MINNESOTA Management & Budget

MINNESOTA · REVENUE

January 15, 2014

The Honorable Richard Cohen
Chair, Senate Finance Committee
121 Capitol
St. Paul, MN 55155

The Honorable Michelle L. Fischbach
Ranking Minority Member, Senate Finance Committee
15 State Office Building
St. Paul, MN 55155

The Honorable Tony Lourey
Chair, Senate Health and Human Services Finance Division
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The Honorable Julie A. Rosen
Ranking Minority Member, Senate Health and Human Services Finance Division
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The Honorable Rod Skoe
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The Honorable Julianne E. Ortman
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The Honorable Lyndon Carlson Sr.
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The Honorable Thomas Huntley
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The Honorable Greg Davids
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The Honorable Tina Liebling
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The Honorable Tara Mack
Ranking Minority Member, House Health and Human Services Policy
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Dear Members of the Minnesota Legislature:

We are pleased to present the enclosed report, entitled *Health Care Access Fund Projections*. This report, which was requested in Laws 2013, Chapter 108, Article 1, Section 64, presents an assessment of current and projected revenues supporting the Health Care Access Fund.

As context for this assessment, this report also includes an overview of past and present spending for the state's health care programs funded through the Health Care Access Fund and the General Fund.

This report was prepared by Minnesota Management and Budget and the Minnesota Department of Revenue in consultation with the Minnesota Department of Human Services and the Minnesota Department of Health.

If you need additional information or assistance, please feel free to contact Angela Vogt (Minnesota Management & Budget) at 651-201-8036.

Sincerely,

James Schowalter, Commissioner
Minnesota Management & Budget

Myron Frans, Commissioner
Minnesota Department of Revenue

January 2014

Health Care Access Fund Projections

Submitted to the Minnesota Legislature by
Minnesota Management & Budget and the
Minnesota Department of Revenue

400 Centennial Office Building
658 Cedar Street
Saint Paul, Minnesota 55155

Table of Contents

I. Introduction

The Health Care Access Fund was created to increase access to health care, contain health care costs, and improve the quality of health care services. Revenues into the Health Care Access Fund include a two percent tax on providers; a one percent gross premium tax on health maintenance organizations and nonprofit plans; federal funding; and MinnesotaCare enrollee premiums. The Health Care Access Fund supports health care coverage for populations currently or historically eligible for MinnesotaCare. MinnesotaCare is a publicly subsidized program for residents with modest incomes who do not otherwise have access to affordable health care coverage.

During the 2013 legislative session, a number of changes were made to MinnesotaCare to enable the program to qualify as a basic health program under federal law. These changes, which modified program eligibility and benefits, will enable the state to participate in a new federal payment model available under Section 1331 of the Affordable Care Act.

Separate from the fiscal changes associated with this new federal payment model, under current state law the two percent provider tax will sunset at the end of 2019. In recent years this tax has accounted for about 85 percent of state funding for the Health Care Access Fund.

This required report (Laws 2013, Chapter 108, Article 1, Section 64)[1] presents an assessment of current and projected revenues supporting the Health Care Access Fund. To provide the appropriate policy context, this report also includes an overview of past and present spending for the state's health care programs funded through the Health Care Access Fund and the General Fund.

This report was prepared by Minnesota Management and Budget and the Minnesota Department of Revenue, in consultation with the Minnesota Department of Human Services and the Minnesota Department of Health.

II. Revenues

Current Health Care Taxes

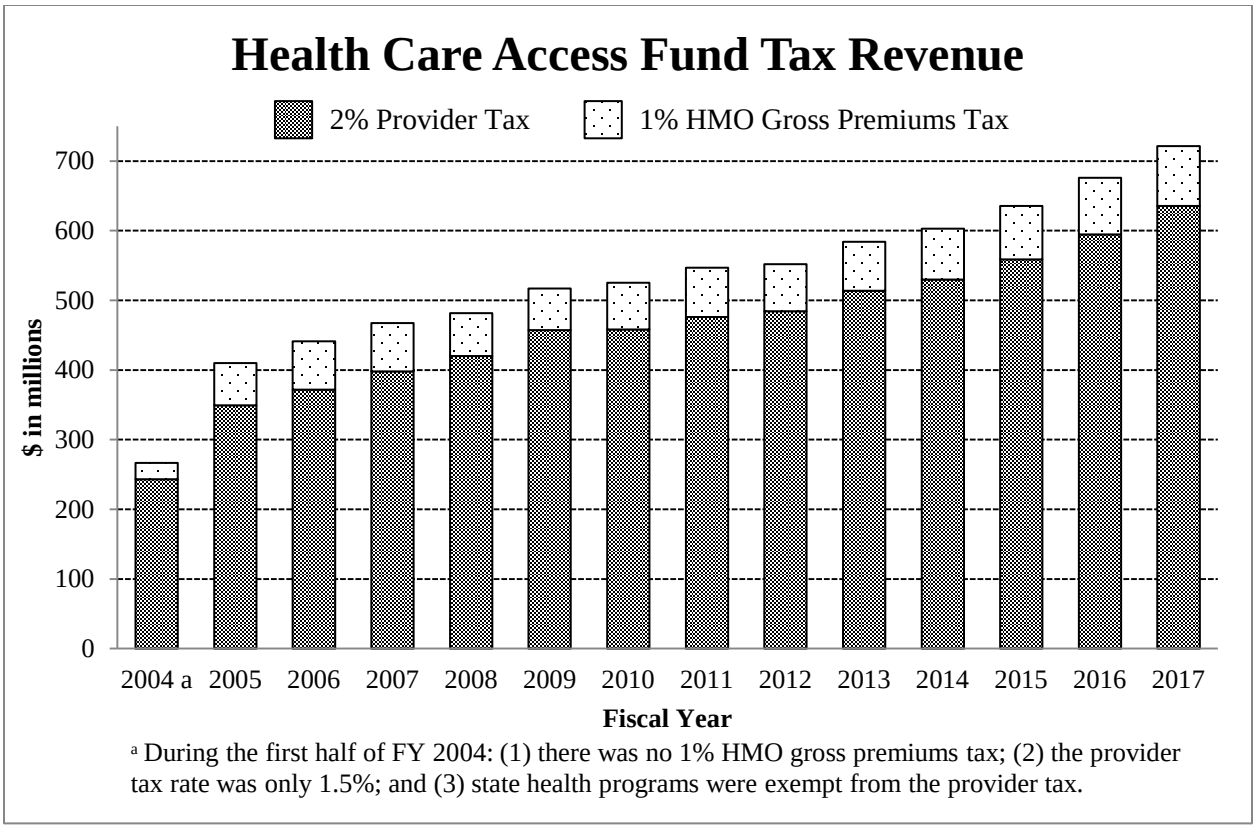
State funding for the Health Care Access Fund comes from two types of health care taxes:

- *Provider tax* - Health care providers are subject to a two percent tax on gross revenues for patient services. Wholesale drug distributors are subject to a two percent tax on gross revenues from the sale or distribution of prescription drugs delivered in Minnesota. In 2012, these taxes, which are collectively referred to as the "provider tax" in this report, were paid by 177 hospitals and surgical centers and 7,696 health care providers and wholesale drug manufacturers that directly furnish medical, surgical, optical, visual, mental, hearing, nursing, laboratory, diagnostic, or therapeutic services, or drugs.[2] The tax rate is subject to reduction for any year that revenues to the Health Care Access Fund are projected to exceed uses by more than 25 percent.[3]
- *Gross premiums tax* – Health maintenance organizations (HMOs) and nonprofit health service plan corporations are subject to a one percent tax on gross premiums. This tax is paid by 9 HMOs and 2 nonprofit plans.[4]

Historic and Forecasted Collections

Historically, the two percent provider tax has provided 85 percent of the tax revenue into the Health Care Access Fund. Revenue from the one percent gross premiums tax makes up the remaining 15 percent, as reflected in the Figure A.

Figure A



[a] During the first half of FY 2004: (1) there was no 1% HMO gross premiums tax; (2) the provider tax rate was only 1.5%; and (3) state health programs were exempt from the provider tax.

