

**MNsure Consumer and Small Employer Advisory Committee**  
**Using Active Purchaser Authority to Improve QHP Affordability**

**Background**

For both the 2014 and 2015 plan years, Minnesota has the lowest average premiums for marketplace Qualified Health Plans (QHPs) in the nation. Because premiums are the most recognizable component of the cost of health insurance, the cost of premiums are often conflated with the cost of the plan. So, for example, Kaiser Health News and NPR published a story this past February that proclaims the Twin Cities metropolitan region as the “least expensive” and three other Minnesota regions making the top 10.<sup>1</sup>

The problem, however, is that the cost of the premium is not the same as the cost of the plan. Other costs, which are not mentioned in the article, include deductibles, copays, and coinsurance, known collectively as “out-of-pocket” costs. These costs may not be as prominent in the consumer’s mind as she shops for health insurance, since they are not inevitable and instead depend on her use of the insurance. However, any family that experiences an illness, an injury, pregnancy, etc., for any family member needs to be concerned about out-of-pocket costs.

It should be recognized that Minnesota currently stands alone in the nation in providing affordable public insurance to adults who are over the income limit of Medical Assistance (MA). MinnesotaCare’s maximum \$50 per adult premiums and low out-of-pocket costs put insurance within reach for those who make too much for MA qualification but who cannot realistically balance the cost of private insurance with their other expenses, given their relatively low incomes. This recommendation is not about that group, but rather about those with limited income that nevertheless exceeds eligibility for MinnesotaCare.

**The Relationship between Premiums and Costs**

As described above, premiums are only part of the cost equation for consumers. Even with that stipulated, though, the intuitive assumption is that lower premiums are still a good thing, including for people with lower incomes or higher health needs. For two important reasons, however, that is not necessarily true:

1. The amount of premiums are inversely proportionate to the amount of deductibles and other out-of-pocket expenses. Although the occasional exception may exist, a look at the marketplace for any state in the country will quickly reveal that plans with lower-than-average premiums have higher-than-average deductibles, and that the inverse is true. This is certainly the case in Minnesota, and makes sense from the standpoint of insurance companies that offer lower premiums. They need to make sure their costs will be covered to maintain profitability. The impact of a high deductible plan is that benefits will generally not kick in (other than those for in-network preventive care) until the deductible is met. The 2015 legal limit for a deductible is \$6,600 for an individual and \$13,200 for a family. Not including catastrophic plans, 13 of the

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<sup>1</sup> Rau, Jordan. "The 10 Least Expensive Health Insurance Markets In The U.S." *Kaiser Health News*. Henry J. Kaiser Family Foundation, 13 Feb. 2014. Web. 08 Oct. 2014.

2015 MNsure plans have an individual deductible of over \$6,000 and 16 have a family deductible of over \$12,000.

The problem is that consumers, especially lower income consumers, gravitate toward low-premium plans in spite of very high deductibles. There are likely several reasons for this, including:

- a. Lack of information about the costs of medical services.
- b. Unfamiliarity with out-of-pocket expenses and how they work.
- c. Having limited monthly budgets that force them to focus solely on the only inevitable expense (premiums).
- d. Optimism about anticipated health needs.

The result is that many families who are not in a position to pay down deductibles that approach \$13,000 / year are nevertheless purchasing such plans, due to the allure (or even necessity) of low premiums. Sadly, this often leads to families forgoing use of their insurance entirely, something that the ACA aims to prevent.

2. Low silver plan premiums reduce the number of families who can lower their insurance costs through Advance Premium Tax Credits. Advance Premium Tax Credits (APTCs) are the primary insurance affordability feature of the MNsure marketplace.<sup>2</sup> In theory, individuals and families with household incomes up to 400% of the federal poverty level (FPL) may be eligible for APTCs that reduce their monthly premiums. The problem, though, is that low premiums lead to many fewer families qualifying for APTCs for the reasons that follow.

Whether a consumer receives an APTC and the amount of that APTC is determined by the cost of the “benchmark plan” to that consumer.<sup>3</sup> The benchmark plan is the silver plan with the second lowest premium for that consumer, which will vary by person based on their age, where they live, and whether they smoke. Under the law, each consumer also has an “affordability limit”, which ranges from 6.32% to 9.5% on a sliding scale. The idea is that, under the ACA, the cost of premiums should not exceed a consumer’s affordability limit.

If the annual premium of the benchmark plan exceeds the consumer’s affordability limit, he or she will receive an APTC that will bring down the premium cost to that affordability limit, and the consumer can apply that APTC amount to any marketplace plan. If, however, the silver plan with the second-lowest premium does not cost more than their affordability limit (regardless of whether the consumer plans to buy a costlier plan), the consumer will not receive a reduction to the premium through an APTC.

