
**The Impact of the ACA and Exchange on Minnesota:
Updated Estimates**

Prepared for State of Minnesota

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Introduction

The passage of the Affordable Care Act of 2010 (ACA) will have wide-reaching implications for health insurance markets, businesses and households. An important feature of the ACA is the wide latitude it leaves states to implement key provisions of the legislation, including the establishment of an Exchange. As such, it is critical that states understand how the ACA will impact their states in order to assess state policy leading up to and after the implementation of the major ACA provisions in 2014.

The State of Minnesota commissioned Gorman Actuarial and Dr. Jonathan Gruber to assess the impact of the ACA and the Exchange on the state and project the effect on insurance coverage, pricing, and budgets in Minnesota. An important element of our analysis considers the implications of establishing a Basic Health Plan (BHP). Results from our first analyses were presented in an April 2012 report. This report utilizes more recent data and updates the results of the previous actuarial and economic modeling analyses. The methodology, assumptions, and approaches for the actuarial and economic modeling analyses match those described in the April 2012 report and are thus not included in this report.

1. Key Findings

Unlike our earlier April 2012 report, we focus our analysis here on the single case where public health insurance coverage for children is maintained to 275% of the federal poverty level. We compare the impacts of the ACA in 2016 with the alternative scenario where healthcare reform was not enacted.

➤ **By 2016, the number of uninsured is projected to decrease by 298,000 or 60%**

Due to the individual responsibility requirement, the expansion of public health insurance program eligibility, and the premium tax subsidies, the number of uninsured will drop by 298,000 leaving 201,000 uninsured. Roughly 46% of this population will receive premium tax subsidies through the Exchange and 20% of this population will receive coverage through a public health insurance program. Another 25% are covered through employer sponsored insurance (ESI) and the remaining 8% will receive unsubsidized coverage through the Exchange. If the state pursues a Basic Health Plan (BHP), the number of uninsured could be further reduced by up to 42,000 depending on the structure of the BHP.

➤ **There will be a large rise in non-employer insurance coverage, with little change in employer-provided coverage**

The number of individuals purchasing insurance outside the employment setting will almost double, rising to 530,000 enrollees. There will be little change in employer sponsored insurance (ESI) as those who exit due to new insurance options are offset by new enrollment among those previously eligible for ESI.

➤ **The Exchange will enroll roughly 1.3 million persons**

While there is some uncertainty about who will ultimately purchase insurance through the new state insurance Exchange, we project that 605,000 privately insured persons will enroll in coverage through the Exchange, either as individuals purchasing on their own or through small group insurance purchase. In addition, another 690,000 publicly insured individuals will be enrolled in public health insurance through the Exchange. If the state pursues a Basic Health Plan (BHP), 153,000 to 195,000 individuals are projected to get coverage under a BHP through the Exchange depending on the structure of the program. If the state implements a BHP, private sector enrollment in the exchange would be reduced from 605,000 to 452,000.

➤ **After the application of tax subsidies, overall premium costs for those in the individual market will fall by 34% on average; approximately 70% of the individual market will experience either no change or premium decreases**

The tax credits available to low income families through the ACA and the Exchange will offset overall premium increases resulting from more comprehensive plan design standards, higher morbidity of new entrants in the market, and the merger of the state's high risk pool into the broader individual market, and lead to net premium cost reductions for those who remain in the individual market.

2. Overview of Modeling Approach

The results of this report represent the coordination of economic (by Jonathan Gruber) and actuarial (by Gorman Actuarial) modeling. In this section we provide a brief overview of those modeling approaches. As mentioned previously, the methodology, assumptions, and approaches for the actuarial and economic modeling analyses conducted for this report match those described in the April 2012 report and are thus not included in this report. Please refer to the April 2012 for a detailed description of the methodology for the actuarial and economic modeling.

GMSIM Overview

The Gruber Microsimulation Model (GMSIM) uses updated population benchmark data from the 2011 Minnesota Health Access Survey (MHAS) and state administrative data to establish a 2012 insurance coverage baseline for the non-elderly (under 65) population. By utilizing population growth projections from the U.S Census Bureau and insurance enrollment projections from the Congressional Budget Office (CBO) and the state of Minnesota, we are able to project forward from this 2012 baseline, and establish a 2016 pre-ACA status quo baseline.

We augment these data with updated 2011 information from survey data received from insurers in each of the individual, small group, and larger group (51-100 employee size)

market segments in Minnesota. This survey data included detailed benefit design information, demographic information, claims distributions, rating information and other financial information by insurer. This information was also collected from the Minnesota Comprehensive Health Association (MCHA), the state's high risk pool. Additional descriptions of this survey data can be found in the Gorman Actuarial overview below.

Lastly, we also received detailed updated data from the Minnesota Department of Human Services on public program enrollment by age and income and wage distribution data from the Minnesota Department of Employment and Economic Development.

These data are then used to implement and update a detailed microsimulation model of the impacts of the ACA and an Exchange on the state. We consider the following aspects of the ACA, including:

- The expansion of Medicaid up to 133% of poverty. Existing state policy covers adults and children to higher levels of income. In this modeling, we assume that non-pregnant adults above 133% of poverty would move from public health insurance to private subsidized coverage through the Exchange. We also assume that children retain their public insurance eligibility up to 275% of poverty and those above 275% of poverty are eligible for private subsidized coverage through the Exchange.
- Insurance market reform, whereby insurers face modified community rating (prices can differ by age, but not by health status), must guarantee issue insurance to all applicants and cannot exclude pre-existing conditions. There are also minimum standards put in place for insurance products in the individual and small group markets, most importantly a minimum actuarial value floor of 0.6.
- An Exchange which provides a competitive shopping place for individual and small group insurance.
- An individual responsibility requirement to purchase health insurance, which applies to those with incomes above the tax filing threshold who can obtain insurance for no more than 8% of their income.
- Employer responsibility payments of \$2,000 to \$3,000 for those employers whose employees use tax credits in the Exchange.
- Tax credits of up to 50% for small and low wage firms.
- New payroll taxes on the highest income families.

Gorman Actuarial Modeling Overview

The actuarial modeling was performed by Gorman Actuarial (GA). For the most part, GA relied on data collected and analysis performed for the state of Minnesota for an earlier report that was issued in April 2012. However, based on input from the state, GA revised the actuarial value analysis based on new and updated data collected from the insurers for 2011.