Evaluation of Revenue Sources

In this section, the two state revenue sources that support the Health Care Access Fund[5] are examined in the context of five criteria commonly used for evaluating revenue sources:

- *Adequacy* – extent to which a revenue source increases or decreases commensurate with its associated uses.
- *Stability* – extent to which a revenue source's collections are predictable, with limited variation in growth rates from year to year.
- *Simplicity* – extent to which a revenue source can be efficiently administered and collected.
- *Fairness* – extent to which a revenue source offers vertical equity (those with more resources pay more) and horizontal equity (equal treatment of equals), and the extent to which those who make payments also benefit.
- *Competitiveness* – extent to which a revenue source avoids putting Minnesota businesses at a disadvantage relative to out-of-state providers of similar goods or services in the same markets.

When MinnesotaCare was established in 1992, it expanded subsidized health insurance coverage to modest-income families with children.[6] The new state expenditures were financed through the establishment of a two percent tax on the gross revenues brought in by health care providers and a one percent tax on gross insurance premiums collected by HMOs and nonprofit plans. The provider tax is levied directly on health care services, including those paid for by self-insured plans which cannot be taxed directly.[7] As a result, the provider tax can reach a broader base than the gross premiums tax. Provider tax revenue has been quite stable and has grown at the same rate as expenditures on medical services. Provider tax revenue has not been subject to wide swings over the economic cycle, and in years when medical service expenditures grew much faster than the economy as a whole, provider tax revenue grew much faster as well. By comparison, the 1 percent gross insurance premiums tax has grown at a slower rate and has shown less stability than the provider tax.

Adequacy. Provider tax revenue has grown fast enough to keep up with the growing costs of health care. Provider tax revenue grew at an average annual rate of almost 8 percent between 1995 and 2012, almost twice as fast as total state tax revenue (4 percent). Between 2005 and 2012, average growth was almost 5 percent compared to 1.6 percent for total state tax revenue. In contrast, the 1 percent gross premiums tax on HMOs grew at roughly the same rate as all state taxes between 2005 and 2012.

Stability. The provider tax has shown more stability in annual revenue growth rates than state taxes overall, while the 1 percent gross premiums tax on HMOs has shown less stability than state taxes overall.[8]

Simplicity. The simplicity of the provider and gross premiums taxes is comparable, with both being straightforward to administer and collect.

Fairness. Tax fairness can be examined from the following three perspectives:

- Vertical equity implies that those with more resources pay more. In its biennial study of the burden of Minnesota state and local taxes, the Department of Revenue assumes that the provider tax is passed along in higher prices to those who purchase health care services and health

insurance. Because average expenditures on health care rise fairly slowly as income increases, that report estimates that the tax burden is a much smaller share of household income for those with higher incomes. When tax burden as a share of household income falls as income increases, economists refer to the tax as a regressive tax. The provider tax is estimated to be more regressive than the general sales tax, but less regressive than many state excise taxes. By comparison, all Minnesota General Fund taxes combined are progressive, with the tax burden as a share of income rising with income. This is largely due to the progressive income tax.[9]

From the beginning, provider and premium tax revenue has been dedicated to financing health insurance subsidies for those with relatively low incomes. When considered as a package, the impact of these taxes and the health insurance subsidies they pay for are progressive and satisfy the goal of vertical equity.[10] The health care taxes finance a benefit for individuals with low income and assets through contributions from a broader spectrum of households and organizations. When the MinnesotaCare program was enacted – as a package – it was considered fair to have those with insurance pay more so those with lower incomes could have more affordable insurance.

- Horizontal equity implies equal treatment of equals. The provider tax offers horizontal equity because the same rate of taxation applies to a broad universe of health care services and products. The gross premiums tax offers less horizontal equity because self-insured plans are excluded from taxation.[11]
- Tax fairness can also be examined in terms of whether those paying the tax also benefit from the use of its revenue. This would be true, for example, for taxes that are similar to user fees. The health care taxes are not like user fees because the subsidies they finance are targeted at lower-income households. However, to the extent that expanding health coverage for lower-income households reduces uncompensated care, it reduces the need for hospitals and other providers to pass the costs of uncompensated care along to consumers in higher prices for care.

Competitiveness. It is generally assumed that any increase in cost (net of any reduction in the cost of uncompensated care) is passed along in higher prices. To the extent that the medical care market is a local market, a provider's competition is limited to other Minnesota providers who also are subject to the tax on medical services, so the tax does not create a competitive disadvantage. This conclusion may not apply to medical providers located near state borders whose competitors in the other state are not subject to the tax. It also may not apply in the case of a medical center that competes for patients across the nation and globe. In general, though, the health care taxes are less harmful to competitiveness than alternative taxes would be.

In evaluating competitiveness and horizontal equity, it is important to recognize that health care providers in Minnesota are subject to additional surcharges and taxes that are deposited in the General Fund. Medical surcharges include: (1) a 1.56 percent surcharge on hospitals' net patient revenues; (2) a 0.6 percent surcharge on HMO revenue; (3) a $2,815 per bed annual charge for nursing facilities; and (4) a $3,679 per bed annual charge for intermediate care facilities for persons with developmental disabilities.[12] These surcharges allow the state to leverage additional federal revenue, and reimbursement rates have been generally increased at the same time the surcharges were adjusted, protecting some – but not all – from the added costs.

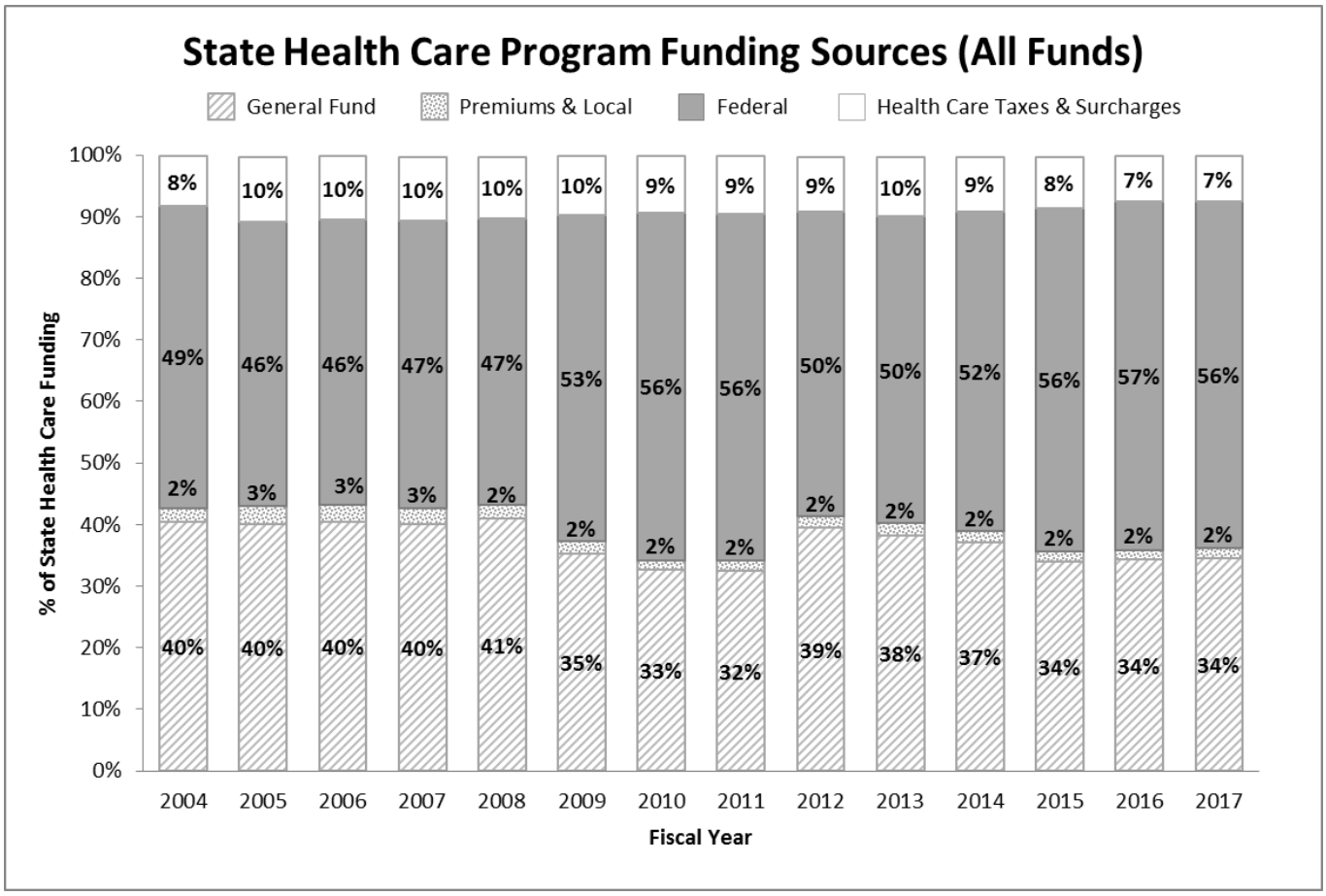
Health insurance gross premiums (other than HMOs and self-insured plans) are also subject to a two percent insurance gross premiums tax. The same fairly narrow group of insurance gross premiums is

also currently subject to a variable annual assessment to finance coverage for high-risk individuals through the Minnesota Comprehensive Health Association (MCHA). The MCHA fee will be phased out under current law, as those with preconditions switch to the health plans available under the Affordable Care Act. Starting in 2014, insurers will start to pay a variable annual assessment on premiums for individual and small market group plans sold through the state's health insurance marketplace.[13]

