DEPARTMENT OF HEALTH

Evaluating the Stability of Minnesota's Individual Insurance Market

JANUARY 2018

Background

Approximately 5 percent of Minnesotans don't get health insurance through their employer or a public health care program; instead they purchase their coverage in the individual health insurance market, either through MNsure, an insurance broker or directly through an insurance company. Concerns over the stability of the individual insurance market have dominated health care policy debates in recent years on both a state and national level, particularly as this segment of the health insurance market was significantly changed by the Affordable Care Act (ACA).

One of the most pressing concerns has been the rising costs facing individual market consumers. Average individual market premium prices increased by double digits in Minnesota in both 2016 and 2017. Some consumers received income-based federal premium subsidies, which largely insulated them from these increases; however, over half of Minnesotans who purchased their own coverage were generally subject to the full premium cost due to their higher incomes.

Much of the premium trend in the individual market reflects high and increasing costs paid for health care services, indicating that effective strategies to address underlying cost growth are still needed. But these cost trends, coupled with changes in the make-up of the risk pool, raise concerns that ongoing high premium growth could destabilize the market. High premiums could drive away a greater number of healthy enrollees and create a risky business environment for health insurers, while leaving individuals vulnerable to one or zero options for purchasing coverage.

Minnesota has been one of the more active states in shoring up its individual health insurance market. Recent efforts to aid in stabilizing the market in Minnesota include the following:

- In 2016, the Minnesota Department of Commerce accepted health plan enrollment capacity limits for 2017 policies under which enrollment was constrained for some carriers to diffuse risk but maintain carrier participation in the market.[1]
- In January 2017, Minnesota enacted over $300 million in health insurance premium relief for 2017 policies by providing a 25 percent discount on premiums to all Minnesotans in the individual market who did not receive federal subsidies.[2]
- In March 2017, Minnesota established a two-year, $542 million state-based reinsurance program, set to begin in 2018, which uses a combination of state and federal funding (1332 waiver) to help insurance companies cover the cost of patients with high health care claim costs.[3]

- Minnesota policymakers continue to debate a number of additional proposals to shore up the individual market, including the governor's plan to allow Minnesota residents to purchase health insurance coverage through the state's MinnesotaCare program ("the buy-in").[4]

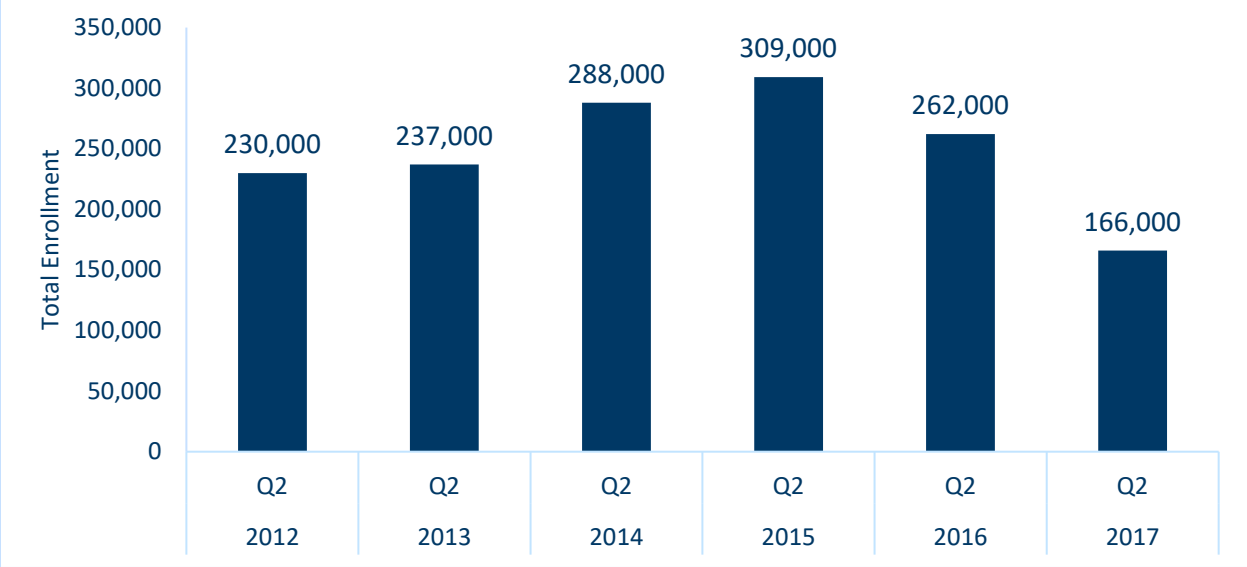
While Minnesota's individual insurance market covers only a small percentage of the population, it offers access to health insurance that is not dependent on income or employment; therefore, ensuring its stability will continue to be a priority for policymakers in the coming years. In this issue brief, we analyze available enrollment and financial information through 2017 for the health plans offering coverage in Minnesota's individual market in order to assess the size and indicators of financial stability in the market.