Actuarial value is defined in simple terms as the share of medical costs covered by the health plan. The higher the actuarial value, the more comprehensive, or richer, the benefit plan design. The lower the actuarial value, the more the member pays for benefits and member cost sharing. For the same benefit plan design, there can be significant variation in estimated actuarial value due to a variation in the assumptions used to calculate them. Actuarial value models use data such as claims distributions and utilization data. The underlying data of a model may vary across geographies due to cost differences as well as different practice patterns. Actuarial value calculations may also vary from one insurer to another within the same state. In November of 2012, HHS released their Actuarial Value Calculator. A comparison of outputs produced by the federal calculator to the GA model results in some variances. However, we believe the actuarial values produced by the GA model provide similar guidance. The actuarial value model developed by GA uses inputs describing key cost sharing elements for each product offering, including the deductible, coinsurance, out-of-pocket maximum, copays, and pharmacy benefits.

Integration of the Approaches

The results of the actuarial modeling analysis are provided to Dr. Jon Gruber who then models the economic effect of the many provisions of the ACA that will impact population movements, including: the expansion of Medicaid to 133% of poverty; tax credits for those from 133% to 400% of poverty; small business tax credits; penalties on firms whose workers use tax credits in the Exchange; the individual responsibility requirement; and others. Key outputs of GMSIM are the characteristics of those who enroll in the newly formed individual market. This output is provided back to GA, who models the premium impacts of the change in population mix in the new individual market relative to the previous individual market. The change in population mix is due to the splitting of the existing individual market pool into grandfathered and non-grandfathered populations, the migration of employer sponsored insurance members, public health insurance program enrollees, high risk pool participants, and the newly insured population. GA then provides these new premiums to Dr. Jon Gruber, who re-models population movements based on the new prices. Through this iterative process our joint team produces both the best estimates of population movements and prices.

A Word of Caution

The estimates that are presented here are based on a number of assumptions – and with such assumptions come uncertainty. These are our best projections of the impact of the

ACA and the Exchange, but they should not be interpreted as precise point estimates. More useful would be to use the estimates to provide a guide as to the magnitude and direction of the impacts that the ACA and the Exchange will have on Minnesota.

3. Analysis of Impacts to Coverage

The first step in our analysis is to model how the ACA will impact insurance coverage in Minnesota. To do so, we contrast two scenarios for the year 2016. We focus on 2016 to allow three years for the ACA to phase in; this follows Congressional Budget Office (CBO) assumptions on the amount of time it takes for the individual responsibility requirement to become fully effective.

The first scenario is a projection for the state of Minnesota without any effects of the ACA. This will reflect underlying trends that would impact insurance enrollment aside from the ACA, but no effects of the ACA itself. The second scenario is the projection for that same year for Minnesota with the ACA in place. The difference between these two scenarios is the projected impact of the ACA relative to the “counterfactual” results had the ACA not been implemented.

The results for overall insurance coverage for the non-elderly population in Minnesota are presented in Table 1. The first row shows that we project only a very small change in employer sponsored insurance (ESI) due to the ACA. We project that the unreformed or “grandfathered” individual market will decline precipitously as individuals and those in the Minnesota Comprehensive Health Association (MCHA) mostly move to the newly reformed market by 2016, including the Exchange. The net result of these movements is that total enrollment in the individual market roughly doubles. There is an increase in public health insurance enrollment of 55,000. Some differences from the April 2012 report are that public health insurance enrollment is higher prior to the impact of the ACA; this trend has also been observed in recent administrative data. Data from the MHAS also shows that incomes are increasing, which leads to less people being newly eligible for public programs under the ACA than in the April 2012 report and more people becoming eligible for premium tax credits in the individual market through the Exchange or a BHP in comparison to the April 2012 report. The share of the population that is uninsured falls by 60%, with a net reduction in the uninsured of 298,000.

Estimate of ACA Effect: 2016 (no BHP)

	No Reform	With ACA	ACA Impact
ESI	3,038,000	3,035,000	-3,000
>Small Firm ESI (1-50 employees)	420,000	426,000	6,000
>51 – 100 employees	108,000	99,000	-9,000
Unreformed Individual Market	291,000	7,000	-284,000
Reformed Individual Market	0	530,000	530,000
Public Insurance	756,000	811,000	55,000
Uninsured	499,000	201,000	-298,000
Total	4,584,000	4,584,000	

Table 1 – Estimate of ACA Effect: Non-Elderly Population 2016

Table 2 shows the sources of change in public health insurance. We see here that the net change of 55,000 represents the offsetting effects of both additions and subtractions to enrollment in public health insurance programs including Medicaid and MinnesotaCare. There are about 31,000 individuals who leave public health insurance as the eligibility is set at lower income levels and these people move to private coverage with subsidies through the Exchange. At the same time, about 46,000 persons join public health insurance who are made newly eligible by the expansion of Medicaid to those below 133% of poverty. Another 40,000 individuals who were previously eligible for public health insurance now enroll due to the individual responsibility requirement.

These population flows reflect inflows and outflows between public health insurance and private coverage; they do not reflect changes in enrollment between different types of public health insurance programs. For example, this table does not reflect population flows from MinnesotaCare to Medicaid as a result of the expansion of Medicaid to 133% of poverty for single adults as these adults are already counted in the public health insurance category.

Changes in Public Enrollment Due to ACA: 2016 (no BHP)

Leaving Public to Private Exchange	31,000
Leaving Public Voluntarily	0
Joining Public, Newly Eligible due to Expansion up to 133% FPL	46,000
Joining Public, Previously Eligible	40,000
Net Change	55,000

Table 2 – Changes in Public Enrollment Due to ACA: 2016

3.1. The Uninsured

Figure 1 shows the sources of coverage for those gaining health insurance due to the ACA and the Exchange. About one-quarter of those gaining coverage are obtaining coverage from employers. As we will see shortly, these are largely individuals who were previously eligible for ESI who now take up that insurance offer due to the individual responsibility requirement. A slightly smaller share obtain coverage through public health insurance. The largest source of new coverage is subsidized coverage through the reformed individual insurance market, including the Exchange, while fewer than 10% of individuals obtain coverage through the reformed market without subsidies.