Health Care Revenues by Source (All Funds)

Various revenue sources, including federal funds, health care taxes, surcharges, premiums, and local shares, have contributed to the overall funding of health care coverage in public programs over time. There has been a shift in the mix of payers in recent years and those trends are projected to continue in the future. The portion of the state's health care costs funded by the federal government increases from 49 percent in FY 2004 to a projected 56 percent in FY 2017. This shift is being driven by the expansion of Medical Assistance for adults without children. Historically, through the General Assistance Medical Care program, Minnesota paid 100 percent of the cost of coverage for eligible individuals within this group. Starting in 2014, federal funds will pay for the vast majority of the cost. While the federal share overall has increased, the state share of health care coverage paid for through the General Fund decreased from 40 percent in FY 2004 to a projected 34 percent in FY 2017. The proportion of health care coverage financed by taxes and surcharges on providers and HMOs has decreased slightly over the same time period.

Figure B



Under the current law sunset of the provider tax at the end of 2019, the percentage of health care funded by other sources will need to increase to maintain projected spending on public programs. Provider taxes represent approximately 5 percent of all sources of health care funding and would need to be replaced by another source to maintain current projected spending levels. Revenue mechanisms that could be considered include partially or wholly continuing the provider tax beyond 2019, expanding the existing HMO gross premiums tax, introducing new revenues, and utilizing General Fund resources.

Future Stability and Likelihood of Federal Funding

During the 2013 legislative session, a number of statutory changes were made to MinnesotaCare to enable the program to qualify as a basic health program eligible for federal funding. As a result of these changes, MinnesotaCare will provide health coverage for individuals 19-64 years old with household income from 138-200 percent of the federal poverty guidelines. Beginning in 2015, the federal government will make per enrollee payments to states equal to 95 percent of the estimated premium tax credits and 95 percent of cost-sharing reductions the enrollees would have otherwise been eligible for through the state's health insurance marketplace.[14] The amount of direct federal subsidy that these individuals would have been eligible for is determined by the second lowest priced silver plan available to them. This plan is referred to as the "benchmark" plan. Under federal law, these payments are scheduled to continue indefinitely. In this regard, federal funding is expected to be stable, absent legislative changes.

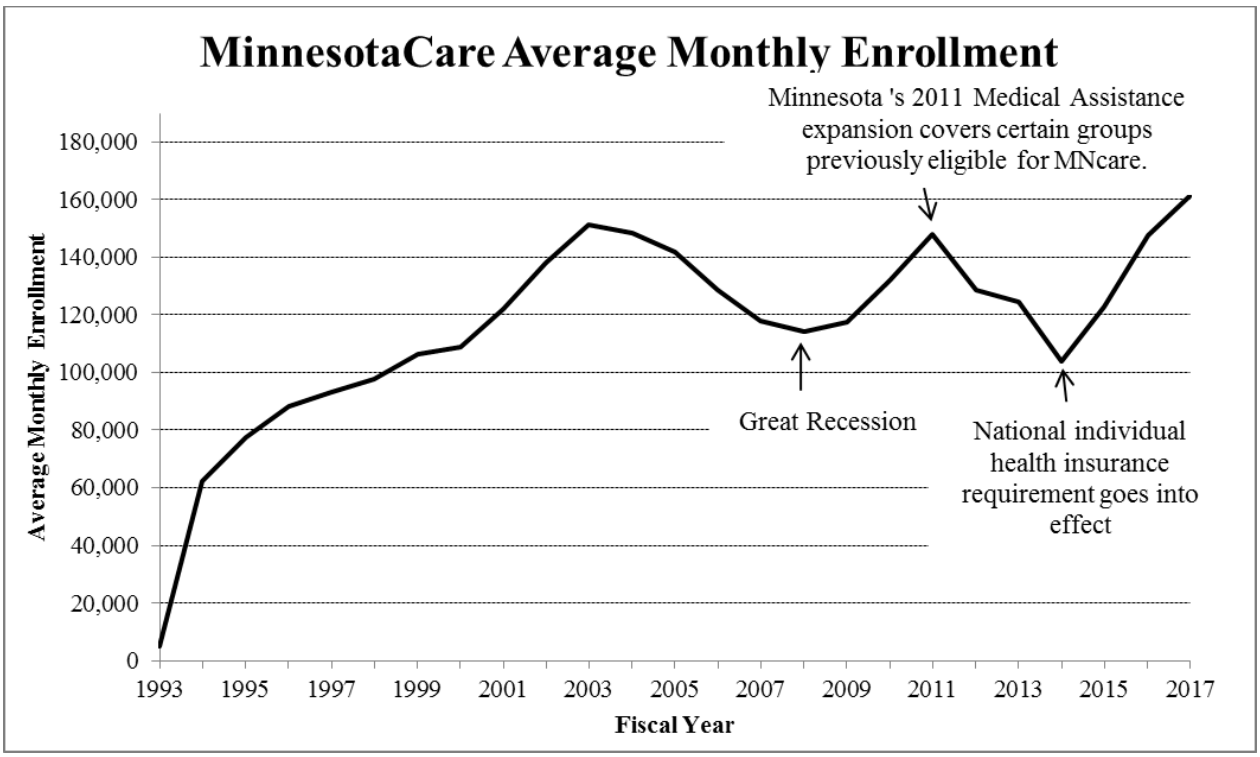
The federal government is currently in the process of establishing a methodology for determining payments to states under this framework, and is expected to officially establish this methodology in the coming months. Once this methodology is established, per enrollee payments from the federal government for any given year will continue to be subject to a certain degree of forecasting uncertainty because these payments will be pegged to benchmark premiums that themselves depend on future pricing decisions of health insurance providers. In summary, while the continued availability of federal funding appears stable, the amounts available for any given year are subject to forecast uncertainty.

III. Enrollment, Expenditures & Transfers

Enrollment

MinnesotaCare has had average monthly enrollment between 100,000 and 150,000 for the past 15 years. Within this range, actual and projected enrollment fluctuates in response to economic and legislative developments. Enrollment is projected to increase throughout the current and following biennia.

