2017 Heath Insurance Rate Summary

Individual and Small Group Markets

September 30, 2016

updated

MINNESOTA DEPARTMENT OF COMMERCE

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In accordance with the Americans with Disabilities Act, this information is available in alternative forms of communication upon request by calling 651-539-1500.

Introduction

On behalf of Minnesota consumers, the Minnesota Department of Commerce carefully reviews proposed health insurance rates and plans submitted by insurance companies to ensure that the rates and policies comply with state and federal law as well as actuarial standards.

The Department has completed its review for 2017 individual and small group health insurance policies that will be available during the annual open enrollment period from November 1, 2016, through January 31, 2017.

The individual market rates apply to about five percent of Minnesotans, who purchase health insurance on their own through MNsure, an insurance broker/agent or directly from an insurer. The small group market also includes about five percent of Minnesotans, with plans that offer health insurance coverage to businesses with two to 50 full-time employees.

Urgent Need for Individual Market Reform

Minnesota's individual health insurance market is experiencing serious disruptions in 2017. The dramatic rate increases facing Minnesotans who purchase their own health insurance are unsustainable and unfair. The rate review process is limited in its ability to address the market dynamics underlying these trends and developments. As a result, there is an urgent need for reform.

Governor Dayton recently announced that he will reconvene the Minnesota Task Force on Health Care Financing to make recommendations to ensure that Minnesotans have access to affordable, high-quality health insurance options in the individual market.

Minnesota has long been a national leader and innovator on health care reform. The challenge and opportunity now is to continue this innovative leadership by reforming the individual market.