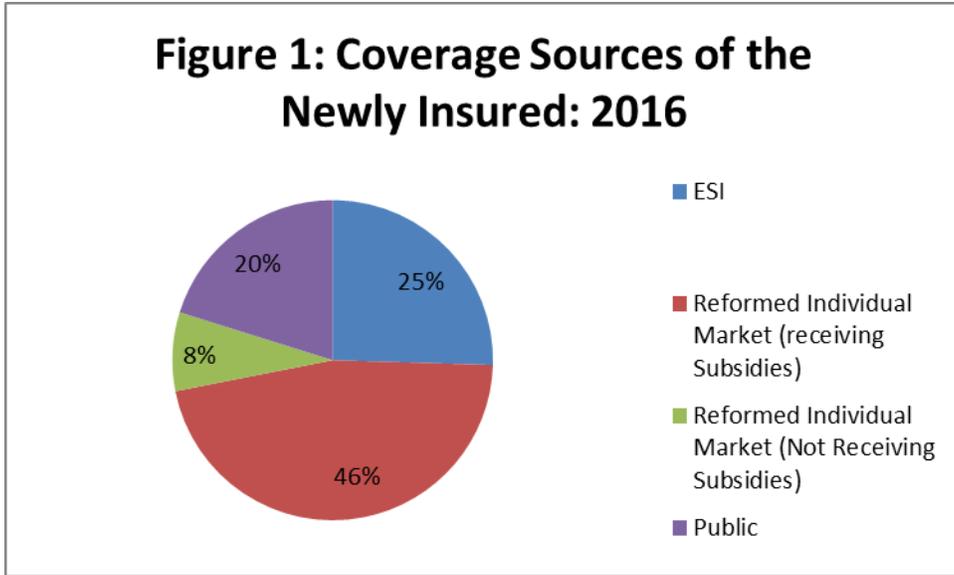


Figure 1 – Coverage Sources of the Newly Insured: 2016

The income distribution of those gaining insurance coverage is shown in Figure 2. The largest group gaining coverage is those between two and four times the poverty line, with smaller shares gaining coverage below 133% of poverty and from 133-200% of poverty, respectively. Only 7% of those who gain coverage have incomes above four times the poverty line.

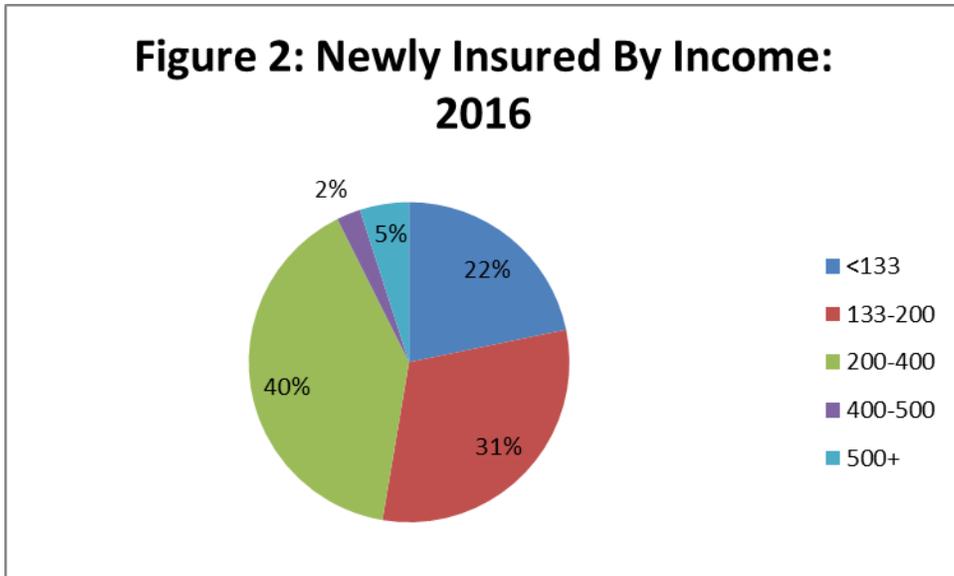


Figure 2 – Newly Insured by Income: 2016

Despite the decrease in the number of uninsured, under the ACA there will still be around 200,000 uninsured individuals in 2016. Figure 3 shows the breakdown of those remaining uninsured.

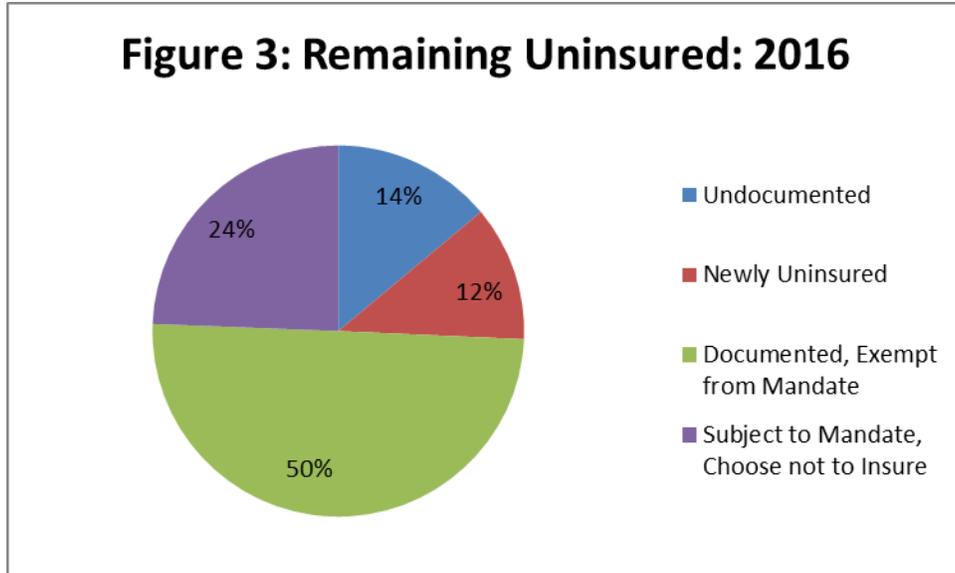


Figure 3 – Remaining Uninsured: 2016

About 12% of those who remain uninsured after the ACA are individuals who were actually insured absent the ACA, but who lose insurance, largely due to reductions in employer sponsored insurance. The remainder of this chart represents individuals who were uninsured absent the ACA and remain so even with the ACA. About 14% of those who are uninsured after the ACA are undocumented immigrants. The coverage provisions of the ACA are explicitly denied to undocumented immigrants, so there is little reason to believe that the ACA will improve insurance coverage in this population. The remaining 74% of individuals uninsured even after the implementation of the ACA can be split into two categories, those who are exempt from the individual responsibility requirement/coverage mandate (because their income is below the individual tax filing threshold or because insurance costs more than 8% of their income) and those that are subject to the individual responsibility requirement and still choose to remain uninsured. Fifty percent of the remaining uninsured are in the exempt group and 24% are in the group choosing to ignore the individual responsibility requirement. In total, the 201,000 remaining uninsured represent less than 5% of the non-elderly population.