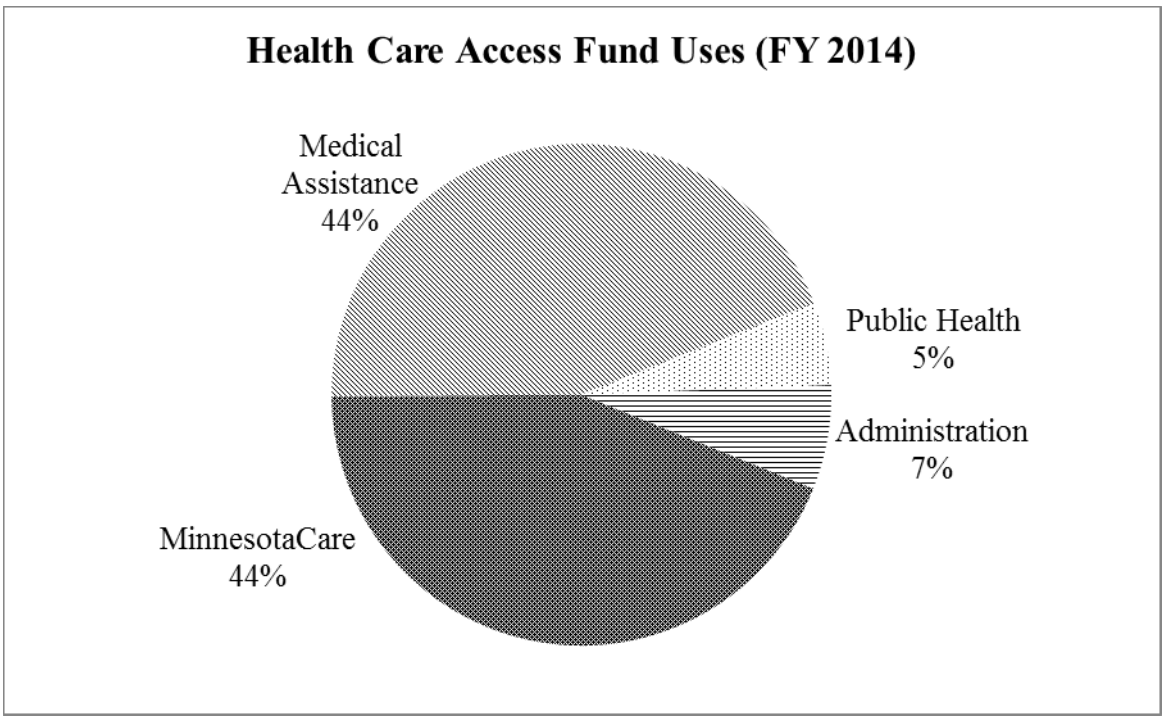
Figure C



Expenditures

The November 2013 Forecast projects $1.4 billion will be spent from the Health Care Access Fund for the current biennium (fiscal years 2014-15). The majority of this funding supports subsidized health care coverage for families and individuals currently or historically eligible for MinnesotaCare. The Health Care Access Fund also supports other health care access and quality improvement activities carried out by the state's departments of Health, Human Services, and Revenue; the University of Minnesota; and the Legislature. Figure D portrays estimated Health Care Access Fund spending, allocated by use, for the current fiscal year.

Figure D



Appendix A contains a table displaying detailed spending and transfers from the Health Care Access Fund for the past two years, as well as current law projections for fiscal years 2014 through 2021.

Beginning January 1, 2014, MinnesotaCare provides health coverage to individuals 19-64 years old with household income between 138 and 200 percent of Federal Poverty Guidelines (FPG), excluding those categorically eligible for coverage through Medical Assistance.

For individuals in the following categories, eligibility changes enacted during the 2013 legislative session (effective January 1, 2014) replaced MinnesotaCare coverage with other coverage options:[15]

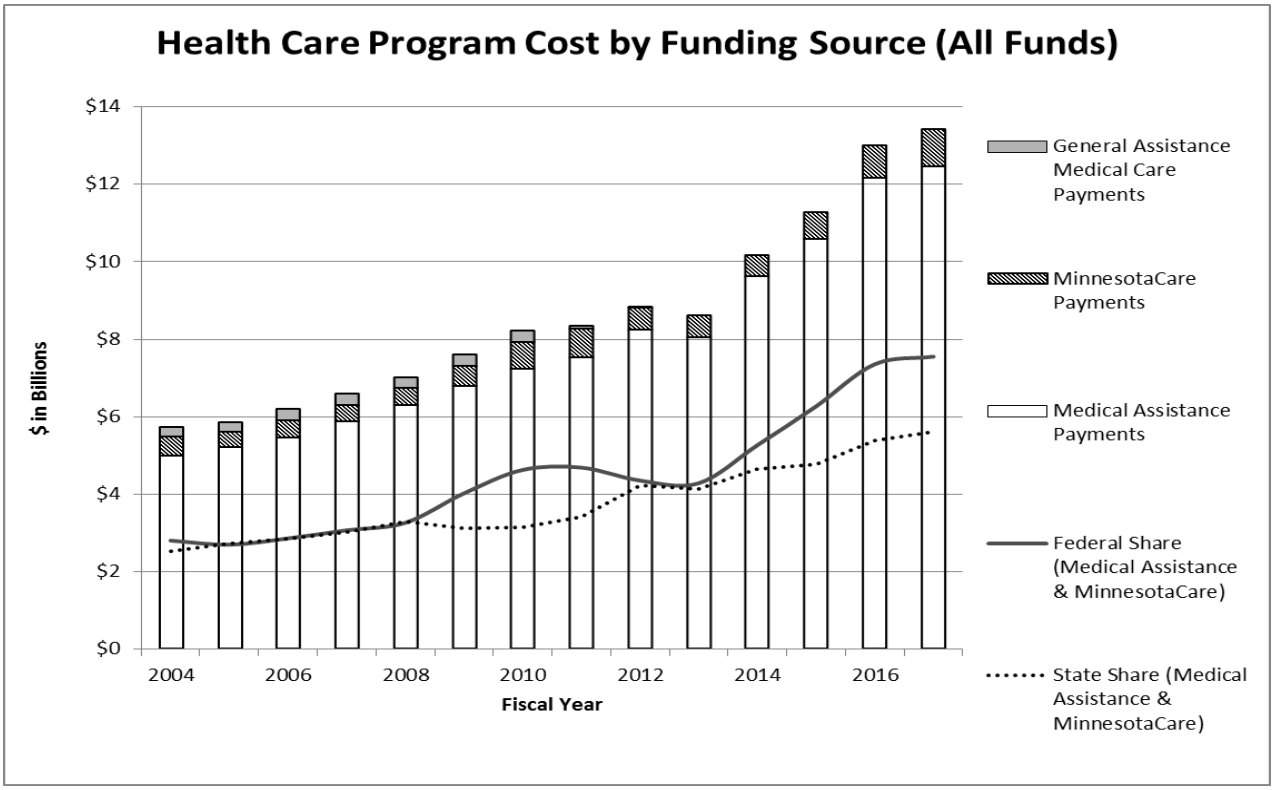
- Children ages 2 to 18 in households between 150 and 275 percent FPG become eligible for Medical Assistance;
- Individuals ages 19 to 20 and parents between 100 and 138 percent FPG become eligible for Medical Assistance;
- Adults without children between 75 and 138 percent FPG become eligible for Medical Assistance;
- Parents in households from 200 to 275 percent FPG are eligible for coverage through the MNsure insurance marketplace; and
- Adults without children from 200 to 250 percent FPG are eligible for coverage through the MNsure insurance marketplace.

While coverage for these individuals is no longer provided through MinnesotaCare, under current law coverage for those who are newly eligible for Medical Assistance will continue to be partiallyfinanced through the Health Care Access Fund.

Over time, total health care expenditures have grown as additional individuals and families have become eligible for public programs based upon their age and income level.Expenditures for all public programs across all funds reflect an average annual growth rate of nearly 10 percent between FY 2004 and FY 2017, a rapid pace relative to other state expenditures. Total health care costs represent three programs, the largest being the Medical Assistance program, followed by MinnesotaCare, and the General Assistance Medical Care program (GAMC) which ended in 2010. Enrollment growth in these programs is driven by demographics, economic conditions, and more recently, the requirement under the Affordable Care Act that all individuals obtain health insurance. Minnesota projects that enrollment in public programs will increase approximately 9 percent to account for individuals who were previously eligible for public coverage but did not enroll absent the mandate being in place.

Since 2002 Minnesota has generally divided the cost of Medical Assistance, the largest driver of health care spending, evenly with the federal government[16]. Federal match has periodically fluctuated, usually in response to an economic downturn or to encourage expanded coverage for certain groups.[17] In recent years, two federal laws, the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act, significantly altered the proportion of costs paid with federal versus state funds. During the period from FY 2009-2011, the state received an enhanced match through ARRA which drove the state proportion of costs down relative to the portion paid by the federal government. Starting in 2011, Minnesota took advantage of a state option under the Affordable Care Act and individuals previously covered under the state-only funded GAMC program became eligible for the Medical Assistance program and the state began receiving a 50 percent federal match for that group. Beginning in 2014, Minnesota will receive a 100 percent federal match for the adults without children previously eligible for GAMC. The shift from state to federal funds for adults without childrenlargely accounts for the divergence between the portion of health care costs funded by the federal versus state government projected beyond FY 2014.

