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2018 Health Insurance Rate Summary
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 of individual and small group health insurance policies that will be available in 2018. Individual policies are available during the open enrollment period from November 1, 2017, through January 14, 2018. There is no open enrollment period in the small group market. Small employers can offer a 12-month plan that begins on the first of any month.

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

Minnesota’s Health Insurance Landscape

Minnesota’s uninsured population has declined dramatically in recent years. According to the U.S. Census Bureau, the percentage of Minnesotans without health insurance coverage reached an all-time historic low level of 4.1 percent in 2016 – less than half the national uninsured rate of 8.8 percent.

Minnesota’s Uninsured Rate Reached an All-Time Low in 2016
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.

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

- MinnesotaCare is a premium-based program for Minnesotans who do not qualify for Medicaid and whose incomes do not exceed 200 percent of Federal Poverty Guidelines.
- 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.

**Where Do Minnesotans Get Their Health Insurance?**

![Pie chart showing insurance sources]

- Uninsured: 4%
- Employer, Self Insured: 34%
- Employer, Fully Insured: 18%
- Medicare: 18%
- Medical Assistance/MnCare: 16%
- Small Group: 5%
- Individual: 4%

### Small Group Market

Small group health plans are designed to provide coverage for businesses and organizations with two to 50 full-time employees. They are sold directly by insurance companies and broker/agents. About five percent of all Minnesotans receive coverage through small group plans. As of December 2016, about 263,000 Minnesotans were covered by these plans.
Nine companies are approved to sell small group health policies in 2018:

- Blue Cross and Blue Shield of Minnesota
- Blue Plus
- 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 increases for 2018 plans offered by companies in Minnesota’s small group market range from essentially no change to an increase of 23 percent. As in years past, these rate increases reflect the general rise in costs for medical services and prescription drugs. The rate increases for 2018 also reflect higher medical utilization levels and claims reported by the insurers due to a somewhat less healthy enrollment population. Each insurance company’s final average rate change is listed in the table below.

**Minnesota Small Group Health Insurance Policies**

**2018 Average Rate Changes**

<table>
<thead>
<tr>
<th>Company Name</th>
<th>2018 Average Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Blue Shield MN</td>
<td>9.20%</td>
</tr>
<tr>
<td>Blue Plus</td>
<td>6.40%</td>
</tr>
<tr>
<td>Gundersen Health Plan MN</td>
<td>0.30%</td>
</tr>
<tr>
<td>HealthPartners, Inc.</td>
<td>14.00%</td>
</tr>
<tr>
<td>HealthPartners Insurance Company</td>
<td>12.20%</td>
</tr>
<tr>
<td>Medica Insurance Company</td>
<td>7.82%</td>
</tr>
<tr>
<td>PreferredOne Community Health Plan</td>
<td>23.00%</td>
</tr>
<tr>
<td>PreferredOne Insurance Company</td>
<td>11.00%</td>
</tr>
<tr>
<td>Sanford Health Plan</td>
<td>0.37%</td>
</tr>
</tbody>
</table>
**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. As of April 2017, about 166,000 Minnesotans purchased their health insurance on the individual market.

The following five companies are approved to sell health insurance plans to Minnesotans in 2018 in the individual market.

- Blue Plus
- Group Health, Inc.
- Medica Insurance Company
- PreferredOne Insurance Company *(not available through MNsure)*
- UCare *(only available through MNsure)*

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 changes for 2018 plans offered by companies in Minnesota’s individual market range from a decrease of 38 percent to an increase of less than three percent. These rates reflect the new state reinsurance program. Each insurance company’s final average rate change, compared to the 2017 average rate, is listed in the table below.

### Minnesota Individual Health Insurance Policies

#### 2018 Average Rate Changes

<table>
<thead>
<tr>
<th>Company Name</th>
<th>2018 Average Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Plus</td>
<td>+2.80%</td>
</tr>
<tr>
<td>Group Health</td>
<td>-7.50%</td>
</tr>
<tr>
<td>Medica Insurance Company</td>
<td>-0.40%</td>
</tr>
<tr>
<td>PreferredOne Insurance Company</td>
<td>-38.00%</td>
</tr>
<tr>
<td>UCare</td>
<td>-13.30%</td>
</tr>
</tbody>
</table>

(Note: Neither the 2017 nor 2018 rates include the temporary, one-year 25 percent premium rebate that the Legislature enacted in 2017 specifically for those Minnesotans who do not qualify for federal tax credits that reduce premiums.)
Many Minnesotans who purchase individual policies through MNsure will be eligible for federal tax credits that lower the monthly premiums they must pay. Eligibility for the tax credits is automatically determined when applying to purchase a plan through MNsure. Four companies – Blue Plus, Group Health, Medica Insurance Company and UCare – offer their plans through MNsure.