The data in this issue brief, unless otherwise noted, is from the second quarter (through June 30) of each year, and comes from the National Association of Insurance Commissioners (NAIC) quarterly filings released on August 15, 2017.

Enrollment

Enrollment in Minnesota's individual market began rising with implementation of key provisions of the ACA that included a requirement that individuals hold insurance, the availability of premium subsidies to eligible enrollees, the establishment of minimum benefit requirements, and the creation of insurance exchanges to facilitate comparison shopping for consumers, among other things. The number of people with individual market coverage in Minnesota peaked in 2015, then declined in 2016 and in 2017 (Figure 1).

Figure 1: Enrollment Peaked in 2015 and Dropped to Historically Low Levels in 2017



Source: Minnesota Department of Health analysis of data from the National Association of Insurance Commissioners (NAIC) second quarter data for major Minnesota carriers (Blue Cross Blue Shield of Minnesota, HealthPartners, Medica, PreferredOne, UCare Minnesota, and affiliates); the Minnesota Department of Commerce; MNsure; and Minnesota Management and Budget. Data from the Department of Commerce, MNsure and Minnesota Management and Budget was used to verify Minnesota-level enrollment for one health plan and confirm overall market size.

In 2017, enrollment fell substantially, dropping considerably below pre-ACA levels. A number of substantial shocks to the market likely contributed to the drop:

- Blue Cross Blue Shield of Minnesota (BCBS MN), which prior to 2017 held about 39 percent of enrollment in the individual market (about 100,000 enrollees), exited the market in totality.
- Other carriers, including HealthPartners, reduced the availability of policies in much of rural Minnesota.
- Individual market premiums increased in 2016 and 2017, leading some enrollees to drop coverage.
- The comprehensiveness of provider networks narrowed for more enrollees, constraining access to certain local providers for a number of enrollees and reducing the value of insurance coverage for some, particularly in rural settings.[5]

All carriers were impacted by congressional refusal to fund several billion dollars of federal risk corridor payments to carriers in 2014, meaning some losses that were expected to be covered have not been.[6]