Figure E

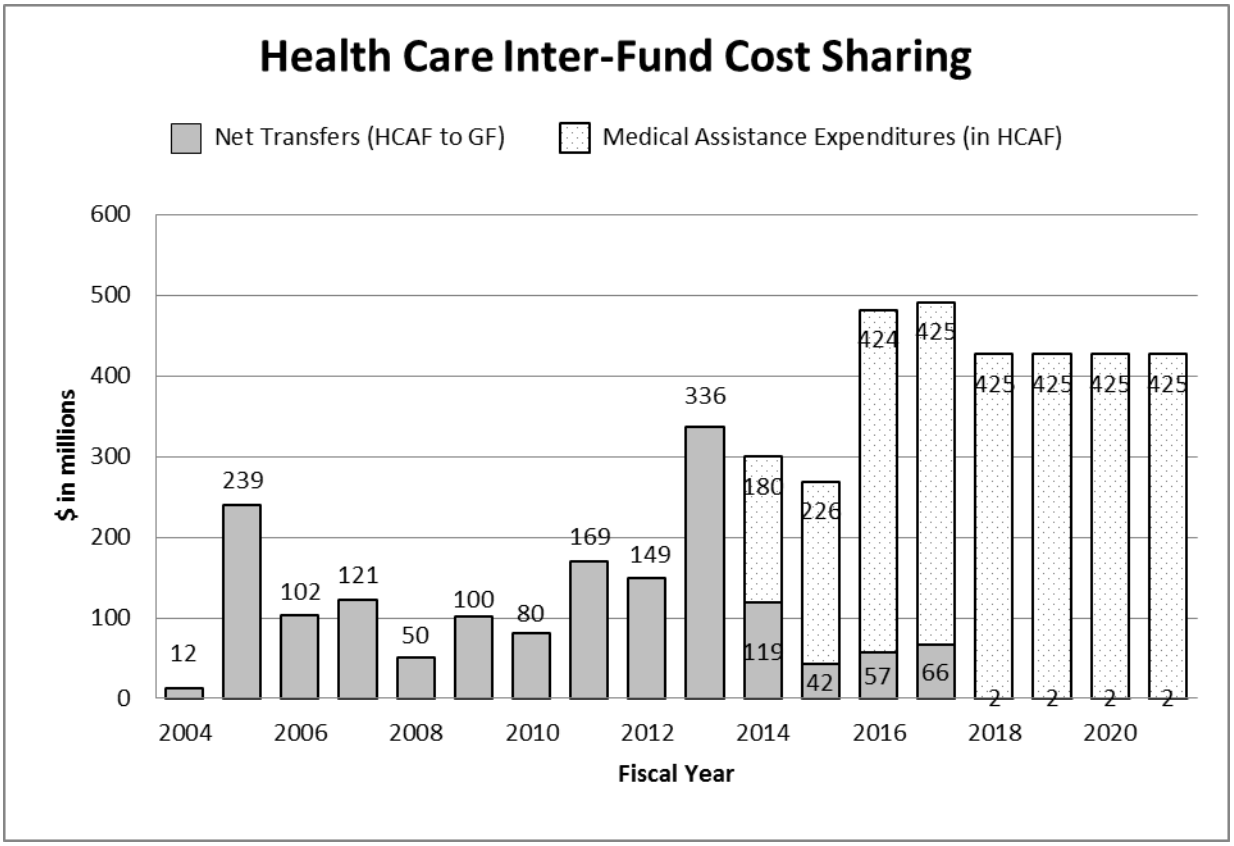


Transfers & Expenditure Realignments

The magnitude of transfers from the Health Care Access Fund to the General Fund is projected to grow substantially from past amounts to reflect the movement of enrollees from MinnesotaCare to the Medical Assistance program. Significant eligibility shifts in past years included an expansion for childless adults to 75 percent of the federal poverty guideline in 2011 and further to 133 percent in 2013.[18] The remaining ongoing transfers to the Health Care Access Fund reflect the cost of legacy rate increases to providers and enhanced funding for medical education.[19]

Beginning in fiscal year 2014, significant Medical Assistance expenditures will be made within the Health Care Access Fund. These expenditures relate to increased costs that would otherwise be borne by the General Fund and are in part a result of eligibility realignment and expansion in the MinnesotaCare and Medical Assistance programs enacted in the 2013 legislative session.[20] Increased Medical Assistance expenditures in the Health Care Access Fund are projected to contribute to the structural deficit projected in the Health Care Access Fund. Transfers and Medical Assistance spending in the Health Care Access Fund together represent more than one-third of total fund costs. (See Appendix B).

Figure F



Estimates for Medical Assistance expenditures in the Health Care Access Fund are forecasted in accordance with legislative intent through FY 2017.[21] Beyond FY 2017, which is outside the budget horizon for which projections are typically done, expenditures are forecasted consistent with state statute which directs that base budgets in the planning years are established at the amount appropriated for the last year of the previous biennium.[22] These estimates are subject to change as actual amounts are

appropriated for FY 2016 and FY 2017. To the extent decreases are made to these appropriated amounts going forward to balance the Health Care Access Fund, the General Fund would bear the costs.

IV. Long-Term Projections

Overview of Assumptions for 2018-2021 Projections

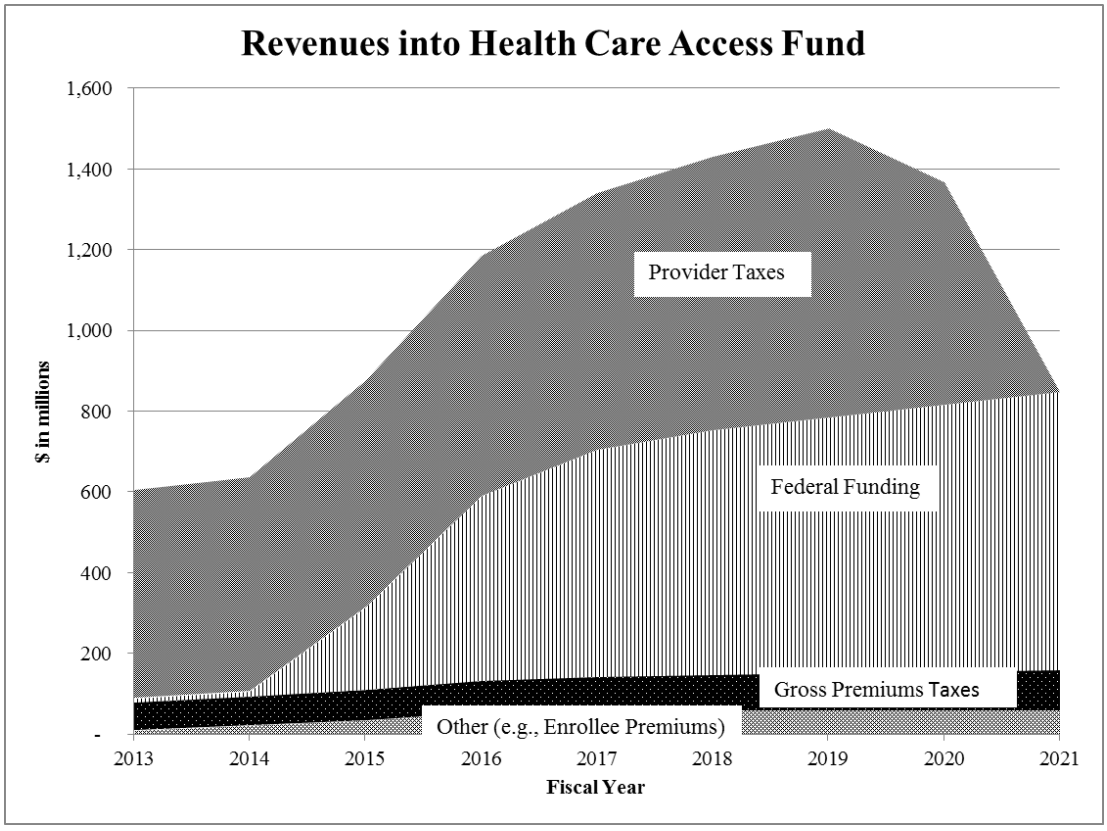
By law, the November 2013 forecast contains budget projections through the next biennium (FY 2016-2017). As specified in session law, this report provides projections for two additional biennia (FY 2018-2019 and FY 2020-2021); in order to extend beyond the date the provider tax is scheduled to sunset. The same forecast methodology has been applied for the entire period covered by this report.

Caution Regarding Forecasting Uncertainty: Given the substantial reforms underway in the health care industry, the projections contained in this document are subject to significant uncertainty. Given the nature of forecasting, projections for the last years covered by this report are subject to an even greater degree of uncertainty than projections for earlier years.

Projected Revenues

As reflected in Figure G, revenues into the Health Care Access Fund are projected to increase through FY 2019. This increase primarily results from the introduction of federal Basic Health Plan funding beginning in FY 2015.[23] Revenues are projected to decline significantly after FY 2019, as provider tax revenue disappears with the scheduled sunset of the tax.