**Rate Trend Factors**

Some key factors that insurance companies cite for the 2018 rate trends in Minnesota’s individual market include:

- A higher percentage of less healthy, costlier enrollees are in the individual market.
- Insurers incurred significantly higher claims than expected for medical care and prescription drugs, especially high-cost specialty drugs.
- Minnesota’s individual market is relatively small compared to other states, resulting in a smaller risk pool across which insurers can spread their administrative and risk costs, which pushes up rates for everyone in the individual market.
- The newly-established state reinsurance program (Minnesota Premium Security Plan) will help partially offset high-cost claims.

**Reinsurance**

After two years of large rate increases in Minnesota’s individual health insurance market, the Legislature enacted a new state reinsurance program to help stabilize rates for Minnesotans who buy their own coverage. Beginning in 2018, the reinsurance program provides the market with a financial safety net against high-cost claims.

Minnesota’s individual health insurance premiums increased significantly in 2016 and 2017 due to the number of high-cost claims that must be paid by premium revenue from the relatively small risk pool of the individual health insurance market. For example, a Commerce Department analysis found that just 2.2 percent of individuals in this market accounted for nearly half of the total amount of claims.

The new law authorizes up to $271 million per year in 2018 and 2019. These funds will be used to reduce premiums for consumers by partially reimbursing insurers for high-cost claims. Specifically, reinsurance will cover 80 percent of an individual’s annual claims costs between $50,000 and $250,000.

As a result of this financial protection against high-cost claims beginning in 2018, insurers are able to reduce premiums for all consumers in Minnesota’s individual health insurance market. It is estimated that the new program reduced premiums for 2018 by about 20 percent on average from what they otherwise would have been without reinsurance.
Aside from the impact on premiums, reinsurance does not affect the consumer health care experience – and its actual operation will be invisible to consumers, with no paperwork required.

Minnesota’s new reinsurance program received federal approval in September 2017, which will allow the state to use federal funds to cover a significant portion of the annual reinsurance costs and hold down rates for consumers.

Federal funding is based on the savings in premium tax credits that the federal government would have otherwise paid to Minnesotans due to higher rates. The federal funding is estimated to be $139 million in 2018 and $184 million in 2019. State funds will finance the remaining cost of the reinsurance program. The actual cost of reinsurance, as well as the final amount of federal funding, will depend on a number of factors, including overall market enrollment and the number of high-cost claims.

As a market-stabilizing program for Minnesota, reinsurance replaces the temporary, one-year state program in 2017 that offered a 25 percent premium rebate specifically for consumers in the individual market who were not eligible for federal tax credits that lower premiums.

**Capacity Limits**

Four of the five insurance companies (Blue Plus, Group Health, PreferredOne, UCare) requested and were approved for capacity limits in order to manage their financial or network capacity to serve enrollees in 2018. (The fifth insurer – Medica – did not request a capacity limit and is offering plans statewide.)

A capacity limit is the maximum number of people that an insurer can accept into its plans for 2018. All current enrollees are guaranteed renewal of their coverage as long as they sign up during the open enrollment period.

If a company reaches its capacity limit, its insurance plans will no longer be offered for sale. However, current enrollees with the insurer will still be able to renew their policies for 2018 by contacting the insurer or MNsure. The Commerce Department will monitor the insurers’ enrollment activity on an ongoing basis.

Even with the capacity limits, every Minnesotan who needs coverage will be able to find an insurance plan in 2018, 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 select a plan as early as possible once the open enrollment period begins on November 1.

**Renewal Crosswalks**

In 2018, current HealthPartners Insurance Company enrollees will be renewed into a Group Health plan and current Medica Health Plans of Wisconsin enrollees will be renewed into a Medica Insurance
Company plan. This is known as a “crosswalk.” Federal guidance allows an insurer to renew policies from one of its issuers to another issuer in its group. The insurer must renew its current enrollees into new plans that are at the same metal level, if that metal level is available (e.g., from a silver plan to another silver plan).

For a consumer, the “crosswalk” means that a current HealthPartners enrollee would be automatically renewed into an equivalent 2018 plan offered by Group Health, and a current Medica Health Plans of Wisconsin enrollee would be automatically renewed into an equivalent 2018 plan offered by Medica Insurance Company. However, a consumer is not required to accept the default renewal plan and may select any available plan from any insurer during open enrollment.