3.2. Employer Sponsored Insurance

As previously mentioned, ESI will experience only a small net decline in enrollment, although there will be larger gross flows within the employer sponsored insurance population. There are a few reasons for this lack of effect. The first is that the full effects of the ACA will take a few years to manifest themselves. Exchange enrollment is expected to phase-in over the first 3 to 4 years of the ACA, so 2016 impacts on ESI enrollment will be somewhat muted. The second major reason is that firms will not generally take up some of the incentives provided by the ACA to drop coverage. This is due to the employer responsibility requirement codified in the ACA. Firms with 50 or more employees will face fines if they do not offer adequate, affordable policies to their employees and those employees as a result become eligible for and utilize premium tax

credits through the Exchange to purchase coverage. These fines partially offset the financial incentives to drop coverage and shift employees to the Exchange. In addition, the presence of the individual responsibility requirement provides an incentive for individuals to pressure employers to maintain ESI coverage. Since insurance coverage is mandatory at the individual level, employees will desire the security provided by the ESI plans they are already enrolled in. Furthermore, evidence from the recent health insurance reform in Massachusetts suggests that most firms will not drop coverage, even with the presence of a viable alternative like the Exchange. It is not clear how relevant this experience is for Massachusetts given the differences in the two states, but it further confirms the conclusions from our analysis (and CBO's) that show small effects on employers.

Figure 4 summarizes the flow in and out of ESI in 2016. In this figure we divide the ESI movements into three categories: those dropped by their firm; those who voluntarily leave employer sponsored insurance to move to the Exchange, Medicaid, or even to become uninsured; and those who join employer sponsored insurance either due to changing prices, the individual responsibility requirement, or the expansion of dependent coverage to young adults. The last set of bars shows the very small overall net effects.

Figure 4: Number of People Experiencing Changes in ESI

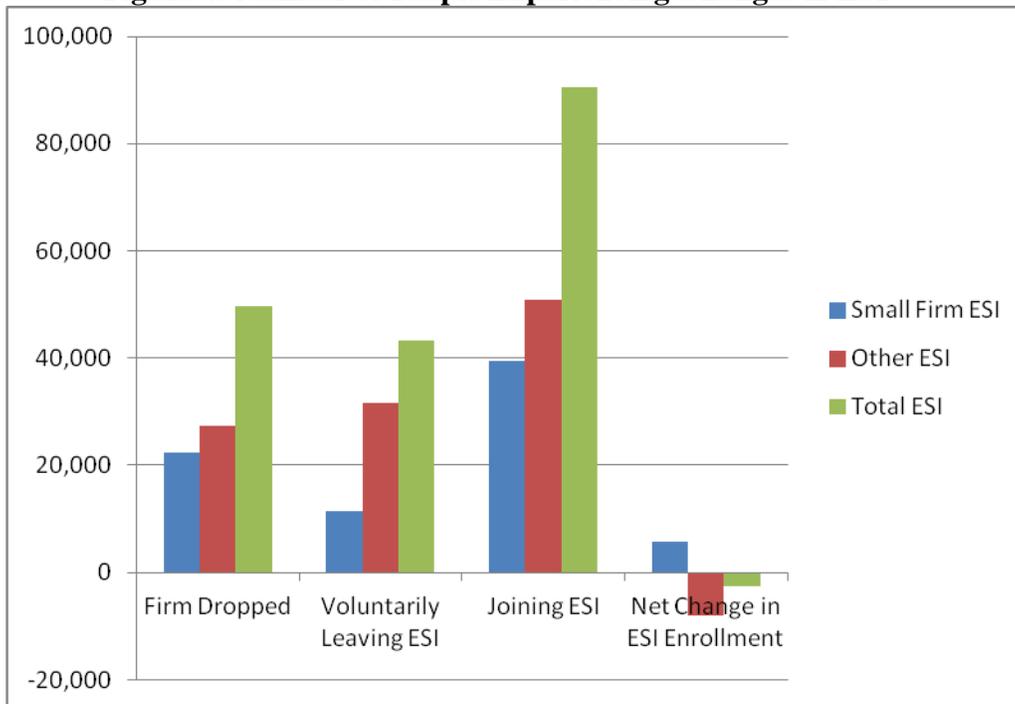


Figure 4 – Number of People Experiencing Changes in ESI

We estimate that roughly 50,000 individuals are dropped from ESI. Another 40,000 individuals voluntarily leave ESI for other forms of insurance. But at the same time about 90,000 persons join ESI. Thus, we get a roughly net zero effect on ESI coverage.

3.3. Individual Insurance Market and the Exchange

By 2016, individuals desiring non-group insurance can participate in one of three different markets. The first is to stay in the traditional individual market by maintaining their “grandfathered” plan (which was held in 2010). Individuals in this market will be able to retain non-community rated insurance policies, but they will not be eligible for the new tax credits. This market will decline substantially by 2016, however, as very few individuals maintain consistent individual market coverage for that long a period. The second is to move to the new Exchange in the newly reformed market, which provides federal subsidies for those who are eligible. The third is to move to the newly reformed market, but to purchase a policy outside of the Exchange. This may be attractive for non-subsidized individuals if there are a wider variety of health plan choices or different health plan regulatory rules available outside the Exchange.

The Exchange will also garner enrollment from employees in small firms. This will include any enrollees in small group insurance who wish to take advantage of the small business tax credit, which must be claimed through the Exchange, as well as other firms with fewer than 100 employees who find it attractive to purchase through the Exchange. Finally, the Exchange will be the source of eligibility determination and enrollment for (non-disabled, non-elderly, and non-waivered) children and adults signing up for Medicaid.

Table 3 forecasts the size of the Exchange in Minnesota. The first column shows the number of persons projected to be in each category that might use the Exchange, while the second column shows the projected Exchange enrollment from that group. For tax credit recipients in both the individual and small group markets, 100% of those in the group are enrolled in the Exchange, since tax credit receipt requires Exchange enrollment. For individuals and small firms that do not receive tax credits, there will only be partial enrollment, as the Exchange competes with outside markets; we assume that half of such individuals, and one-quarter of small firms, will choose to enroll in the Exchange, but the outcome here will very much depend on future decisions that impact the attractiveness of the Exchange as a source of insurance purchase, such as choice of plans and differences in regulatory rules inside versus outside the Exchange. Finally, we add publicly insured individuals who will now be enrolling through the Exchange; this number is smaller than the number with public health insurance presented in Table 1 due to the fact that non-elderly disabled individuals have a different basis of eligibility and are not required to determine eligibility or enroll in coverage through the Exchange.

Predicting the Size of the Exchange, 2016

	No BHP		With BHP	
	# of individuals	Enrollment in the Exchange	# of individuals	Enrollment in the Exchange
Tax credit Recipients	370,000	370,000	217,000	217,000
Enrollees in Firms 1-50 Receiving Tax Credit	33,000	33,000	33,000	33,000
Non-tax Credit Recipients in Reformed Market	Up to 160,000	80,000	Up to 160,000	80,000
Enrollees in Firms 1-50 Not Receiving Tax Credit	Up to 393,000	98,000	Up to 393,000	98,000
Enrollees in firms 51-100 Public Insurance	Up to 99,000	24,000	Up to 99,000	24,000
Enrollees	690,000	690,000	843,000	843,000
Total Exchange Enrollment		1,295,000		1,295,000

Table 3 – Predicting the Size of the Exchange: 2016

In total, we estimate that roughly 1.3 million individuals will obtain coverage through the Exchange. A little less than half will be purchasing insurance on the Exchange, and a little more than half will be the publicly insured determining eligibility and enrolling through the Exchange.