Figure G



The tax revenue projections contained in this report are produced by applying forecasted growth factors to an existing baseline. Projected revenue from the two percent provider tax is produced by applying forecasted growth for nominal consumer spending on health care services, pharmaceuticals, and other medical products. The estimate for FY 2020 represents revenue from the half of the fiscal year during which the provider tax will be in effect under current law plus another quarter to account for the lag in the timing of the tax payments. No revenue from this tax is projected for FY 2021 or beyond.
The provider tax rate is projected to remain at the current rate of two percent until the tax sunsets on December 31, 2019. Current law requires a downward rate adjustment if the ratio of sources to uses is projected to exceed 1.25 for any given year, but no such adjustment is anticipated.[24] Forecasted revenue from the one percent gross premiums tax is based on expected growth in private insurance premiums.

Projected revenue from enrollee premiums and federal payments are based on forecasted enrollment and per enrollee payments from the federal government under the Basic Health Program.

Projected Uses

As reflected in Figure H, Health Care Access Fund uses are projected to increase through FY 2019. This increase primarily results from the projected increase in enrollment in MinnesotaCare as previously uninsured individuals respond to the new federal health insurance mandate by signing up for coverage.

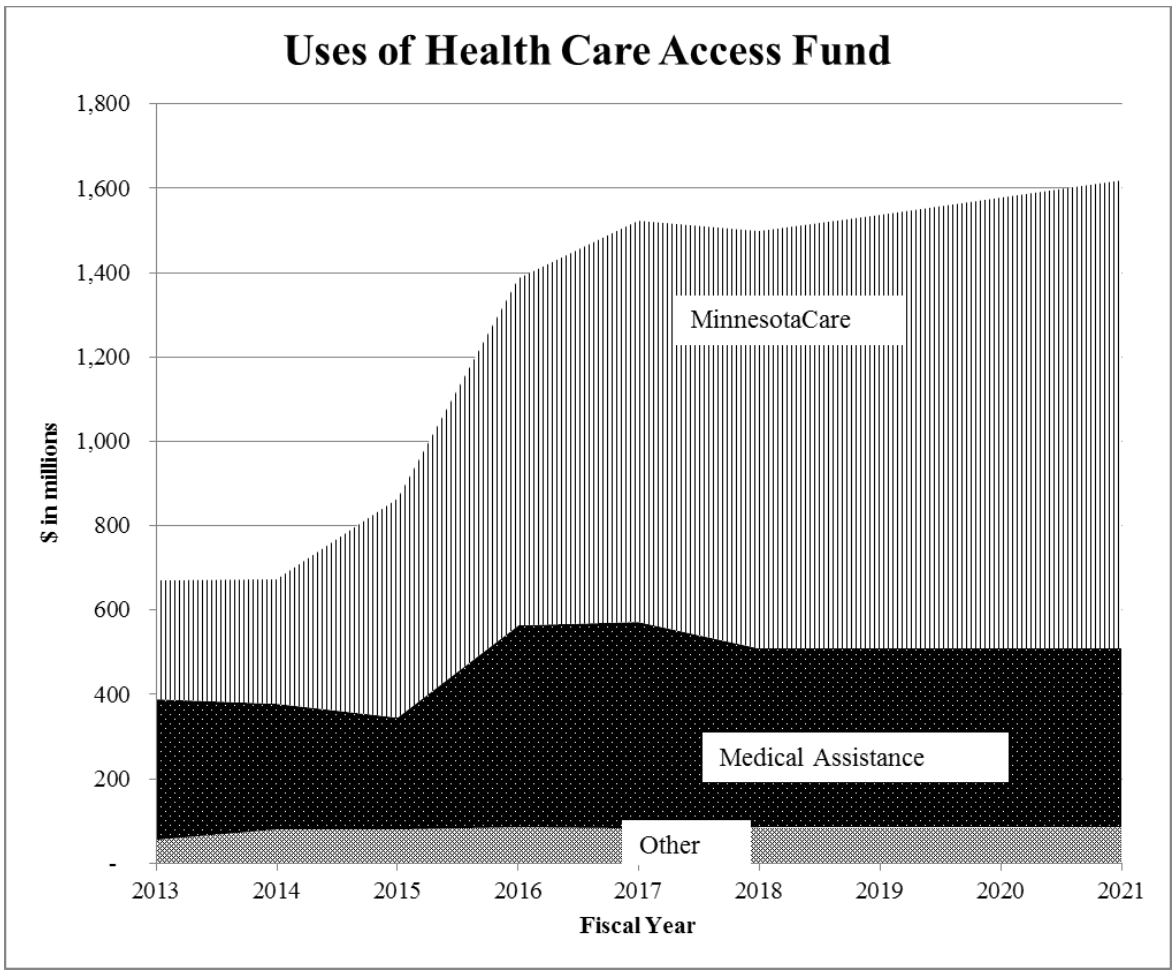
The MinnesotaCare expenditure projections contained in this report are produced by forecasting enrollment and cost changes relative to an existing baseline.[25]

Non-forecasted direct appropriation figures contained in this report reflect levels established in law for the period through 2017, and the recurrence of 2017 levels thereafter, in keeping with budgeting rules for the planning years.[26]

Under current law, two transfers from the Health Care Access Fund are subject to the availability of resources. One of these transfers is a recurring $96 million biennial transfer to the General Fund for Medical Assistance.[27] For this report, this transfer is not assumed to recur after the 2014-2015 biennium, given the projected shortfall beginning in 2016. The second of these transfers is a $1 million annual transfer to the Medical Education and Research Costs Fund.[28] For this report, this transfer is not assumed to recur after 2015, given the projected shortfall beginning in 2016.

Under current law, specified amounts will be transferred to the General Fund each year through 2017, as a result of the expansion of Medical Assistance eligibility in 2013 to a population previously covered through MinnesotaCare.[29] Given the absence of statutory language authorizing this transfer beyond 2017, for this report this transfer is not assumed to occur after 2017.

Figure H



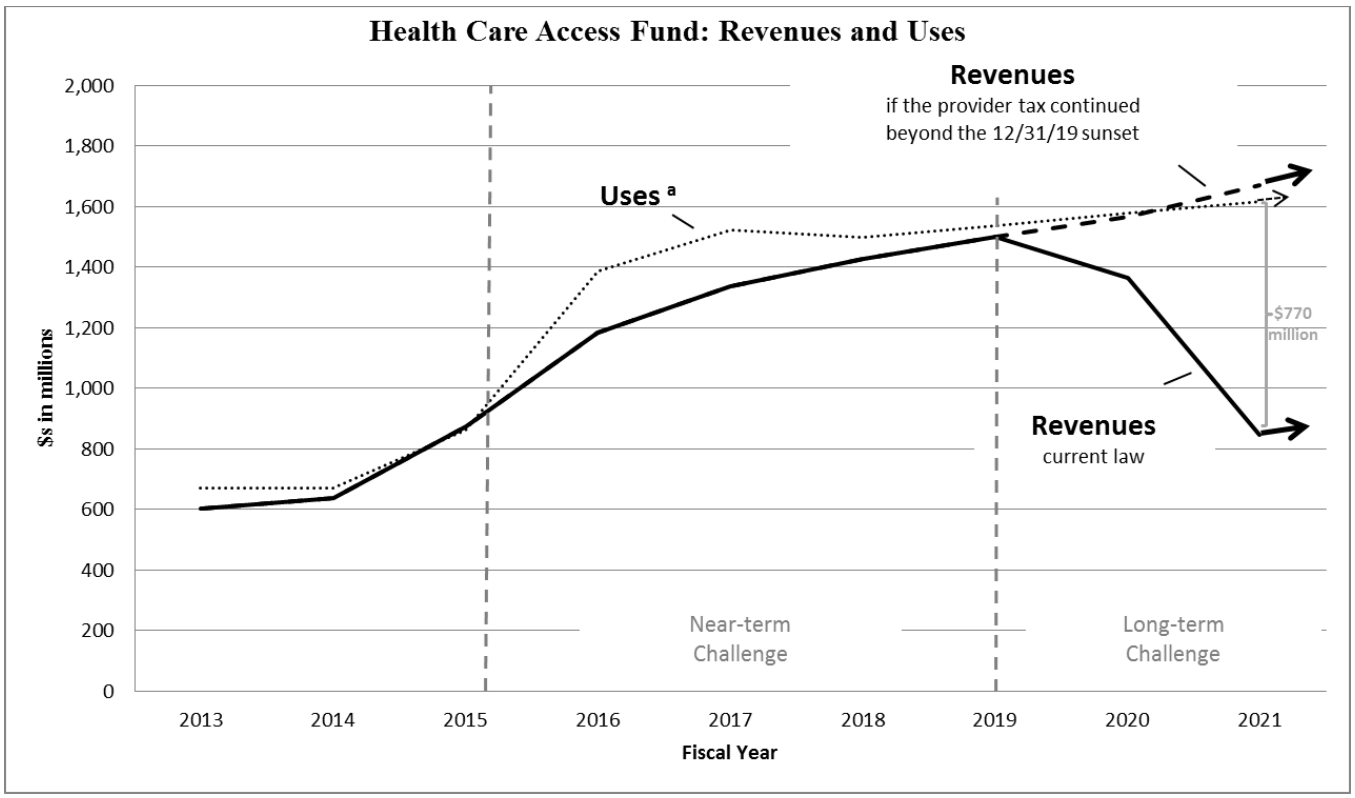
Comparison of Revenues and Uses

Figure I displays projected Health Care Access Fund revenues and uses. For the current biennium (2014-2015), revenues into the Health Care Access Fund are projected to be sufficient to cover uses.