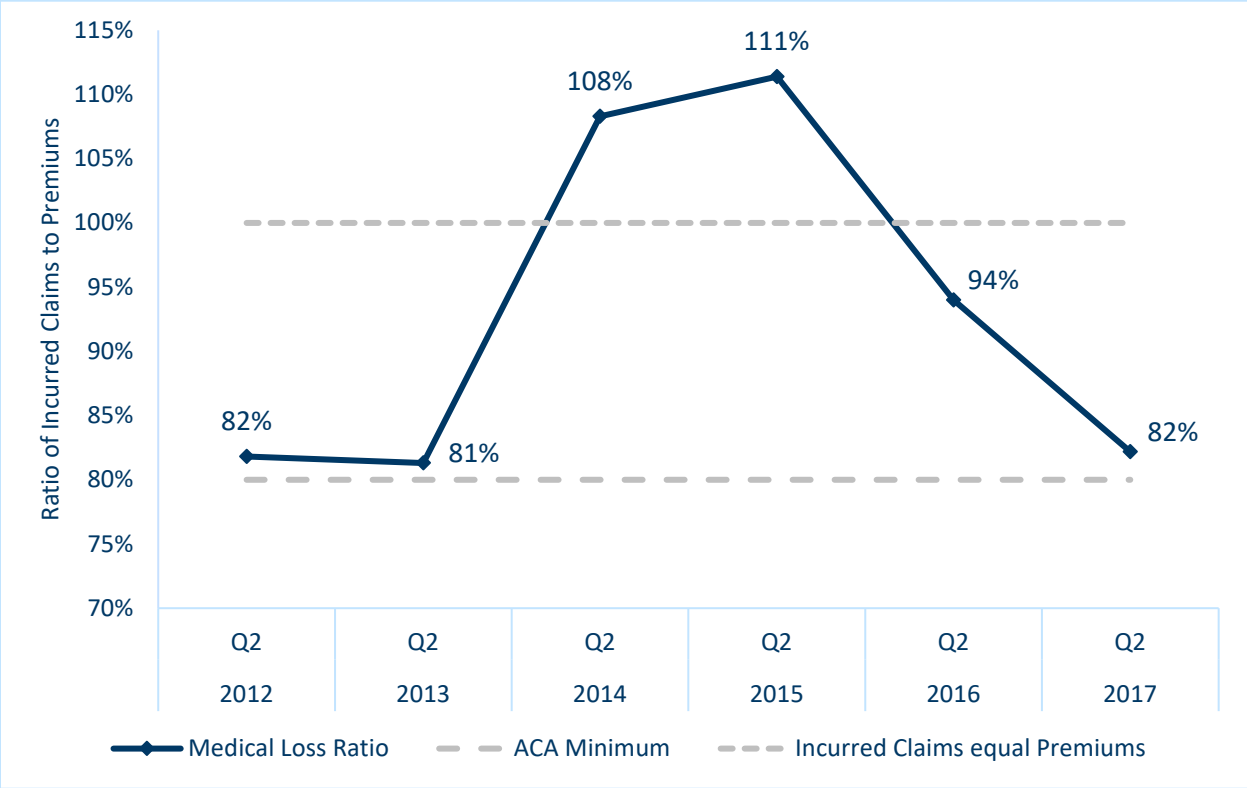
Insurer Financial Performance

The medical loss ratio (MLR) is one way to measure the financial performance of insurers. The MLR represents the share of collected premiums that are paid out to cover health care claim costs, after cost-sharing payments by consumers in the form of co-pays and deductibles.[7] A number below 100 percent signifies that after paying all health care claim costs, the health insurance carrier had premium revenue left to cover administrative expenses or earn a profit. Conversely, a value above 100 percent indicates that the insurance carrier failed to collect premiums sufficient to cover health care expenses for their enrollees. Beginning in 2011, the ACA required individual market insurers to operate at an MLR of 80 percent, meaning that at least 80 percent of premium dollars had to be spent on health care claim costs.[8]

In looking at the combined MLR for all major insurers in Minnesota's individual market mid-year, we found levels above 100 percent (indicating insurers were already paying out more for health care claim costs than they earned through premiums) for 2014 and 2015, the first two years of implementation of the ACA (see Figure 2). In the second quarter of 2016, the MLR dropped back below 100 percent, and in 2017, it returned to levels seen prior to full implementation of the ACA (at about 82 percent).[9] This seems to demonstrate, similar to evidence in other markets across the nation, that carriers succeeded in pricing premiums to more accurately reflect the risk in the market and the use of health care services by enrollees.[10]

It is also important to note that the end-of-year MLR is typically higher than at mid-year, and that plan design can impact change in MLR over the period of a year. Plans with higher deductibles, such as bronze plans, are most costly to insurers in the fourth quarter of the year after many enrollees have met their deductibles. Over time, more enrollees in the individual market have purchased such plans.