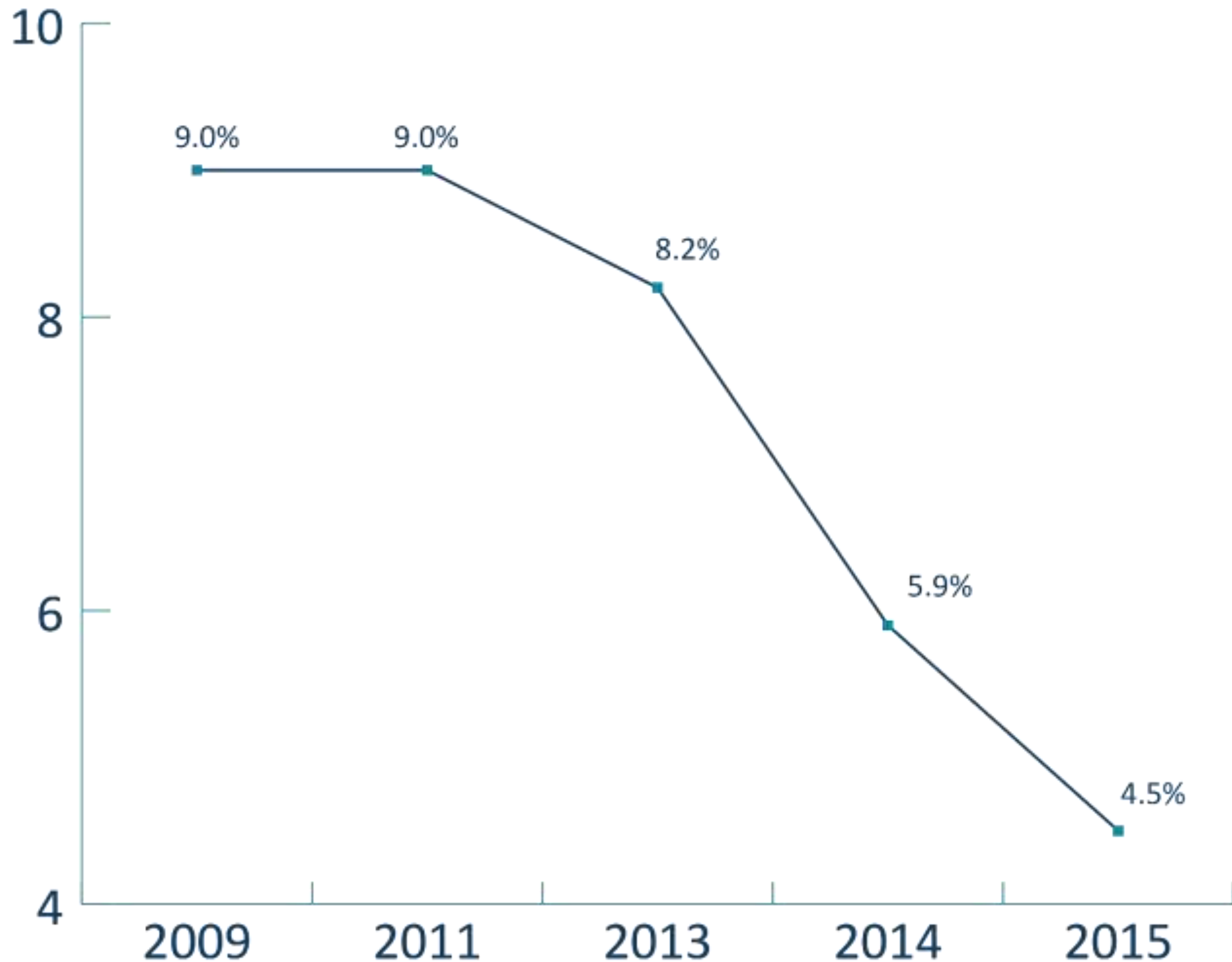
Minnesota's Health Insurance Landscape

According to the U.S. Census Bureau, the percentage of Minnesotans without health insurance coverage has reached an all-time historic low level of 4.5 percent – less than half the national uninsured rate of 9.1 percent. Minnesota's uninsured

population has declined dramatically in recent years, with many more Minnesotans having vital access to the benefits and security of health insurance coverage.

Minnesota's Uninsured Rate Is at an All-Time Low

Percentage of Uninsured Minnesotans



Most Minnesotans continue to receive their health insurance coverage through employer-based plans. These include plans that an employer purchases from an insurance company to cover employees. They also include plans that are self-funded – generally, a large employer that accepts direct