For 2016-2019 sources are projected to be insufficient to cover uses.

After the scheduled sunset of the provider tax in 2019, the annual shortfall projected for the Health Care Access Fund is projected to increase. Under current law, 2021 will be the first fiscal year the Health Care Access Fund will receive no revenue from the health care provider tax. Under current projections for 2021, uses will exceed this fund's sources by $770 million. If the two percent provider tax were in place for this year, revenues would be sufficient to cover uses.

Figure I



[a] *Reflects legislative intent with respect to the amount of Medical Assistance spending that is financed through the Health Care Access Fund each year. Legislative action is needed to clarify these amounts beyond FY 2015.*

V. Summary

This report was prepared in response to legislation requesting: (a) an assessment of health care taxes and their relationship to the Health Care Access Fund; (b) the amount of state funding required for this fund after 2019; (c) an assessment of the stability of long-term federal funding for MinnesotaCare; and (d) recommendations for changes to state revenue if such revenue is required beyond 2019.[1] This section addresses each of these topics by summarizing information presented in the preceding sections.

Assessment of Health Care Taxes

The two health care taxes that support the Health Care Access Fund are a two percent tax on health care providers and wholesale drug manufacturers and a one percent gross premiums tax on HMOs and nonprofit plans. Both taxes are simple to administer, relative to other taxes. Provider tax revenue has grown faster than total state revenue, matching the relatively large increases in the cost of health care to a greater degree than HMO gross premiums tax revenue. Provider tax revenue growth has also shown more stability from year to year than the gross premiums tax. The provider tax provides greater horizontal equity than the gross premiums tax, which does not apply to self-insured plans.

Amount of State Funding Required Beyond 2019

Under current law, FY 2021 will be the first year the Health Care Access Fund will receive no revenue from the health care provider tax. If this revenue source sunsets, it will require a fundamental rethinking of the financing of health care for the populations served by MinnesotaCare, which this revenue source was established to fund. Under current projections for FY 2021, the Health Care Access Fund's uses will exceed revenues by $770 million. These projections extend beyond the budget window for which state forecasts are traditionally developed and are subject to significant forecasting uncertainty as a result of the significant changes underway in the health care sector.

Stability of Long-Term Federal Funding

Under current federal law, funding for MinnesotaCare through the Basic Health Program is scheduled to continue indefinitely, and is therefore expected to be stable, absent legislative changes. However, payments from the federal government for any given year will be subject to significant forecasting uncertainty, because federal per enrollee payments are pegged to benchmark premiums that result from the future pricing decisions of health insurance providers. As a result, while the continued availability of federal funding appears stable, the federal payments for any given year are subject to significant forecast uncertainty.

Recommendation for Changes to State Funding Beyond 2019

Minnesota health care programs and related financing streams are in a state of transition resulting from substantial reforms that will streamline and enhance eligibility. Each of these changes will have a fiscal impact on the Health Care Access Fund. First, hundreds of thousands of Minnesotans are expected to gain health insurance in the next few years, through Medical Assistance, MinnesotaCare, MNsure, and the broader private market. Projections of the rate at which people will take up coverage through each of these routes remain subject to uncertainty. Second, enhanced federal funding is available for populations newly eligible for Medical Assistance. Third, beginning in 2015, federal funding will cover a greater proportion of the overall cost of health care for those covered by MinnesotaCare, and will be subject to fluctuations in the benchmark premium subsidy and other factors. As a result of these changes, current

revenue and spending projections are subject to significant uncertainty and each successive forecast will benefit from additional information. Under current projections, policymakers will need to make incremental changes to address near-term deficits.

In this context, it is recommended that policymakers continue to observe developments in the health care sector as they consider revenue changes for the Health Care Access Fund for the period beyond 2019. However, given that federal requirements limit the state's options for reducing the cost MinnesotaCare, policymakers will need to establish a plan for aligning revenues into the Health Care Access Fund with ongoing responsibilities within a timeframe that enables the affected parties to plan accordingly.

Appendix A: Health Care Access Fund Statement through 2021 (November 2013 Forecast)

$ in thousands	Closing	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
Sources	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21
Balance Forward from Prior Year	111,546	49,862	14,104	26,046	(177,181)	(362,335)	(431,593)	(469,499)	(680,783)
Prior Year Adjustments	4,120	-	-	-	-	-	-	-	-
Adjusted balance forward	115,666	49,862	14,104	26,046	(177,181)	(362,335)	(431,593)	(469,499)	(680,783)
Revenues:									
2% Provider Tax	526,248	545,654	575,423	612,407	654,455	696,199	737,267	577,494	-
1% Gross Premium Tax	70,163	73,408	77,613	82,059	86,502	90,752	94,861	99,157	103,379
Provider and Premium Tax Refunds	(12,484)	(16,376)	(17,343)	(18,492)	(19,762)	(21,433)	(22,713)	(27,969)	(1,061)
State Share of MnCare Enrollee Premiums	[5,639]	21,838	33,539	53,664	58,789	58,766	58,731	58,660	58,549
Investment Income	1,126	150	90	-	-	-	-	-	-
Federal Basic Health Program Payments[1]	-	-	197,656	454,223	558,888	605,053	631,546	658,758	686,614
Federal Medicaid and S-CHIP Offsets[2] [Non-Add]	[278,513]	[256,077]	[179,826]	[18,527]	-	-	-	-	-
Federal Match on Administrative Costs	10,942	10,285	8,206	-	-	-	-	-	-
Managed Care Organization Excess Profits	8,175	-	-	-	-	-	-	-	-
DSH Claim for Legal Non-Citizens in MinnesotaCare	-	1,600	600	-	-	-	-	-	-
Total Revenues	604,170	636,558	875,785	1,183,859	1,338,872	1,429,336	1,499,692	1,366,100	847,480
Transfers In:									
Electronic Health Records Revolving Loan Fund	1,200	-	-	-	-	-	-	-	-
Total Sources	**721,037**	**686,420**	**889,889**	**1,209,906**	**1,161,692**	**1,067,001**	**1,068,099**	**896,601**	**166,698**
Uses									
Expenditures:									
MinnesotaCare: Direct Appropriation	278,601	267,344	287,004	314,355	334,596	326,150	338,673	351,405	364,301
MinnesotaCare: Federal Basic Health Program	-	-	197,656	454,223	558,888	605,053	631,546	658,758	686,614
Medical Assistance: Laws of MN 2013 Ch 108, Art 14, Sec 2 [3]	-	179,550	226,050	424,262	424,707	424,707	424,707	424,707	424,707
Healthy Minnesota Contribution Program	3,651	5,165	-	-	-	-	-	-	-
State Share of MnCare Enrollee Premiums	[5,639]	21,838	33,539	53,664	58,789	58,766	58,731	58,660	58,549
Department of Human Services	28,334	33,864	36,386	42,789	41,324	41,624	41,624	41,624	41,624
Department of Health [4]	12,639	33,173	29,143	29,743	29,143	29,143	29,143	29,143	29,143
Legislature	-	128	128	128	128	128	128	128	128
Department of Revenue	1,410	1,749	1,749	1,749	1,749	1,749	1,749	1,749	1,749
Interest on Tax Refunds	457	335	353	375	399	422	446	357	-
Total Expenditures	325,090	543,145	812,008	1,321,287	1,449,724	1,487,742	1,526,746	1,566,532	1,606,816
Transfers Out:									
To General Fund									
Medical Assistance: M.S. 16A.724 Subd 2(a)	48,000	96,000	-	-	-	-	-	-	-
2011 MA Expansion: Laws of MN 1sp 2010 Ch 1, Art 25	286,150	-	-	-	-	-	-	-	-
2013 MA Expansion: Laws of MN 2013 Ch 1 [5]	-	21,319	39,983	54,947	63,451	-	-	-	-
University of Minnesota: MN Laws 1sp 2011 Ch 5, Sec 5	2,157	2,157	2,157	2,157	2,157	2,157	2,157	2,157	2,157
Legislature: MN Laws 1sp 2011 Ch 10, Art 1, Sec 1	128	-	-	-	-	-	-	-	-
Other	854	-	-	-	-	-	-	-	-
Total General Fund Transfers	337,289	119,476	42,140	57,104	65,608	2,157	2,157	2,157	2,157
Special Revenue Fund: MAXIS/MMIS and Other	8,795	8,695	8,695	8,695	8,695	8,695	8,695	8,695	8,695
Medical Education & Research Costs (MERC) Fund, M.S. 16A.724 Subd 2(	-	1,000	1,000	-	-	-	-	-	-
Total Transfers Out	346,084	129,171	51,835	65,799	74,303	10,852	10,852	10,852	10,852
Total Uses	**671,174**	**672,316**	**863,843**	**1,387,086**	**1,524,027**	**1,498,594**	**1,537,598**	**1,577,384**	**1,617,668**
Annual Balance	(65,804)	(35,758)	11,942	(203,227)	(185,154)	(69,258)	(37,906)	(211,284)	(770,187)
Cumulative Balance	**49,862**	**14,104**	**26,046**	**(177,181)**	**(362,335)**	**(431,593)**	**(469,499)**	**(680,783)**	**(1,450,970)**