Figure 2: Lower Medical Loss Ratio in 2017 Suggests Health Plan Pricing is more in Line with Health Care Claim Costs



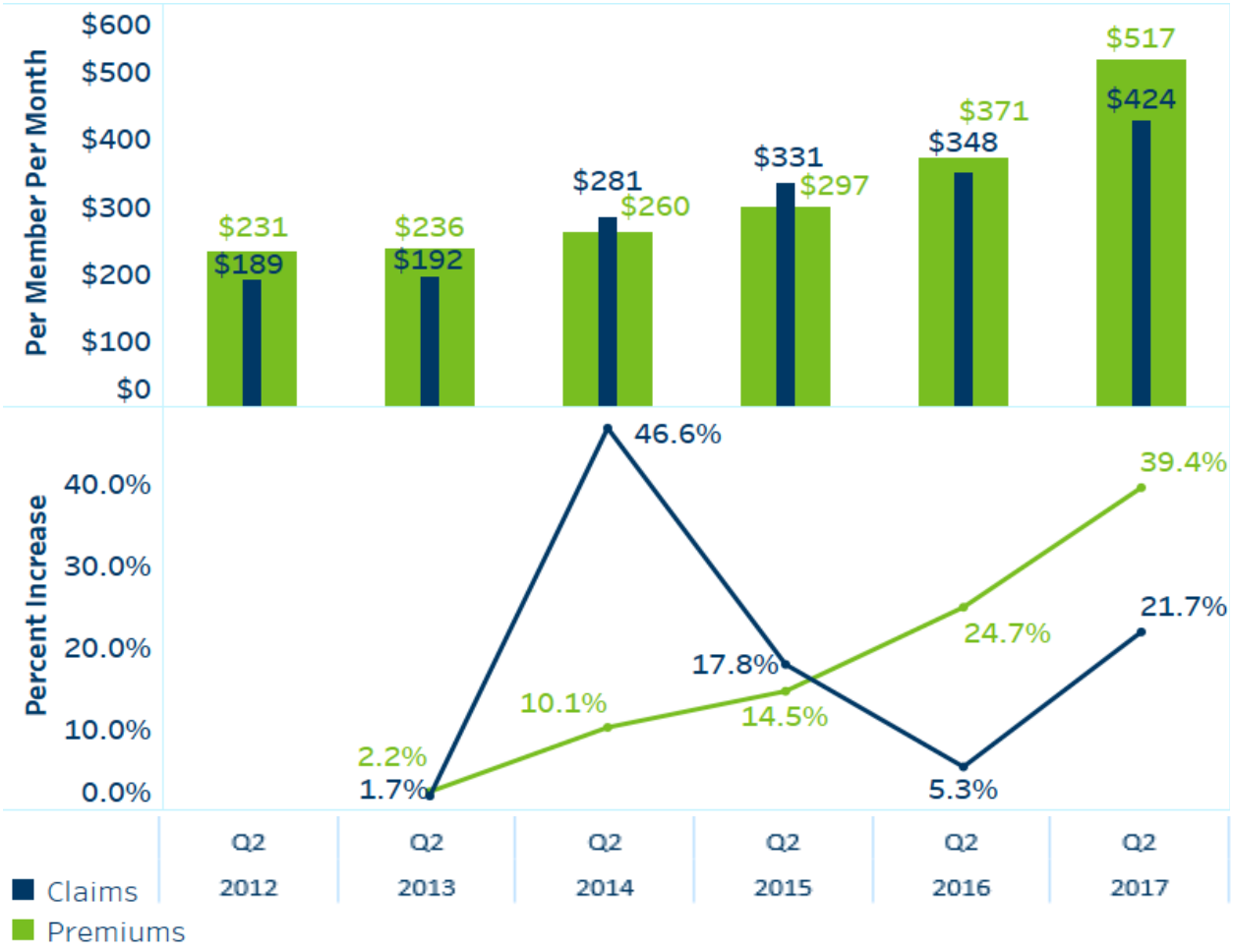
Source: Minnesota Department of Health analysis of data from the National Association of Insurance Commissioners (NAIC) second quarter data for major Minnesota carriers (Blue Cross Blue Shield of Minnesota, HealthPartners, Medica, PreferredOne, UCare Minnesota and affiliates).