It is important for consumers to carefully review the renewal notice they receive from their insurer to ensure that the coverage and provider network in the crosswalked plan meets their needs.

### 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).
Minnesota consumers have the option to choose from five categories of health insurance plans in the individual market. These are known as “metal levels” – bronze, expanded 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 you will have lower out-of-pocket costs in deductibles and copayments.

**Bronze** – the plan covers 58-62% of expected costs

**Expanded Bronze (new for 2018)** – the plan covers 62-65% of expected costs

**Silver** – the plan covers 66-72% of expected costs

**Gold** – the plan covers 76-82% of expected costs

**Platinum** – the plan covers 86-92% 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 MinnesotaCare.

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 a 40-year-old individual.
2018 Benchmark Plans with Monthly Premium for Age 40 Individual

Insurer
- Blue Plus
- Group Health
- Medica Insurance Company
- UCare

Map of Minnesota with counties colored to indicate different insurers and their respective premiums for the age 40 individual.
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, 2017, and continues through January 14, 2018.

Insurance companies, insurance agents and MNsure will have specific plan information, including provider network information, available for consumers in October.

Every county will have at least one insurer with 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 (list of covered medications).

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 2018, the top income threshold for tax credits is $48,240 for an individual and $98,400 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.

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

<table>
<thead>
<tr>
<th>Area 5</th>
<th>Area 6</th>
<th>Area 7</th>
<th>Area 8</th>
<th>Area 9</th>
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</thead>
<tbody>
<tr>
<td>Big Stone</td>
<td>Becker</td>
<td>Aitkin</td>
<td>Anoka</td>
<td>Clearwater</td>
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<td>Beltrami</td>
<td>Benton</td>
<td>Kittson</td>
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<td>Douglas</td>
<td>Cass</td>
<td>Carver</td>
<td>Mahnomen</td>
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<tr>
<td>Lac Qui Parle</td>
<td>Grant</td>
<td>Chisago</td>
<td>Dakota</td>
<td>Marshall</td>
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<td>Otter Tail</td>
<td>Crow Wing</td>
<td>Hennepin</td>
<td>Norman</td>
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<td>McLeod</td>
<td>Pope</td>
<td>Hubbard</td>
<td>Ramsey</td>
<td>Pennington</td>
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<tr>
<td>Meeker</td>
<td>Stevens</td>
<td>Isanti</td>
<td>Scott</td>
<td>Polk</td>
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<tr>
<td>Renville</td>
<td>Traverse</td>
<td>Kanabec</td>
<td>Sherburne</td>
<td>Red Lake</td>
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<td>Sibley</td>
<td>Wilkin</td>
<td>Mille Lacs</td>
<td>Stearns</td>
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<tr>
<td>Swift</td>
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<td>Morrison</td>
<td>Washington</td>
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<tr>
<td>Yellow Medicine</td>
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<td>Pine</td>
<td>Wright</td>
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<td>Wadena</td>
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</table>
Insurers in Each County with Actively Marketed Plans

[Map of Minnesota showing insurers in each county with actively marketed plans, color-coded by insurer.]

- Blue Plus, Group Health, Medica Insurance Company, PreferredOne Insurance Company, UCare
- Blue Plus, Group Health, Medica Insurance Company, UCare
- Blue Plus, Medica Insurance Company
- Blue Plus, Medica Insurance Company, UCare
- Group Health, Medica Insurance Company, UCare
- Medica Insurance Company
- Medica Insurance Company, UCare
Number of Actively Marketed Plans Per County

Number of Available Plans

24

58
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 who are working for 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.

Beginning in 2018, Minnesota’s new reinsurance program will cover 80 percent of an individual’s annual claims costs between $50,000 and $250,000. As a result, insurers are able to reduce premiums for all consumers in Minnesota’s individual health insurance market. It is estimated that reinsurance will reduce premiums for 2018 by about 20 percent on average from what they otherwise would be without reinsurance.

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 (rating area); and
- The benefits and network of providers in the plan.

Your premium cannot be based on whether you have a pre-existing 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, how much reserves they need to hold and reinsurance. 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:
  o salaries of employees;
  o costs to maintain computer systems to pay claims;
  o costs to manage the provider network (for example, signing up doctors, hospitals and pharmacies);
  o commissions for agents and brokers (called “producers”);
  o rent;
  o taxes, fees, and assessments that health plans pay to the State or federal government; and
  o 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 2017, the Minnesota Commerce Department website provides the public with access to information submitted by insurance companies for their plans with proposed rate increases. 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).