financial liability for the costs of claims (though enrollment, claims processing and other operations may still be administered by an insurance company).

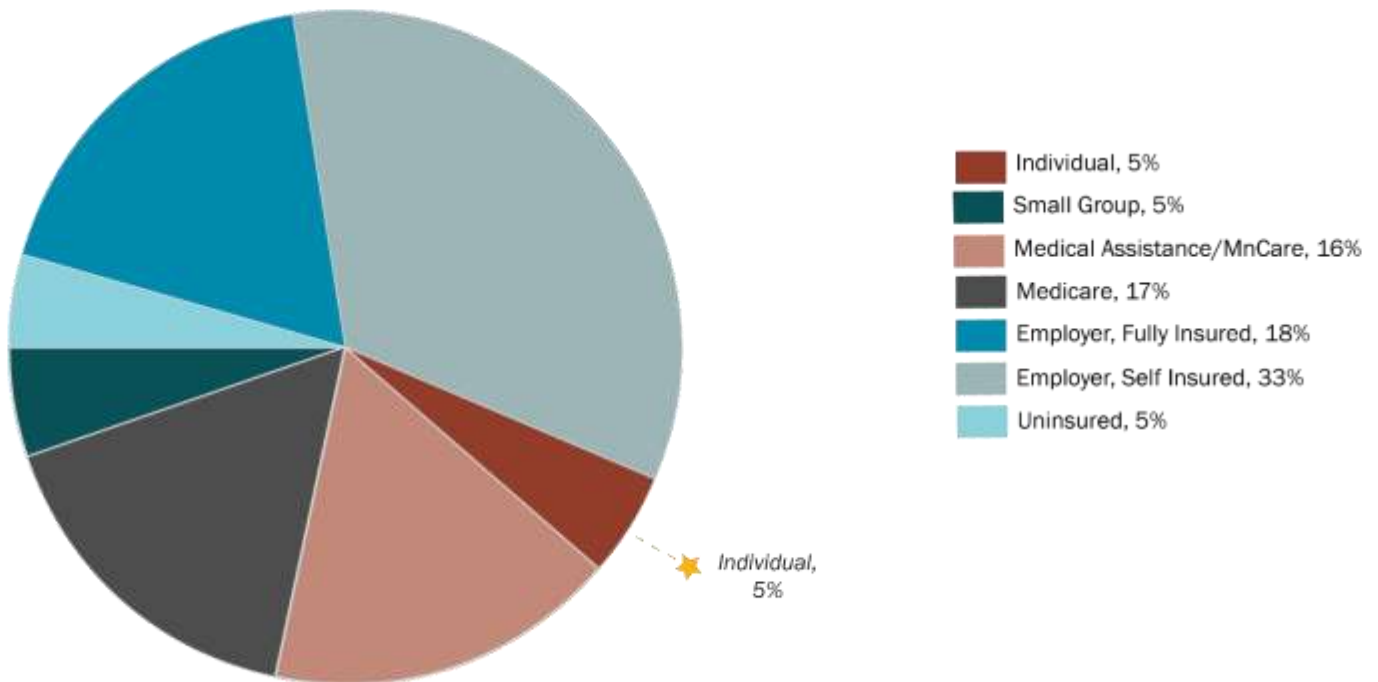
Many other Minnesotans receive their coverage through public programs such as Medicare, Medicaid and MinnesotaCare.

- Medicare is the federal health insurance program for people who are 65 or older, as well as for certain younger people with disabilities and people with End-Stage Renal Disease.

- Medicaid (known in Minnesota as Medical Assistance) is a joint federal-state program that helps with medical costs for people with low incomes.

- MinnesotaCare is a subsidized premium-based program for lower-income Minnesotans who do not qualify for Medicaid and do not have access to affordable insurance coverage.

Where Do Minnesotan's Get Their Health Insurance?