Appendix B: Summary of Inter-fund Activity

$s in millions	General Fund FY 2014-15	General Fund FY 2016-17	Health Care Access Fund FY 2014-15	Health Care Access Fund FY 2016-17	Total State Funds FY 2014-15	Total State Funds FY 2016-17
Medical Assistance & MinnesotaCare Costs	19,836	23,910	1,816	2,765	21,652	26,675
Federal Share	10,961	13,907	601	1,032	11,562	14,938
State Share	9,139	10,664	560	649	9,698	11,313
Local Share/Premiums	304	312	88	112	392	424
Interfund Transfers/Expenditures	(567)	(972)	567	972	-	-
Total HHS Expenditures & Transfers	**11,327**	**12,568**	**1,536**	**2,911**		
% of Health Care Costs Moving Between Funds	**(5.0%)**	**(7.7%)**	**36.9%**	**33.4%**		

[1] This report was prepared pursuant to Minnesota Laws 2013, Chapter 108, Article 1, Section 64, which reads:

> *The commissioners of revenue and management and budget, in consultation with the commissioner of human services, shall conduct an assessment of health care taxes, including the gross premiums tax, the provider tax, and Medicaid surcharges, and their relationship to the long-term solvency of the health care access fund, as part of the state revenue and expenditure forecast in November 2013. The commissioners shall determine the amount of state funding that will be required after December 31, 2019, in addition to the federal payments made available under section 1331 of the Affordable Care Act, for the MinnesotaCare program. The commissioners shall evaluate the stability and likelihood of long-term federal funding for the MinnesotaCare program under section 1331. The commissioners shall report the results of this assessment to the chairs and ranking minority members of the legislative committees with jurisdiction over human services, finances, and taxes by January 15, 2014, along with recommendations for changes to state revenue for the health care access fund, if state funding continues to be required beyond December 31, 2019.*

[2] Minnesota Tax Handbook: A Profile of State and Local Taxes in Minnesota (2012 Edition), available at http://www.revenue.state.mn.us/research_stats/research_reports/2012/2012_handbook_links_2_on_a_page.pdf

[3] M.S. 295.52

[4] M.S. 297I.05

[5] Medicaid surcharges are not assessed in this report as they do not provide revenue to the Health Care Access Fund.

[6] Over time, adults without children were provided a MinnesotaCare coverage option as well.

[7] The federal Employee Retirement Income Security Act (ERISA) precludes states from directly taxing self-insured plans. According to a 1992 Department of Revenue publication: "The choice of the financing mechanism for MnCare, as well as the design of the provider tax, was heavily influenced by the existence of ERISA. Under ERISA, states are preempted from regulating employee benefit plans, including self-insured employer health plans. The ERISA restrictions limit the state revenue sources available to finance reform. The preemption provision, for example, has been interpreted by the courts to prohibit states from imposing insurance gross premiums taxes on self-insured plans. With the continued expansion of self-insured plans, ERISA is a formidable barrier for state funding of health care access initiatives." Robert Cline, *State Financing of Health Care Reform: Minnesota's Health Right Act*, presented at the National Tax Association Annual Conference on Taxation in Salt Lake City, Utah on October 12, 1992. Quote is from page 15.

[8] If growth rates are stable, they will vary little from year to year. One statistical measure of such stability is the standard deviation of annual revenue growth rates. The lower the standard deviation in growth rates, the more stable the revenue source. For example, the standard deviation of annual growth rates between 2005 and 2012 was much lower for the provider tax (at 3 percentage points) than for total state tax revenue (at 6 percentage points). In contrast, the revenue from the 1 percent gross premiums tax on HMOs has been less stable than state taxes overall (with a standard deviation of 8 percentage points), as health insurance coverage varies with the state of the economy.

[9] For detailed analysis of the regressivity and progressivity of various state and local taxes, see *the 2013 Minnesota Tax Incidence Study*, page 13 and the right-hand column of Table 2-1 on page 25. The study is available at: http://www.revenue.state.mn.us/research_stats/research_reports/2013/2013_tax_incidence_study_links.pdf. (Page numbers refer to numbers at the bottom of each page.)

[10] See ibid, pages 17-18. Distributional analysis that combines both taxes and the spending financed by those taxes is referred to as "balanced-budget incidence." It has been applied to Social Security, for example, where a regressive tax finances progressive benefits. For a textbook description, see Harvey S. Rosen, *Public Finance* 3rd Edition (Boston, MA: Irwin, 1991), page 277.

[11] The federal Employee Retirement Income Security Act precludes states from directly taxing self-insured plans.

[12] M.S. 256.9657

[13] The MCHA phaseout is described in M.S. 62V.05, Subd. 2. The new fee will be 1.5 percent in 2014, and up to 3.5 percent on January 1, 2015 and after. Fee revenue cannot exceed 50 percent of the total 2012 MCHA assessment in 2015 and 100 percent of the MCHA in later years.

[14] ACA Public Laws 111-148 and 111-152, Sec. 1331 (d)(3)(A)(i)

[15] A concise description of these changes is available at: http://www.house.leg.state.mn.us/hrd/pubs/eligsubcare.pdf.
A detailed description of current eligibility levels can be found at the Department of Human Services website http://www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs16_178695.pdf.
[16] http://aspe.hhs.gov/health/fmapearly.htm

[17] http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8352.pdf.

[18] M.S. 256B.055; M.S. 256B.056, Subd. 4

[19] After the release of the November 2013 Forecast, the Department of Health certified that the state has realized sufficient health care savings to trigger a $50 million repayment from the General Fund to the Health Care Access in FY 2015, pursuant to M.S. 62U.10, Subd. 4. This transfer is not reflected in the figures contained in this report, but will be incorporated into the February 2014 Forecast.

[20] Laws 2013, Chapter 108, Article 14, Sec. 2, Subd. 5 para. g
[21] 2013 Legislative Session Tracking, Line 890;
http://www.senate.mn/departments/fiscalpol/tracking/2013/HHS_2013%20HHS%20Tracking-HF%201233-CC9.pdf

[22] M.S. 16A.11, Subd. 3(b)

[23] Prior to FY 2015, federal funding for MinnesotaCare was deposited in the Federal Fund. By statute, beginning in 2015 federal funding for MinnesotaCare is deposited in the Health Care Access Fund.

[24] M.S. 295.52

[25] A sunset of the provider tax can be expected to reduce the price of health care in the state, as the price would no longer include a two percent tax. This report does not attempt to quantify this impact or its corresponding implications for state health care program expenditures and corresponding federal payments.

[26] M.S. 16A.11, Subd. 3(b)

[27] M.S. 16A.724 Subd 2(a)

[28] M.S. 16A.724 Subd 2(c)

[29] Laws 2013 Ch 1, Sec. 6.