Premiums and Health Care Claim Costs

To extend our understanding of financial performance in the individual market, we also monitored how average monthly per-enrollee trends in premiums and health care claim costs (claims paid by health insurers for care received by enrollees) changed over time and how that change affected health plan MLRs. Corresponding to findings in Figure 2, data in Figure 3 shows that average per-member per-month health care claim costs for 2014 and 2015 exceeded premiums.[11] This indicates that health plan premiums in 2014 and 2015 were priced too low to account for the health care needs of the population who enrolled in individual health insurance coverage.

Figure 3 also shows that the lower MLR in 2016 and 2017 resulted primarily from increased premiums rather than a decline in per-person spending for health care use. For both years, premium growth exceeded health care claim costs growth by double-digit rates (19.4 percentage points and 17.7 percentage points, respectively). By 2017, total cumulative growth for premiums and health care claim costs over the past four years were nearly equal (119.1 percent and 120.8 percent, respectively; data not shown).

Figure 3: Trends in Per-Member Premiums and Health Care Claim Costs, 2012 through 2017



Source: Minnesota Department of Health analysis of data from the National Association of Insurance Commissioners (NAIC) second quarter data for major Minnesota carriers (Blue Cross Blue Shield of Minnesota, HealthPartners, Medica, PreferredOne, UCare Minnesota, and affiliate). Premiums and health care claim costs are both shown per member per month (PMPM). Plans purchased prior to 2014 often covered fewer benefits, may have had cost-sharing requirements, and people could be denied coverage based on their health, which led to lower premiums and claims costs, as many people could not get coverage.

Demographic Change among Individual Market Enrollees?

Rising premiums have led to concerns that healthier people, or people who expect to use few health care services, would exit the market. This could exacerbate rising premiums by increasing the average risk level of those who remain in the market.

Premiums and health care claim costs data alone cannot tell us who is enrolled in the individual market or whether aggregate health care use might have changed over time. Absent more detailed data from the NAIC, this analysis uses available survey and enrollment data, including supplemental information collected by Minnesota's insurance exchange, MNsure, to shed some light on what is known about enrollment patterns.

In a previous analysis, MDH noted that the individual market appeared to get older between 2013 and 2015, going from 22 percent of enrollees age 55 or older in 2013 up to 28 percent in 2015.[12] Similarly, the age of those obtaining individual market coverage through MNsure has increased slightly over time, with around 35 percent of enrollees in 2017 age 55 or older, compared to 32 percent in 2015.[13,14] Further, the Minnesota Comprehensive Health Association (MCHA, the state's high risk pool) ended in December 2014; many of these Minnesotans had existing high health care needs, and moved to the individual market in 2014 and 2015.[15]

As mentioned earlier, the types of policies chosen by individuals can also impact changes in mid-year financial performance, as well as potentially impacting how health care is used. Since 2014, we have noticed a change in the type of policies enrollees chose as premiums rose. The number and share of enrollees in bronze plans, which offer comparatively less generous coverage than silver, gold or platinum plans in exchange for lower premiums, has increased. Even for MNsure, where a percentage of enrollees are shielded against premium increases because they receive federal subsidies, bronze plan enrollment increased from around 25 percent in 2014 to around 55 percent in 2017; the Minnesota Department of Commerce has noted similar trends across the entire individual market.[16] While bronze plans help to control known monthly expenses (premiums), they also leave individuals with a greater responsibility over health care spending due to higher deductibles and cost sharing.

Particularly in the context of understanding how premium rebates and reinsurance mechanisms have affected health care use and to what extent the market can benefit from care coordination and utilization management, it would be relevant to study measures of utilization broadly and for specific services. Unfortunately, available data through financial filings and other sources are substantially limited and not consistently reported to be of use to this analysis.

Summary and Discussion

The performance of the individual health insurance market in Minnesota and nationally has concerned policy-makers, health insurance carriers, and people who rely on the market for access to insurance coverage. Large financial losses for some carriers in Minnesota's market, departures of some carriers from the market altogether, enrollment caps and sizable jumps in premiums have motivated state legislation on strategies to stabilize the market. Although based on partial year information, this analysis shows some cause for optimism but also highlights continuing concerns about the stability of Minnesota's individual insurance market.