Small Group Market

Small group health plans are designed to provide coverage for businesses with two to 50 full-time employees. They are sold both through MNsure and directly by insurance companies and broker/agents. About five percent (or 250,000) of all Minnesotans receive coverage through small group plans.

Ten companies are approved to sell small group health policies in 2017:

- Blue Cross and Blue Shield of Minnesota
- Blue Plus
- Federated Mutual Insurance Company
- Gundersen Health Plan Minnesota
- HealthPartners Inc.
- HealthPartners Insurance Company
- Medica Insurance Company
- PreferredOne Community Health Plan
- PreferredOne Insurance Company
- Sanford Health Plan

The final rate changes for 2017 plans offered by companies in Minnesota's small group market range from a decrease of 1.0 percent to an increase of 17.8 percent. Most of the rate increases for 2017 are in the single digits. These rate increases largely reflect the general rise in costs for medical services and prescription drugs. Each insurance company's final average rate change is listed in the table below.

Minnesota Small Group Health Insurance Policies - 2017 Average Rate Changes

Company Name	2017 Average Change
BCBSM Inc	14.80%
Blue Plus	12.10%
Federated Mutual Ins Co	17.80%
Gunderson HP MN	8.11%
Healthpartners Inc	6.00%
Healthpartners Ins Co	7.20%
Medica Ins Co	0.56%
PreferredOne Community Health Plan	-1.00%
PreferredOne Ins Co	6.00%
Sanford Health Plan	7.00%

Individual Market

The individual market for health insurance is available for Minnesotans who do not have access to employer-based coverage and are not eligible for coverage through public programs like Medicare, Medicaid and MinnesotaCare. About five percent (or 250,000) of all Minnesotans currently purchase their health insurance on the individual market.

Seven companies are approved to sell health insurance plans to Minnesotans in 2017 in the individual market.

- Blue Plus
- Group Health, Inc.
- HealthPartners Insurance Company
- Medica Health Plans of Wisconsin
- Medica Insurance Company
- PreferredOne Insurance Company
- UCare

Consumers will be able to purchase individual market insurance plans either through MNsure or directly from the insurance companies or insurance broker/agents.

The final rate increases for 2017 plans offered by companies in Minnesota's individual market range from 50 percent to 66.8 percent. Each insurance company's final average rate increase is listed in the table below.

Minnesota Individual Health Insurance Policies - 2017 Average Rate Changes

Company Name	2017 Average Change
Blue Plus	55.00%
Group Health	53.00%
HealthPartners	50.00%
Medica Ins Co	57.50%
Medica Health Plans of WI	59.40%
PreferredOne	63.00%
Ucare	66.80%

Many Minnesotans who purchase individual policies through MNsure will be eligible for federal tax credits that immediately lower their monthly premiums and help offset the impact of rate increases. Eligibility for the tax credits is automatically determined when applying to purchase a plan through MNsure. Four companies – Blue Plus, HealthPartners, Medica Health Plans of Wisconsin and UCare.

Some key factors that insurance companies cite for their rate increases in Minnesota's individual market include:

- A higher percentage of less healthy, more costly enrollees than expected are in the individual market.

- Insurers incurred significantly higher claims than expected for medical care and prescription drugs, especially high-cost specialty drugs.

- Minnesota has a relatively small individual market compared to other states, resulting in a smaller risk pool across which insurers can spread their costs and pushing up rates for everyone in the individual market.

- The federal reinsurance program is ending in 2016 and will no longer provide funds to insurers in 2017 to stabilize premiums by helping to offset high-cost claims.

Citing ongoing financial losses, Blue Cross and Blue Shield of Minnesota announced in late June 2016 that it would leave the individual market in 2017, except for its Blue Plus HMO affiliate. The company's decision affects approximately 103,000 Minnesotans who currently have Blue Cross individual policies. This number represents about 40 percent of the state's total individual market.

Some insurers are also modifying their service areas and networks in 2017, which will affect the specific plans available to some consumers.

In addition, each insurer (except Blue Plus) will be limiting its total 2017 enrollment in order to manage its financial or provider network capacity to absorb the large number of consumers who will be shopping for new plans, especially current Blue Cross enrollees who must find a new insurer for 2017.

Even with the discontinued policies and capacity limits, every Minnesotan who needs to will be able to find an insurance plan in the individual market in 2017, though not

necessarily the specific insurer or provider network they prefer. To have the best choice, it is important for consumers to shop, compare and make a plan selection as early as possible once the open enrollment period begins on November 1, 2016.

Essential Health Benefits - Comprehensive Coverage for All

Starting in 2014, the Affordable Care Act requires that all health plans offered in the individual and small group markets provide a comprehensive package of items and services, known as "essential health benefits." No matter what plan you choose, you will have standardized coverage for these essential health benefits – with no dollar limits on the coverage.

