

MNsire takes no position on this recommendation.

OLA Recommendation 2: MNsire should improve its referral guidance for customer service staff in its contact center and in DHS and county call centers.

MNsire Response

Contact center staff are constantly updating their reference materials and are working with contact centers at DHS to improve transfers of calls related to public programs.

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Law Enforcement's Use of State Databases, February 2013
Public Defender System, February 2010
MINNCOR Industries, February 2009
Substance Abuse Treatment, February 2006

Education, K-12, and Preschool

Special Education, February 2013
K-12 Online Learning, September 2011
Alternative Education Programs, February 2010
Q Comp: Quality Compensation for Teachers, February 2009
Charter Schools, June 2008

Education, Postsecondary

Preventive Maintenance for University of Minnesota Buildings, June 2012
MnSCU System Office, February 2010
MnSCU Occupational Programs, March 2009

Energy

Renewable Energy Development Fund, October 2010
Biofuel Policies and Programs, April 2009
Energy Conservation Improvement Program, January 2005

Environment and Natural Resources

Recycling and Waste Reduction, February 2015
DNR Forest Management, August 2014
Sustainable Forest Incentive Program, November 2013
Conservation Easements, February 2013
Environmental Review and Permitting, March 2011
Natural Resource Land, March 2010
Watershed Management, January 2007

Government Operations

Councils on Asian-Pacific Minnesotans, Black Minnesotans, Chicano/Latino People, and Indian Affairs, March 2014
Helping Communities Recover from Natural Disasters, March 2012

Government Operations (continued)

Fiscal Notes, February 2012
Capitol Complex Security, May 2009
County Veterans Service Offices, January 2008

Health

Minnesota Health Insurance Exchange (MNsure), February 2015
Financial Management of Health Care Programs, February 2008
Nursing Home Inspections, February 2005

Human Services

Medical Assistance Payment Rates for Dental Services, March 2013
State-Operated Human Services, February 2013
Child Protection Screening, February 2012
Civil Commitment of Sex Offenders, March 2011
Medical Nonemergency Transportation, February 2011
Personal Care Assistance, January 2009

Housing and Local Government

Consolidation of Local Governments, April 2012

Jobs, Training, and Labor

State Protections for Meatpacking Workers, 2015
State Employee Union Fair Share Fee Calculations, July 2013
Workforce Programs, February 2010
E-Verify, June 2009
Oversight of Workers' Compensation, February 2009
JOBZ Program, February 2008
Misclassification of Employees as Independent Contractors, November 2007

Miscellaneous

The Legacy Amendment, November 2011
Public Libraries, March 2010
Economic Impact of Immigrants, May 2006
Liquor Regulation, March 2006
Gambling Regulation and Oversight, January 2005

Transportation

MnDOT Selection of Pavement Surface for Road Preservation, March 2014
MnDOT Noise Barriers, October 2013
Governance of Transit in the Twin Cities Region, January 2011
State Highways and Bridges, February 2008