Later in the report we will discuss the state’s choice about whether to offer a Basic Health Plan (BHP) option. If the state does so, it will reduce the number of tax credit recipients purchasing through the Exchange, and raise the number of publicly insured enrolling through the Exchange. Depending on the structure of a BHP, the total number of individuals passing through the Exchange could increase by 42,000 under the public insurance enrollee category.

4. Impacts on Individual Market Premiums

There are many changes that will take place starting in 2014 that will affect premiums within the individual market. Some changes will affect just portions of the individual market and others will affect the market as a whole. Our previous study focused on five categories of change. However, for our revised analysis, we focus on the four most important categories of change which are listed below. The fifth category is the impact of rating limitations and as noted in the April 2012 report, the elimination of health status rating will increase premiums for a healthier demographic and decrease premiums for the less healthy, but the limitation alone will not affect overall premiums. The impact to the individual market rating pool due to member migrations as a result of premium changes

are explored in the third category below. Note that these estimates do not explicitly reflect the impact of the risk adjustment, reinsurance, and risk corridor programs. In addition, these estimates do not reflect the ACA tax. Since our focus is on 2016, we believe that the premium reductions through reinsurance recoveries would mostly be offset by the reinsurance assessment and the ACA tax. In addition, these premium impacts do not reflect the impact of annual medical trends. These premium impacts are shown prior to the implementation of the federal tax subsidy. There will be a portion of the individual market that will be eligible for these subsidies as discussed later.

- (1) **The impact of product limitations:** In 2014, all products sold within the individual market will be required to be within a metallic tier. The actuarial values required for each metallic tier are:
- Platinum 0.88 to 0.92
 - Gold 0.78 to 0.82
 - Silver 0.68 to 0.72
 - Bronze 0.58 to 0.62

Individuals enrolled in products with a different actuarial value will be required to either “buy up” or “buy down” to the approved metallic tier. For example, a non-grandfathered individual that is currently enrolled in a product with an actuarial value of 0.75 will either need to purchase a less comprehensive product (“buy down”) to an actuarial value of 0.72 (approximately a 3% reduction in premium) or purchase a richer product (“buy up”) with an actuarial value of 0.78 (approximately a 3% increase in premium.) All individuals enrolled in a product with an actuarial value below a 0.58 will be required to buy up to a 0.58. Due to this requirement there will be premium increases and decreases due to product requirements within the market. We have estimated the premium impact due to product limitations to the entire individual market to be approximately 4% without a BHP and 3% with a BHP.

- (2) **The impact of merging the Minnesota Comprehensive Health Association (MCHA) with the individual market:** We have estimated two scenarios for the merger of the high risk pool with the individual market. Under one scenario, we assume that all of MCHA will be enrolled within the individual market. We estimate the premium impact under this scenario is 21% without a BHP and 19% with a BHP. Under the second scenario we assume that MCHA is phased out over a three year period and that by 2016 less than 20% of MCHA members, but the sickest members, do not migrate to the individual market. We estimate the premium impact to be approximately 16% without a BHP and 15% with a BHP.
- (3) **The impact of the new individual market:** In 2014, with the introduction of the individual responsibility requirement, the tax subsidies provided within the Exchange, and a move of some individuals from public health insurance coverage to the private coverage tax subsidies through the Exchange, there will also be new individual market entrants. These new individual market members will come primarily from the uninsured and public health insurance and to a lesser extent

from employer sponsored insurance. These new members will have an impact on the existing individual market premiums and the magnitude of the impact will depend on how their risk profile compares to the risk profile of the individual market. This last modeling exercise was performed by Dr. Gruber using his microsimulation model (GMSIM). Neither we nor Dr. Gruber have incorporated in our modeling the impact of the risk adjustment, reinsurance, and risk corridor programs that are mandated by the ACA, which may mitigate premium changes due to the law. In the absence of these programs, we find the premium impact for the entire individual market as a result of these new entrants to be approximately 11% without a BHP and 6% with a BHP.

- (4) **Managed Competition Effect:** The introduction of transparency and easy comparison through an Exchange and corresponding tax subsidies provides insurers with a membership growth opportunity and incentive to be more competitive. Insurers may strive to achieve efficiencies which may lead to lower premiums within the Exchange. Dr. Gruber has assumed a 7.5% reduction in premiums due to this effect, which follows the efficiencies assumed by the CBO in their analysis.

Table 4 illustrates the estimated premium impact to the individual market, prior to the application of premium tax subsidies. The overall expected premium impact ranges from 15% to 29%. These premium changes do not include the ACA changes related to preventive services, annual limits and lifetime limits, which are estimated to increase premiums from 1% to 3%.

Individual Market 2016 Premium Impact	No BHP	BHP
Actuarial Value Requirement	4%	3%
MCHA - All Move to the Individual Market	21%	19%
MCHA - 3 year phase out	16%	15%
New Risk Mix of Individual Market Pool	11%	6%
Managed Competition effect from Exchange	-7.5%	-7.5%
Premium Change- MCHA All move to Individual Market	29%	19%
Premium Change - MCHA 3 year phase out	23%	15%

Table 4 – MN Individual Market Summary of Premium Change

4.1. Impact of Product Limitations

The benefit plans of members in the current individual market and small group market differ greatly. In general, plans in the individual market are much less rich than plans in

the small group market. What is also noticeable from 2009 to 2011 is the level of “benefit buy down”. Over the two year period, many members within the market have shifted to higher deductibles. For example, as shown in Table 5, in 2009, 25.5% of the market was enrolled in plans with deductibles between \$3000 and \$5000, and in 2011 it increased to 37.7%.

Single Policy In Network Deductible	CY 2011	CY 2009
\$0	0.0%	0.1%
<=\$1000	7.2%	13.1%
\$1001-\$2000	13.5%	33.9%
\$2001-\$3000	27.1%	18.2%
\$3001-\$5000	37.7%	25.5%
\$5001-9500	8.3%	3.6%
\$10,000	4.8%	4.6%
\$12,000 to \$15,000	1.5%	0.9%

Table 5 – MN Individual Market 2011 Market Share by Deductible

As described above, using the GA actuarial value model GA estimated the actuarial value for the most popular benefit plans in each of the individual and small group markets. At a high level, the actuarial value represents the average percent of medical expenses that would be paid by an insurer. The higher the actuarial value, the more comprehensive or the richer the plan design. The lower the actuarial value, the more the member pays in member cost sharing. For this analysis GA used data provided as part of the insurer survey. This information included the number of covered lives for each benefit plan and several plan attributes, including annual deductible, out of pocket maximum, coinsurance, copayments, benefit limits and prescription drug benefits. GA calculated high-level actuarial values using GA pricing models that take into account varying cost sharing by major service categories including inpatient, outpatient hospital, primary care visits, specialist visits, emergency room visits and pharmacy.