The essential health benefits are designed to protect consumers and provide a basic level of coverage in 10 categories of benefits:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities or chronic conditions gain or recover mental and physical skills)
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric dental and vision services (sometimes offered through a separate plan).

Metal Levels – A Consumer-Friendly Way to Compare Plans

Minnesota consumers have the option to choose from four categories of health insurance plans in the individual market. These are known as "metal levels" – bronze, silver, gold and platinum.

The difference in the metal levels is the percentage of average overall costs paid by the insurance company versus the consumer. If you choose a plan at a higher metal

level, you will pay a higher monthly premium – but will be at risk for lower out-of-pocket costs in deductibles and copayments.

Bronze – the plan covers 60% of expected costs

Silver – the plan covers 70% of expected costs

Gold – the plan covers 80% of expected costs

Platinum – the plan covers 90% of expected costs

Benchmark Plans

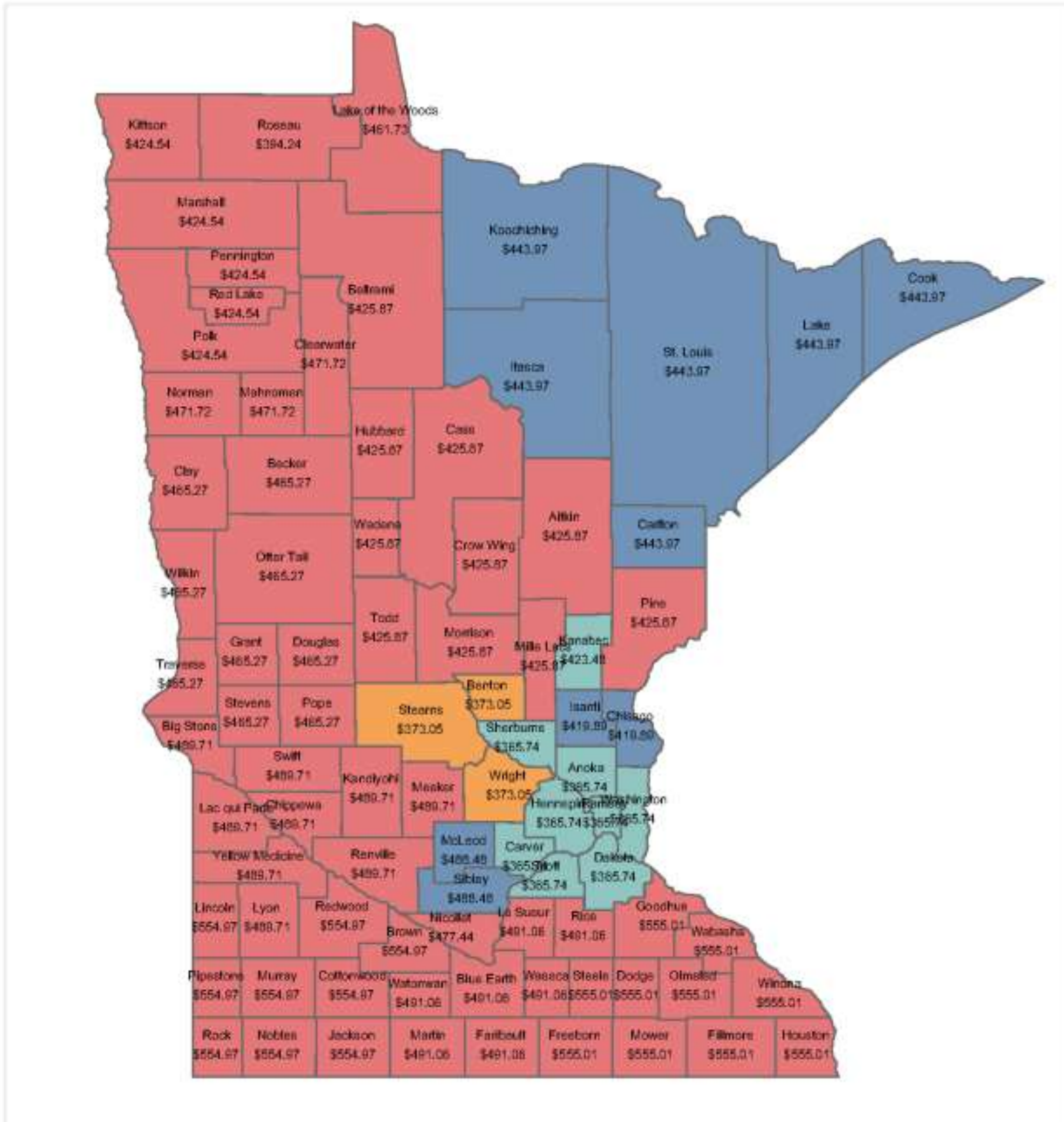
The second-lowest priced silver plan available through MNsure for a given geographic area is called the "benchmark plan."

The price of this benchmark plan is used to calculate the federal tax credit that reduces monthly premiums for eligible individuals and families. (The tax credit amount is adjusted in relation to the allowable percentage of the consumer's income.)