In much of Minnesota (although geographic differences exist), receipt of APTCs are more the exception than the rule, even for those making less than 400% of the FPL. The reason for this is

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<sup>2</sup> Although some families also benefit from Cost-Sharing Reductions (CSRs), the income threshold is much lower – 250% of the federal poverty level (FPL) versus up to 400% FPL for APTCs. In addition, CSRs are modest in Minnesota due to the availability of MinnesotaCare, resulting in only a 3% actuarial value increase for silver plan purchasers who meet the income limits.

<sup>3</sup> The same analysis is applied to families, but it is simpler in this context to use an individual consumer in the explanation.

that the benchmark premiums tend to be so low, that they commonly do not exceed the consumer's affordability limit. This means that many fewer Minnesotans get APTCs than do residents of other states.

One may argue that the lack of APTC reductions for so many Minnesota families is not really a loss. After all, the reductions are less common in Minnesota simply because our premiums are lower. However, going back to #1 above, the problem with this is that low-premium plans are accompanied by high deductibles, often very high deductibles. APTCs are intended to reduce the cost of insurance, but they are designed only to reduce premiums ... they do not touch the cost of deductibles. In addition, Minnesota loses out on much more federal money that pays for APTCs versus other states.

### How Does This Play Out For Minnesotans?

For Minnesotans who avoid illness and injury and use their insurance primarily for preventive care alone, the low-premium landscape in Minnesota is advantageous and saves them money. But what about Minnesotans who experience illness or injury, often unexpectedly? For the reasons detailed above, the results are often not very favorable.

The Committee looked at some simple scenarios in order to compare the Twin Cities area to other regions of the country, using one key assumption – that the hypothetical consumer is forced to go through her entire deductible in the plan year. In other words, the consumer had significant health needs. In addition, the consumer's income was low enough to qualify him for APTCs, although the amount of the APTC varied by state, for the reasons noted above.<sup>4</sup>

The comparisons used the benchmark plan<sup>5</sup> from several other states, and specifically focused on four metropolitan areas: San Diego, CA (due to its similar size to the Twin Cities); Seattle, WA (for the same reason); Vail, CO (because it is considered the "most expensive" market in the U.S.); and Milwaukee, WI (since it is a neighboring state). In all four cases, the Minnesota consumer who used his entire deductible fared significantly worse than his counterpart from another part of the country. In fact, the notion that the Twin Cities is the "least expensive" market in the nation and that Vail, CO, is the "most expensive" only holds true for consumers who do not exhaust their deductibles or who do not qualify for tax credits. And the differences were profound:

- **Twin Cities:** \$1,800 premium + \$4,400 deductible – \$24 tax credit = **\$6,176 total cost**
- **San Diego:** \$3,624 premium + \$2,000 deductible – \$1,752 tax credit = **\$3,872 total cost**
- **Seattle:** \$3,264 premium + \$1,500 deductible – \$1,512 tax credit = **\$3,252 total cost**

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<sup>4</sup> For simplicity, the state-by-state comparison only uses premiums and deductibles, as they are the largest expenses. While copays and coinsurance are important factors, they vary too much from consumer to consumer to usefully include in a simple comparison, and their inclusion would not disrupt the conclusions of this analysis. The consumer in this scenario was 37 years old and a resident of Saint Paul. He made \$23,500 per year, which put him at 210% of the federal poverty level. He is over-income for MinnesotaCare, but well within the income range for tax credits (200% to 400%).

<sup>5</sup> In other words, we assumed for simplicity that the consumer chose the second cheapest silver plan. Choosing a higher or lower metal level would not change the analysis, but using the benchmark plan makes it easier to follow, since that plan is the basis for the amount of APTCs a consumer receives.

- **Vail:** \$5,772 premium + \$2,000 deductible – \$3,852 tax credit = **\$3,920 total cost**
- **Milwaukee:** \$3,672 premium + \$2,500 deductible – \$1,896 tax credit = **\$4,276 total cost**

Let's review what causes these inequities. The total costs in these hypotheticals are a sum of the premiums and deductible, minus savings from tax credits. Although the Twin Cities premiums are by far the lowest, the tax credits are almost nonexistent, compared to tax credits in other states that range from over \$1,500 to nearly \$4,000 for the year. The reason has to do with the balance between premiums and deductibles. Since tax credits only help with premiums, they are much lower in the Twin Cities. Simply put, Twin Cities residents are entitled to less premium assistance because the premiums are low to begin with. Unfortunately, those low premiums come with far higher deductibles, and the APTCs simply do not help with deductibles. So the Minnesotan who incurs significant healthcare costs ends up paying far more than people in other states.

### **Who Is Most Impacted By This?**

As noted, consumers with high health needs and chronic conditions are far more likely than healthier consumers to exhaust their deductibles. As such, more frequent users of (non-preventive) medical services are the most harmed by the Minnesota QHP landscape. It is primarily healthier consumers who benefit from Minnesota's low premiums.

In addition, those on the lower end of QHP eligibility (slightly over the MinnesotaCare income limit of 200% of the federal poverty level) are disproportionately harmed by the QHP landscape. The reason is that they are more likely to purchase low deductible plans that come with high premiums. While they may be aware of the looming deductible and their inability to pay it, they may feel constrained by their budgets to purchase plans with lower premiums. This could lead insured consumers to avoid seeking medical care.