Beginning in 2014, all products sold within the individual market will be required to be within a metallic tier. The actuarial values required for each metallic tier are: Platinum 0.88 to 0.92; Gold 0.78 to 0.82; Silver 0.68 to 0.72 and Bronze 0.58 to 0.62. Individuals enrolled in products with a different actuarial value will be required to either “buy up” or “buy down” to the approved metallic tier. All individuals enrolled in a product with actuarial values below a 0.58 will be required to buy up to a 0.58.

Approximately 23% of Minnesotans in the individual market are currently enrolled in benefit plans that have an actuarial value below the ACA bronze level minimum. Figure 5 shows that benefit plans in the individual market vary widely. There are many people with “bare bones” plans that have high deductibles, copays and out of pocket expenses, and there are others with more rich benefit plans. About 4% of individuals in the individual market are in plans with an actuarial value greater than 0.80.

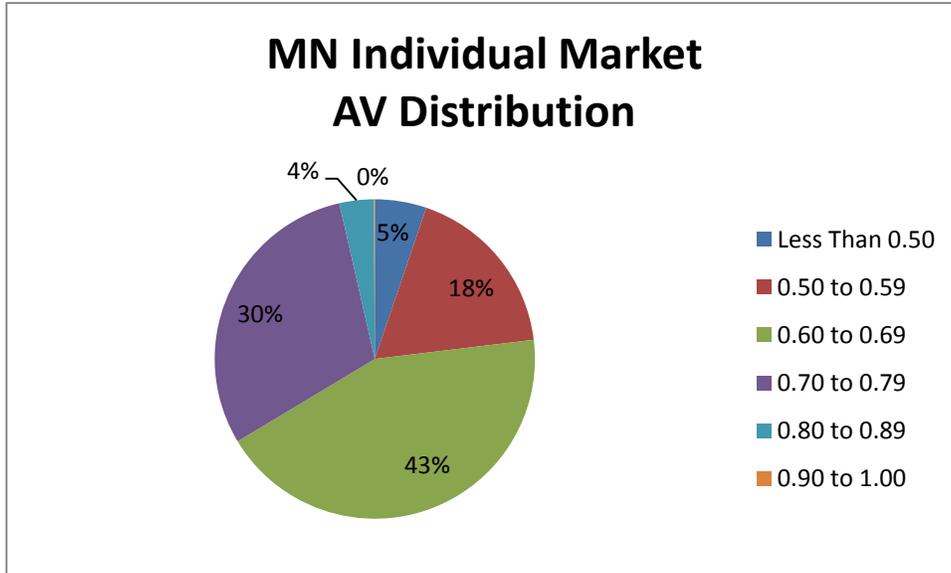


Figure 5 – 2011 Individual Market Actuarial Value Distribution

We have estimated that the overall premium impact due to the ACA’s product requirements will increase premiums approximately 4% without a BHP and 3% with a BHP. Note that these increases do not take into account other aspects of the ACA, such as premium tax credit subsidies or cost sharing subsidies.

4.2. Impact of Minnesota Comprehensive Health Association

Due to changes in the market rules under the ACA, including guaranteed issue and the elimination of health underwriting, it is expected that the current Minnesota high risk pool, known as the Minnesota Comprehensive Health Association (MCHA), will become part of the individual market by 2016. The premiums for MCHA are currently set at up to 125% of the standard rate in the individual market. In addition to member premiums, MCHA is also funded through state assessments.

GA reviewed the distribution of claims for MCHA members and compared their claims to the current individual market. We have estimated two scenarios for the movement of high risk pool members to the individual market. Under one scenario, we assume that by 2016 that all of MCHA will be enrolled in the individual market. We estimate the premium impact to be approximately 21% with no BHP. With a BHP, the premium impact is 19% as we assume that 10% of the high risk pool would be eligible. Under the second scenario, we assume that MCHA is phased out over a three year period and that by 2016 less than 20% of MCHA members, but the sickest members, do not migrate to the individual market. We estimate the premium impact to be approximately 16% without a BHP and 15% with a BHP.

4.3. Individual Market Premium Impacts After Implementation of Tax Subsidy

Many changes will take place in 2014 that will impact what a consumer will pay in the individual market. Federal premium tax subsidies will be offered through the Exchange, based on income. After receiving premium changes from Gorman Actuarial, Dr. Gruber modeled the effect of the tax subsidy on the individual market. Note that, once again, our results do not account for any further reduction in premiums from risk adjustment/reinsurance or from redirecting the high risk pool assessment.

Without ACA reforms, premiums in the individual market in 2016 are projected to be \$3,877 on average per person annually with an average actuarial value at a bronze level. With ACA reforms, including the tax subsidies available through the Exchange, the average annual per person premium in the individual market is estimated to be reduced by 34% and the average actuarial values are estimated to be 10% higher than in the individual market without ACA reforms at a silver actuarial value level. As shown in Figure 6, 64% of the individual market will experience premium decreases, 6% will experience no change, and 30% will see premium increases.