Consumers who are eligible for the federal tax credits are not required to purchase the benchmark plan in their area and they will not lose out on these credits by choosing a different plan. However, a plan must be purchased through MNsure in order to receive the tax credit. When applying to purchase a plan through MNsure, eligibility for the tax credit is automatically determined, as is eligibility for Medicaid and Minnesota Care.

Benchmark plans and prices will vary depending on the rating area and plan availability. The map on the next page shows what insurer has the benchmark plan in each county, and the monthly premium for an age 40 individual.

2017 Benchmark Plans with Monthly Premium for Age 40 Individual



Company
- Blue Plus
- Group Health
- Medica Health Plans Of WI
- Ucare

Open Enrollment - Shop, Compare and Choose Early

Minnesotans can purchase their individual health insurance plans during the annual open enrollment period, which begins on November 1, 2016, and continues through January 31, 2017. Insurance companies, insurance agents and MNsure will have specific plan information available for consumers in October.

Every county will have at least two insurers with multiple plan options. Because of the insurers' capacity limits, Minnesotans should shop and make their selection early to have the most options available. Compare insurance plans to find the one that offers the best value for your health needs and budget. For continuity of care, carefully review the provider networks offered by plans to see what doctors, clinics and hospitals are included. If you depend on specific prescription drugs, review the plan's drug formulary.

Minnesotans should go to the MNsure website (mnsure.org) to see if they are eligible for federal tax credits that automatically reduce monthly premiums. The tax credits are available only for policies purchased through MNsure. People with incomes up to 400 percent of the federal poverty level are eligible. In 2017, the top income threshold for tax credits is $47,520 for an individual and $97,200 for a family of four.

What is a Rating Area?

Federal regulations have standardized the factors that insurers are allowed to use when calculating health insurance premiums for consumers in the individual and small group markets. Under these regulations, insurers may only use family size, age, tobacco use and area of residence (rating area) when setting premium rates.

Each state is divided into rating areas, which are used by insurers to set the health insurance premiums for people who live in the counties in an area. Minnesota has nine rating areas.

Insurers are required to calculate their rates based on their projected costs in the specific rating area. These costs may reflect factors such as expected health care provider expenses in the specific rating area.

When insurance companies calculate their premiums, all households within a rating area will have the same geographic adjustment factor applied. This means that

households with similar size, age and tobacco use characteristics buying the same plan will pay the same premium amounts. Depending on the rating area you live in, the premium you pay may be higher or lower than the state average.

Insurers are not required to offer their plans on a statewide basis. Specific insurers and specific plans may be available in some rating areas but not in others. (There may sometimes also be variation among counties within a rating area.) Depending on what rating area you live in, you may have more or fewer plan options.

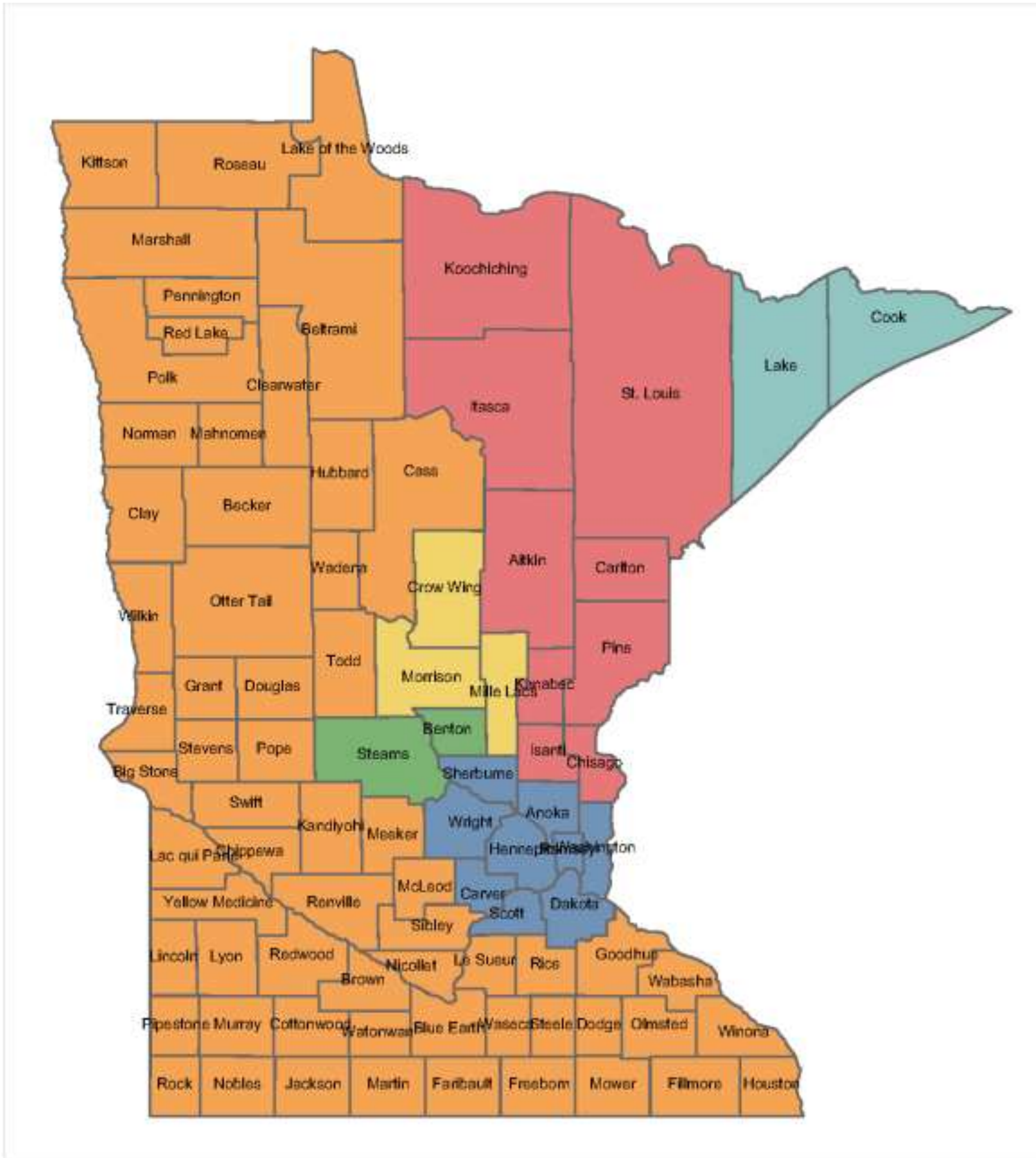
Area 1	Area 2	Area 3	Area 4
Dodge	Carlton	Blue Earth	Brown
Fillmore	Cook	Faribault	Cottonwood
Freeborn	Itasca	Waseca	Jackson
Goodhue	Koochiching	Le Sueur	Lincoln
Houston	Lake	Martin	Murray
Mower	Lake of the Woods	Nicollet	Nobles
Olmsted	St. Louis	Rice	Pipestone
Steele		Watonwan	Redwood
Wabasha			Rock
Winona			