We see a more balanced financial picture for carriers continuing to serve the individual market into 2018, with premiums more in line with the health care needs of the enrollees, although some of the improvement may be related to plan design. The continued stability of MNsure, with enrollment increasing each year, also means more Minnesotans are receiving premium subsidies, and thus are somewhat insulated from any premium growth. Along with limited premium increases for 2018, these are all positive signs for the individual market. The presence of a reinsurance mechanism that provides two years of taxpayer-funded subsidies for health carriers' insurance losses from large health care claim costs (those between $50,000 and

$250,000), has contributed to more moderate premium growth and continued modest insurance competition across much of the individual market.

At the same time, shrinking enrollment and the possibility that it is the healthier individuals who are exiting the market is cause for concern about the longer-term stability of Minnesota's individual health insurance market. Ongoing health care cost inflation, premium growth and a shift towards insurance products with considerable cost sharing creates further worries about a sufficiently sized risk pool. Adding to these concerns are increasing signs that the federal government is stepping away from past financial obligations to patients and insurance providers, and is making changes, such as ending the federal individual mandate to purchase coverage, that could destabilize insurance markets or lead more individuals in this market to drop coverage, as well as put pressure on premiums. For example, the repeal of the individual mandate is expected to increase individual market premiums by 10 percent, on average, as well as reduce health insurance enrollment across all types of coverage.[17]

Minnesota is somewhat insulated from certain of these dynamics – for example, MNsure continues its advertising, enrollment assistance, and maintains a longer open enrollment period. However, the extent to which federal discussions, whether applicable to Minnesota or not, have acted as a deterrent to signing up for coverage are unknown.[18] Together with ongoing premium growth, worries about access to providers and the flexibility of provider networks, and trends towards higher cost-sharing requirements, these federal changes may impact potential enrollees' views of the value of insurance products in the individual market.

Further contributing to the concern over enrollment trends and long-term viability of the market are recent directions to federal agencies to promote the use of association health plans, or groups of small businesses that band together to buy health insurance, and efforts to enable the sale of short-term insurance policies. Resulting regulatory changes, if they supersede existing state regulation, have the potential to further destabilize health insurance risk pools and leave the remaining participants with higher premiums and fewer insurance options. If this bears out, Minnesota policy makers will be challenged to look for viable alternatives and financing options to ensure continued insurance access in Minnesota.

Data Used in this Issue Brief

Data are from a Health Economics Program analysis of National Association of Insurance Commissioners (NAIC) annual filings of insurers in the individual market in Minnesota. They include the six major Minnesota insurance companies who participate in the MNsure marketplace or sell plans outside of the marketplace (Blue Cross Blue Shield of Minnesota, HealthPartners, Medica, PreferredOne, UCare Minnesota and their affiliates). The quarterly reports outline revenue (premiums), expenses (health care claim costs), enrollment (covered lives and member months) and some utilization data at the health insurer or health plan level across all insurance products. This analysis focuses specifically on results from the second quarter (April-June) of 2012 through 2017.

Data obtained from the Minnesota Department of Commerce, MNsure and Minnesota Management and Budget (MMB) was used to verify Minnesota enrollment for one health plan and overall market size.

Endnotes

[1] Minnesota Department of Commerce, "2017 Health Insurance Rate Summary." September 30, 2016; retrieved from http://mn.gov/commerce-stat/pdfs/rate-release-packet-2017.pdf.

[2] 2017 Minnesota Session Laws, Chapter 2, Article 1, retrieved from https://www.revisor.mn.gov/laws/?year=2017&type=0&doctype=Chapter&id=2

[3] Snowbeck, C. (2017, October 16). Dayton signs agreement for 'reinsurance' program. *Star Tribune.* Retrieved from http://www.startribune.com/dayton-signs-agreement-for-reinsurance-program/451144103/

[4] Minnesota Office of Governor Dayton, "Fact Sheet: MinnesotaCare Buy-In." February 2, 2017; retrieved from http://mn.gov/gov-stat/pdf/2017_02_02_MinnesotaCare_Buy-In_Fact_Sheet_FINAL.pdf.