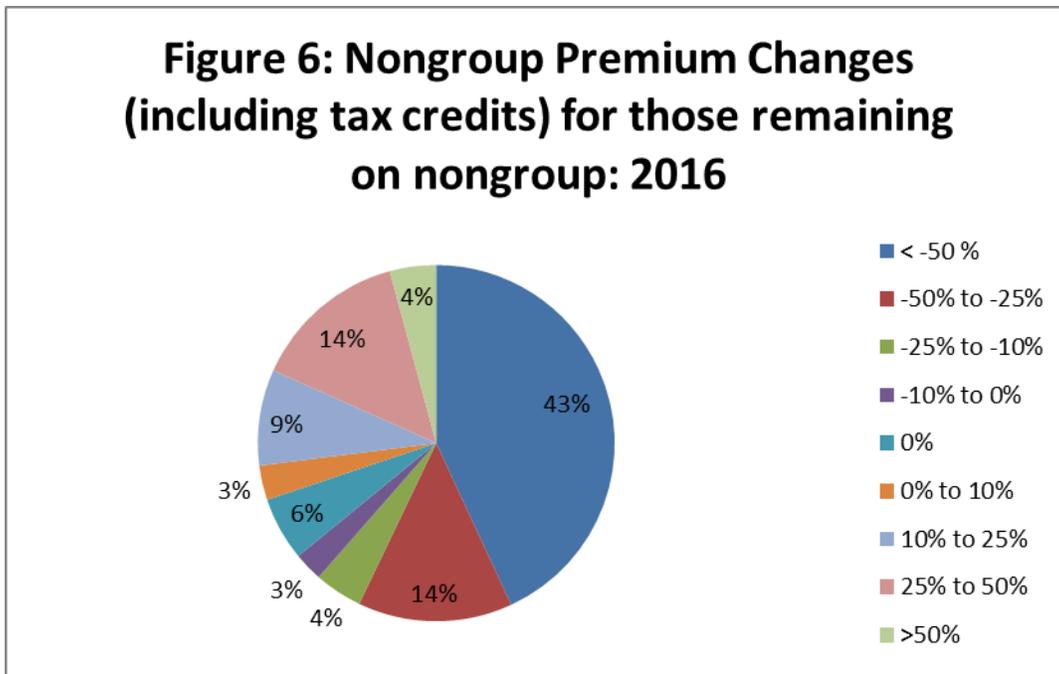


Figure 6 – Nongroup Premium Changes (including tax credits) for those remaining on nongroup: 2016, No BHP

5. Impacts on Small Group Market Premiums

Like the individual market, there are many changes that will take place starting in 2014 that will affect small group premiums. We have focused our analysis on actuarial value and the impact of product limitations in the small group market. As noted in the April 2012 report, the elimination of health status rating will increase premiums for a healthier demographic and decrease premiums for the less healthy, but the limitation alone will not affect overall premiums. These results have not changed for this report.

The impact of product limitations: In 2014, all products sold within the small group market will be required to be within a metallic tier. The actuarial values required for each metallic tier are:

- Platinum 0.88 to 0.92
- Gold 0.78 to 0.82
- Silver 0.68 to 0.72
- Bronze 0.58 to 0.62

Small employers enrolled in products with a different actuarial value will be required to either “buy up” or “buy down” to the approved metallic tier. For example a non-grandfathered group that is currently enrolled in a product with an actuarial value of 0.75 will either need to “buy down” to a product with an actuarial value of 0.72 (approximately a 3% reduction in premium) or buy up to a product with an actuarial value of 0.78 (approximately a 3% increase in premium.) All small groups enrolled in a product with an actuarial value below a 0.58 will be required to buy up to at least a 0.58. Due to this requirement there will be premium increases and decreases due to product requirements within the market. However, the impact to premiums to the market overall will be minimal.

While the managed competition effect has been modeled in the individual market, we have not explicitly modeled it for the small group market. There has been some evidence that due to increased transparency and the greater membership potential in the individual market, there may be some downward pressure on price. Similar pressures may occur in the small group market, especially within a defined contribution model within an Exchange. It is difficult to quantify the premium reduction for the small group market, but it is likely to be less than the 7.5% savings used in the individual market.

5.1. Impact of Product Limitations

The small group market is enrolled in benefit plans that are in general much richer than the individual market. However, the small group market also experienced significant “benefit buy down” from 2009 to 2011. As shown in Table 6, in 2009 21.7% of the market was enrolled in a \$0 deductible plan which compares to 9.9% in 2011.

Single Policy In Network Deductible	CY 2011	CY 2009
\$0	9.9%	21.7%
<=\$1000	35.9%	34.1%
\$1001-\$2000	18.5%	17.9%
\$2001-\$3000	29.6%	26.2%
\$3001-\$5000	4.5%	0.1%
\$5001-9500	1.6%	0.1%
\$10,000	0.0%	0.0%
\$12,000 to \$15,000	0.0%	0.0%

Table 6 – MN Small Group Market Deductible Distribution

As shown in Figure 7, less than 2% of the market is enrolled in plans that are below the ACA minimum actuarial value of a bronze level compared to 23% in the individual market. However, the analysis clearly shows a number of products in the market today that will fall outside of the required metallic tier ranges. This suggests that many small employers will be required to either “buy up” or “buy down” which will result in premium increases and decreases across the market.

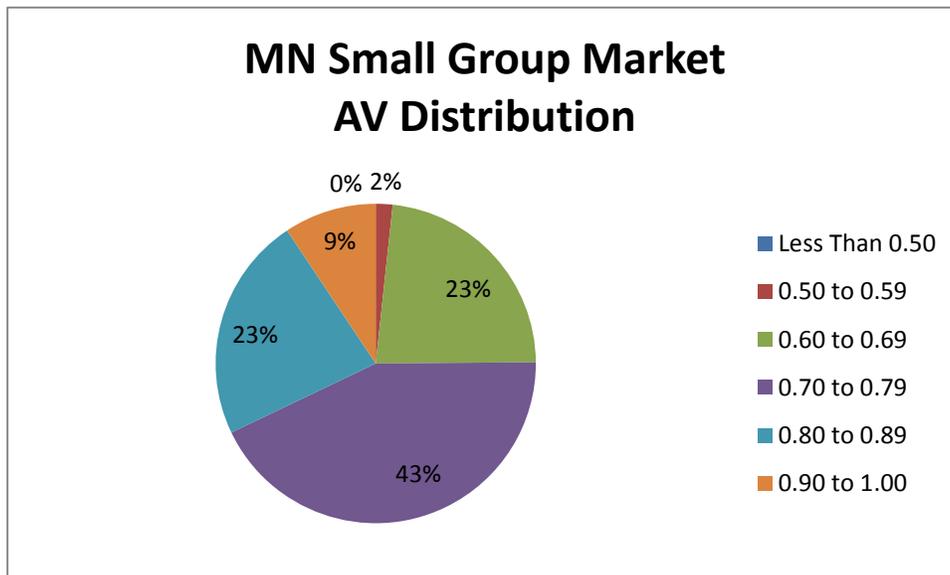


Figure 7 – 2011 Small Group Market Actuarial Value Distribution

6. Impact on State of Basic Health Plan (BHP) Option

One of the policy decisions facing Minnesota under the ACA is whether to use the Basic Health Plan (BHP) to provide public health insurance coverage up to 200% of poverty, rather than ending it at 133% of poverty for adults. There are numerous arguments for and against a BHP program, and we will not present them here. Rather, in this section we will simply evaluate the overall financial impact of a BHP option.

The cost of a BHP option is the state spending on public health insurance. This spending will be for adults from 133% of poverty to 200% of poverty, who would be financed by the state. Offsetting revenues come from the federal government, who will provide 95% of the tax credit spending and cost sharing reductions it would have done on behalf of individuals who would have otherwise received Exchange subsidies for private health insurance. It should be noted that these financial impacts do not incorporate existing state and federal spending on the MinnesotaCare program, but instead reflect a pure comparison of total spending for the population assumed to enroll in this program compared to estimates of the 95% federal funding.