Area 5	Area 6	Area 7	Area 8	Area 9
Big Stone	Becker	Aitkin	Anoka	Clearwater
Chippewa	Clay	Beltrami	Benton	Kittson
Kandiyohi	Douglas	Cass	Carver	Mahnomen
Lac Qui Parle	Grant	Chisago	Dakota	Marshall
Lyon	Otter Tail	Crow Wing	Hennepin	Norman
McLeod	Pope	Hubbard	Ramsey	Pennington
Meeker	Stevens	Isanti	Scott	Polk
Renville	Traverse	Kanabec	Sherburne	Red Lake
Sibley	Wilkin	Mille Lacs	Stearns	
Swift		Morrison	Washington	
Yellow Medicine		Pine	Wright	
		Roseau		
		Todd		
		Wadena		

Rating Areas

1
2
3
4
5
6
7
8
9

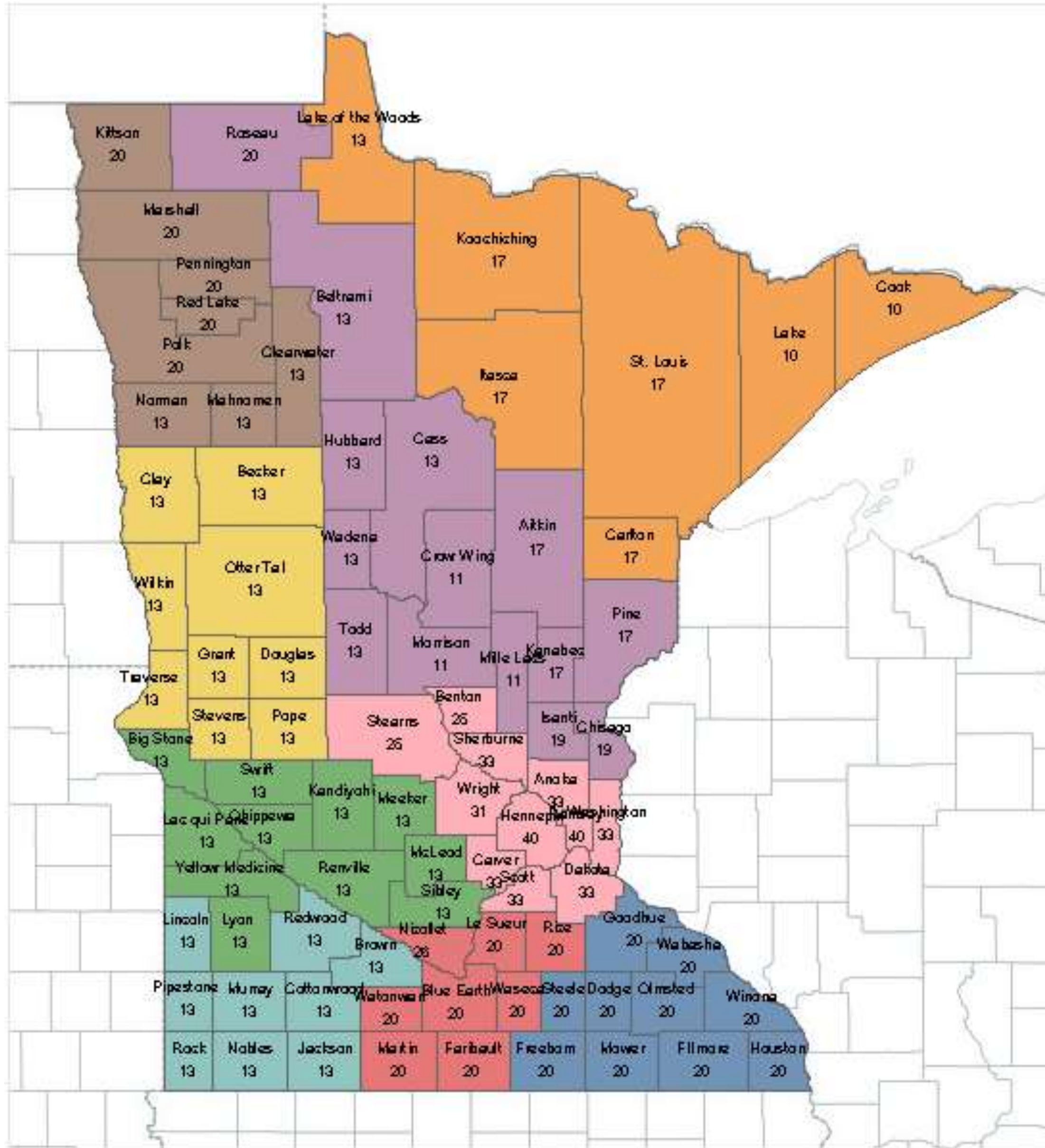
Insurers in Each County with Actively Marketed Plans



Carriers Actively Marketed

- Blue Plus, Group Health, HealthPartners, Medica Health Plans Of WI, UCare
- Blue Plus, Medica Health Plans Of WI
- Blue Plus, Medica Health Plans Of WI, UCare
- Blue Plus, UCare
- Group Health, HealthPartners, Medica Health Plans Of WI, UCare
- Medica Health Plans Of WI, UCare

Number of Actively Marketed Plans Per County



Rating Area (group)

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9

Frequently Asked Questions - Health Insurance Rate Review

What is an "effective" rate review program?

Minnesota has been designated by the federal government as a state with an effective rate review program. This means that all proposed rate increases are scrutinized by expert actuaries in the public interest to make sure the rates comply with appropriate state and federal laws as well as actuarial standards.

The rate review evaluates the assumptions and information used by health insurers to develop their rates. Rates must be based on the value of the benefits that consumers receive for their premiums. Rate review also evaluates whether insurance companies will be able to pay the expected medical claims costs and fulfill their financial obligations to the consumers who purchase their policies.

How does an "effective" rate review system operate?

Under federal requirements, an effective rate review system must do the following:

- Receive sufficient data and documentation concerning rate increases to conduct an examination of reasonableness of the proposed increases.
- Consider the factors below as they apply to the rates:
    - Medical cost trend changes by major service categories
    - Changes in utilization of services (i.e., hospital care, pharmaceuticals, doctors' office visits) by major service categories
    - Cost-sharing changes by major service categories
    - Changes in benefits
    - Changes in enrollee risk profile
    - Impact of over- or under-estimate of medical trend in previous years on the current rate
    - Reserve needs
    - Administrative costs related to programs that improve health care quality
    - Other administrative costs related to programs that improve health care quality
    - Other administrative costs
    - Applicable taxes and licensing or regulatory fees
    - Medical loss ratio
    - The impacts of geographic factors and variations

  - The impact of changes within a single risk pool to all products or plans within the risk pool; and
  - The impact of risk adjustment payments and charges.
- Make a determination of reasonableness of the rate increase under a standard set forth in state statute or regulation.
- Post all rate filings on their websites or post a link to the preliminary justifications that appear on the federal RateReview.Healthcare.gov website.
- Provide a mechanism for receiving public comments on proposed rate increases.
- Report results of rate review to the Centers for Medicare & Medicaid Services (CMS) for rate increases subject to review.

Who reviews the rates?

Health insurance rates are reviewed by the experts in the actuarial unit at the Minnesota Department of Commerce. The Commerce Department also reviews the rates submitted by Health Maintenance Organizations (HMOs) under an interagency agreement with the Minnesota Department of Health.

Must health insurance companies submit rate filings each year?

Yes.

What plans are reviewed?

All health insurance rates must be approved by the Minnesota Department of Commerce or the Minnesota Department of Health prior to becoming effective, as required in Minnesota Statute section 62A.02.