[5] Snowbeck, C. (2017, October 1). 'Narrow networks' that limit choice likely to endure n individual market. *Star Tribune.* RetrievedRetried from http://www.startribune.com/health-plans-that-limit-choice-likely-to-endure/448971543/

[6] MDH estimates that health plans are still owed more than $52.8 million of $62.9 million 2014 Risk Corridor payments as of November, 2017. Also see "Feds owe health insurers $12.3 billion in unpaid risk-corridor payments." *Modern Healthcare*, November 14, 2017. Retrieved from http://www.modernhealthcare.com/article/20171114/NEWS/171119935.

[7] For this issue brief, we calculate the Medical Loss Ratio (MLR) as a straight loss ratio (health care claim costs incurred divided by premiums written) based on quarterly filings. State and Federal end-of-year MLR calculations also take into account state and federal taxes, quality improvement costs and other adjustments to both premiums and claims; thus they will differ from what is reported in this issue brief.

[8] Prior to passage of the ACA, Minnesota law required individual market insurers to use at least 72 percent of premium dollars for health care claim costs.

[9] Analysis of full-year data shows that, generally, MLRs drop somewhat from 2nd quarter results. As such the 2017 results shown here should not be viewed as final results. Those will be posted by the NAIC in April 2018.

[10] National data shows similar trends. See Semanskee, A and Levitt, L. "Individual Market Performance in Mid 2017." *Kaiser Family Foundation*, October, 2017; retrieved from http://files.kff.org/attachment/Issue-Brief-Individual-Insurance-Market-Performance-in-Mid-2017.

[11] The data in Figure 3 is the experienced increase – increases are slightly lower than marketed rates because high premiums have led people to enroll in less-generous bronze plans. (Minnesota Department of Commerce Presentation to Minnesota Health Care Financing Task Force, November 14, 2016.)

[12] Minnesota Department of Health, Health Economics Program. (2017, May). *Enrollment in Minnesota's individual market: What changed and what stayed the same*. [Infographic]. Retrieved from http://www.health.state.mn.us/divs/hpsc/hep/chartbook/infographic.pdf

[13] MNsure. (2017, July 26). *Board of directors meeting.* [PowerPoint slides]. Retrieved from https://www.mnsure.org/assets/bd-2017-07-26-deck_tcm34-304408.pdf

[14] MNsure. (2015, June 17). *MNsure metrics dashboard.* [PowerPoint slides]. Retrieved from https://www.mnsure.org/assets/bd-2015-06-17-dashboard_tcm34-184455.pdf

[15] Also see Minnesota Department of Health, Health Economics Program. "Policy Short Takes: Minnesota Comprehensive Health Association" July 2017. Available at http://www.health.state.mn.us/divs/hpsc/hep/mchabrief.pdf.

[16] MNsure. (2017, July 26). *Board of directors meeting.* [PowerPoint slides]. Retrieved from https://www.mnsure.org/assets/bd-2017-07-26-deck_tcm34-304408.pdf; Montgomery, D. (2017, February 15). Understanding MNsure's evolution in 5 graphics: bigger, a little older and more subsidies. *Pioneer Press*. Retrieved from http://www.twincities.com/2017/02/15/mnsures-evolution-in-5-graphs-bigger-a-little-older-and-more-

subsidies/; Minnesota Department of Commerce Presentation to Minnesota Health Care Financing Task Force, November 14, 2016.

[17] Congressional Budget Office. "Repealing the Individual Health Insurance Mandate: An Updated Estimate." November, 2017; available at https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf.

[18] Minnesota's individual market will likely not be substantially affected by the discontinuation of cost sharing reduction (CSR) payments, because much of the eligible population is covered by the state's Basic Health Plan, MinnesotaCare; the change will affect the state's budget for the BHP and, potentially, the funding required for its 1332 waiver/reinsurance program.

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