A key issue in computing the federal 95% amount is risk adjustment. In principle, the state of Minnesota should be reimbursed for 95% of the amount that those in the BHP would cost if they were receiving tax credits. The problem is that when the BHP individuals are removed from the Exchange, premiums in the reformed individual market are lower (since the BHP population is sicker than average). The BHP population represents individuals between 133% of poverty and 200% of poverty that previously were uninsured, covered by a public health insurance program, covered by Minnesota's high risk pool (MCHA) or covered by a policy in the individual market. As we show in Table 4, reformed non-group premiums are roughly 8-10% lower (before the application of tax credits) with the BHP than without the BHP. So if the federal government reimburses 95% of the amount that the BHP individuals would cost at that lower level of premiums, it will understate the true cost to Minnesota of covering those higher cost individuals in the BHP. In principle, then, the federal government should *risk adjust* the premiums that are used to compute its reimbursement. That is, the federal government should take 95% of what the BHP individuals would have cost - the (higher) premium that would prevail in the individual market had they still been enrolled in that market. In practice, it is unclear if the federal government will undertake such risk adjustment.

6.1. Financial Implications of Various BHP Structures

In addition to the decision on whether to offer a BHP, the state faces a variety of decisions on how to structure the BHP. In this section, we consider the financial implications of those decisions. The results for these alternatives are presented in Table 7 and Table 8. There are four different factors for Minnesota to consider:

- a) Actuarial values of 1 (complete insurance), versus the actuarial values imposed by the ACA (which are 0.94 for those <150% of poverty, and 0.87 for those 150-200% of poverty)
- b) No premiums below 150% of poverty, phasing to MinnesotaCare premiums from 150-200% of poverty, versus ACA silver-level premiums
- c) A richer benefit package on average of \$38 per member per month including additional benefits (e.g. dental, nonemergency transportation, vision, etc.) versus the standard MinnesotaCare benefits package without the hospital cap or essential health benefits (EHB) package
- d) Paying higher private sector health care provider rates, versus paying existing public program health care provider rates

The following rows in the tables consider each of the possible 16 scenarios, while also allowing for the option of risk-adjustment. Each of the factors has a clear effect on the BHP costs. Note that while we do see overall BHP funding affected as well, this is only because the total enrollment in the BHP changes – average BHP funding does not change except for comparing risk-adjusted versus non risk-adjusted. The cost affects that are discussed apply to changes in average BHP costs.

When including (a), we see that the costs increase, as expected because individuals are receiving a plan with an actuarial value of 1, as compared to the ACA actuarial values, which range from 0.87 to 0.94. When including (b), we again see costs increase because the average premium that the BHP enrollee pays is now more heavily subsidized. In addition to increasing the average cost, both (a) and (b) increase the enrollment in the BHP, since they make having coverage more appealing to those individuals from 133-200% of the federal poverty line.

As (c) and (d) do not make the nongroup market any more or less appealing, they do not have effects on BHP enrollment, although they do change average BHP costs. Including (c), we see average cost increase because the benefit costs are increasing. For (d), we see average public costs increase by much more than with the inclusion of (c), as we are using private sector provide rates versus Medicaid provider rates (18% increase).

Given that each of the four factors adds additional costs to the state, it makes sense that the first scenario generates the greatest financial impact, with revenues of 63 million if not risk-adjusted and 121 million if risk-adjusted. Risk-adjustment has the benefit of saving the state additional money, and thus we see that more of the risk-adjusted scenarios lead to a positive financial impact for the state. Very few of the non-risk-adjusted scenarios lead to a positive financial impact.

Alternative BHP Scenarios, Non-Risk Adjusted: 2016

a. AV's of 1 (ACA Otherwise)	b. MNCare Premiums (ACA Otherwise)	c. Increased Benefits (MNCare/EHB Otherwise)	d. Private Provider Rates (Public Provider Rates Otherwise)	BHP Enrollment	BHP Funding (millions)	BHP Costs (millions)	BHP Financial Impact (millions)
				153000	660	597	63
X				161000	694	728	-34
	X			184000	794	809	-15
X	X			195000	841	982	-141
		X		153000	660	654	6
X		X		161000	694	795	-101
	X	X		184000	794	878	-84
X	X	X		195000	841	1066	-225
			X	153000	660	710	-50
X			X	161000	694	858	-164
	X		X	184000	794	943	-149
		X	X	153000	660	773	-113
X	X		X	195000	841	1134	-293
X		X	X	161000	694	938	-244
	X	X	X	184000	794	1020	-226
X	X	X	X	195000	841	1227	-386

Table 7 – Alternative BHP Scenarios, Non-Risk-Adjusted: 2016 (millions of dollars)

Alternative BHP Scenarios, Risk Adjusted: 2016

a. AV's of 1 (ACA Otherwise)	b. MNCare Premiums (ACA Otherwise)	c. Increased Benefits (MNCare/EHB Otherwise)	d. Private Provider Rates (Public Provider Rates Otherwise)	BHP Enrollment	BHP Funding (millions)	BHP Costs (millions)	BHP Financial Impact (millions)
				153000	719	597	122
X				161000	756	728	28
	X			184000	865	809	56
X	X			195000	916	982	-66
		X		153000	719	654	65
X		X		161000	756	795	-39
	X	X		184000	865	878	-13
X	X	X		195000	916	1066	-150
			X	153000	719	710	9
X			X	161000	756	858	-102
	X		X	184000	865	943	-78
		X	X	153000	719	773	-54
X	X		X	195000	916	1134	-218
X		X	X	161000	756	938	-182
	X	X	X	184000	865	1020	-155
X	X	X	X	195000	916	1,227	-311

Table 8 – Alternative BHP Scenarios, Risk-Adjusted: 2016 (millions of dollars)

7. Conclusions

The Affordable Care Act (ACA) will have important implications for insurance markets in Minnesota. In this report we have endeavored to provide an overview and update of those implications we reported on in April 2012.

We find that the ACA and the Exchange will both greatly increase insurance coverage in Minnesota and cause a large rise in individual market coverage through the newly reformed individual market. There will be little effect on employer sponsored coverage.

We find that there will be a rise in prices in the individual market that is more than offset by the sizeable tax credits available through the Exchange. As a result, average premiums fall and the majority of individuals in the individual market see a decline in their premiums. We also see that cost sharing for individuals will decline as individuals are enrolled in more comprehensive coverage. Premiums in the small group market are not projected to increase on average.

We also find that the cost of a Basic Health Plan varies significantly based on its structure for cost sharing, premiums, benefits, and provider rates. We also find that the impact of risk-adjustment is significant for the state given the sicker risk profile of the BHP population.