Self-insured health plans (generally provided by larger employers) are not regulated by the state.

What is the difference between “rate” and “premium”?

The terms “rate” and “premium” are often used interchangeably when discussing insurance. However, those terms represent two different things.

Rate: A rate is the average that an insurance company charges for a defined package of health insurance plans. For example, the rate for your insurance might be $300 per person per month.

Premium: The amount that you pay for health insurance. For example, if a plan covers five people at a rate of $300 per person per month, the premium is $1,500 per month.

How often can premiums go up?

In 2014 and later, rates for individual health plans will change once a year, on January 1. Rates for small employer group coverage can change on a quarterly, semi-annual or annual basis.

What factors affect rates?

Individual and small group rates are based on a particular plan of benefits with a particular network of doctors and hospitals based on the combined medical costs of everyone in that company's market for a particular age, tobacco use and geographic area. This is called "adjusted community rating" – the rates are based on the costs of the entire community (geographic rating area).

The rising costs of medical care and prescription drugs affect rates. With community rating, your premium may go up even if you have not received any medical services, because the average cost of medical care and prescription drugs has increased.

What factors affect my premiums?

In general, how much a health plan company charges depends on the following:

- Your age and the age of any family members in your plan;
- Whether or not each person 18 or older uses tobacco;
- Where you live; and
- The benefits and network of providers in the plan.

Your premium cannot be based on whether you have a preexisting health condition.

Why did my health insurance premiums go up when I didn't have any claims (didn't see a doctor, go to the hospital or get any prescriptions)?

Your premium will not go up solely because you have claims, just as it will not go down solely because you do not have claims.

Insurance is a pooling of risks, so individuals pay a share of the pooled experience in exchange for not assuming the full risk of their own medical costs.

If you have an individual or small group policy, your premium is based on the claims of everyone in your market. If you have coverage under a large employer health plan, your premium is based in part on the claims of everyone in the employer group.

How do insurance companies develop rates?

Companies develop rates using estimates of future claim costs, administrative expenses and how much reserves they need to hold. Rates cannot be based on recovering financial losses from previous years, though past experience will inform rate-setting in future years.

- Claim costs: The amount an insurer expects to pay for health care services and goods, such as physician services, hospital fees and prescription drugs, on behalf of all policyholders with similar policies.
- Administrative expenses: The cost of running a health plan. These costs can typically include:
    - salaries of employees;
    - costs to maintain computer systems to pay claims;
    - costs to manage the provider network (for example, signing up doctors, hospitals and pharmacies);
    - commissions for agents and brokers (called “producers”);
    - rent;
    - taxes, fees, and assessments that health plans pay to the State or federal government; and
    - other costs to administer the policy (for example, fraud detection and prevention activities).
- Contribution to reserves and profit: Money that an insurance company has left after paying for claims and administrative expenses. The reserves are needed to pay for claims and administrative expenses in years when the insurers do not collect enough premiums to cover those costs, or when claims for the current year are submitted late.

What do you consider when reviewing a rate request?

All health plan rate filings must meet these criteria:

- Anticipated loss ratio meets the state's minimum of 71% to 82%;

- Rates are sufficient to cover expected claims and expenses;
- Rates provide a reasonable value to the insured; and
- The filing is complete, correct, and understandable.

In order to demonstrate that the above criteria are met, the filing must include at least the following information:

- Historical information, such as date of issue, any changes in benefits, rates, or profitability;
- Historical experience including premiums, claims and enrollment;
- Statistical reliability of historical experience;
- Assumptions used in projecting the future loss ratio– anticipated changes in claim cost per person and enrollment. The reasons for a rate increase, such as benefit changes, population changes, tax and fee changes.

How does the Commerce Department decide whether to approve or object to a requested rate change?

Approved - If the filing is clear and justifies the filed rates, the filing is approved and the company is notified that the rates may be used.

Objection - If the information in the filing is not clear or does not justify the filed rates or rate increase, the Department of Commerce sends an objection letter to the filing company.

Do rate changes always get approved?

No. A decision is made for each filing as to whether the rate is approved or not approved.

What if the insurance company disagrees with the decision?

The company can request a hearing, and have a judge decide whether the Department's decision not to approve a filing was reasonable or unreasonable.

What is the public's role in the rate review process?

Beginning in 2015 for plan year 2016, the Minnesota public has access to information submitted by insurance companies for their plans with proposed rate increases. This information is posted on the federal RateReview.Healthcare.gov

website. Minnesotans also have the opportunity to submit comments to the Commerce Department about the rate proposals.

As part of the Commerce Department's rate review process, Minnesotans may submit public comments on proposed rate increases by e-mail to healthinsurance.ratecomment@state.mn.us.

Who can I contact if I have questions about the rate review process?

You can contact the Department of Commerce Consumer Services Center by email at consumer.protection@state.mn.us or by phone at 651-539-1600 or 800-657-3602 (Greater Minnesota).