### **Relevance of Active Purchaser**

Although MNSure is a marketplace of private insurance plans, the MNSure Board has the ability to influence the marketplace through its active purchaser negotiating authority. Minnesota's exchange was created as an active purchaser of health insurance, allowing the Board to set criteria for offering plans on the marketplace. The intention is to provide a better marketplace for more Minnesotans. Although not being used now, the MNSure Board has the opportunity to make use of this authority for the 2016 QHP marketplace.

Strategic use of active purchaser authority need not limit marketplace choice or even significantly disrupt the plan models of carriers. For example, a simple redistribution of the premium vs. deductible breakdown could alter the problems detailed above. As can be seen in the comparison states, insurance carriers would actually collect higher premiums, not lower premiums, if these changes were made. Nor would consumers be harmed. Most are eligible for APTCs, which would be increased resulting in no net change to the in premium costs to the consumer. Those who don't qualify for APTCs may pay higher premiums, but with lower deductibles. These benefits can be realized without harming the carriers or insured simply because the federal government would be paying a higher share of total coverage costs,

through the APTCs.

### **Recommendation**

The Committee recommends that the Board take steps to improve the 2016 QHP landscape for consumers who face high deductibles and little or no premium assistance. It can do so by using its active purchaser power to set criteria that result in a menu of plans that are more similar to other states in their balance of premiums and out-of-pocket expenses. This would greatly improve marketplace affordability for many Minnesotans, and would do so by taking advantage of federal APTC funds, rather than passing costs to carriers or consumers.

### **Dissenting Opinion (1 member)**

The majority's recommendation that the MNsure Board use Active Purchaser authority to improve the affordability of MNsure's health insurance plan offerings in 2016 draws attention to a long misunderstood maxim of health insurance economics: a health insurance plan's premium does not necessarily reflect its true cost to the consumer. While I agree that this is an important point that must be better understood by the public and consumers, I do not agree with the majority's recommendation that Active Purchaser can or should be used to help address the concerns raised in the majority opinion.

The majority's recommendation suggests that the disparity between Minnesota's lower than average premiums and our higher than average deductibles compels the Board to intervene and to use "its active purchaser power to set criteria that result in a menu of plans that are more similar to other states in their balance of premiums and out-of-pocket expenses." The goal of the majority's recommendation is to raise premiums in Minnesota's health insurance exchange, particularly for the "benchmark plan" (the silver plan with the second lowest premium, which is used to calculate the amount a consumer can receive in subsidies through the Advance Premium Tax Credit), in an effort to increase the availability of premium subsidies through MNsure for Minnesota consumers.

The majority's recommendation suggests that all this may be accomplished through "a simple redistribution of the premium vs. deductible," as required by the criteria set by the Board using Active Purchaser. Setting aside concerns with the premise of the recommendation, it is not clear that MNsure or the Board has the actuarial expertise or the resources necessary to effectively set criteria that would deliver the results sought by the majority without significant impact on MNsure's marketplace. Additionally, because there are five different health insurance carriers offering various plans on the exchange, and because each of these carriers competitively prices its plans independently of one another, it is also unclear whether it is even possible for the Board to develop criteria sufficient to dictate the ideal redistribution of premium vs. deductible in the second lowest silver "benchmark" plan that is used to calculate the APTC. Finally, it should be noted that low deductible plans are already offered through MNsure by every participating carrier, and for those consumers who expect to utilize a significant amount of health care services in a given year, these already available plans may be a great choice. However, if there is concern about the distribution of premiums vs. deductibles in the health

insurance plans offered through MNsure, it would seem appropriate that these concerns be brought to the Minnesota Department of Commerce. It is the Minnesota Department of Commerce which holds the responsibility, under state law, of reviewing and approving the rates for all health insurance plans before they are marketed to consumers.

There is also reason to question whether the use of Active Purchaser is necessary to bring about the majority's desired change in the pricing and design of health plans. On December 22, 2014, the Commonwealth Fund released a report detailing the shifts in exchange-available health plan premiums and deductibles nationwide. It found that premiums for health plans in Minnesota's exchange have generally increased 19%, with premiums for our benchmark silver plan increasing 17%.<sup>6</sup> Similarly, deductibles for Minnesota's silver plans have dropped 14%. As MNsure put it recently, "The benchmark premium from 2014 to 2015 increased across almost all parts of the state. This means that more consumers will qualify for and receive tax credits. This will reduce consumers' monthly health insurance premiums for 2015 from what their costs would otherwise be."<sup>7</sup> If market forces are already working to bring about the desired "redistribution of premium vs. deductible," it is not clear why the Board must intervene.

It is also important to consider the unintended consequences that may follow from the type of Board intervention supported by the majority. First, if high deductible plans are not available through MNsure but remain available off of the exchange, it may result in adverse selection as healthy individuals who do not expect to use their deductibles buy policies outside of MNsure to secure lower premiums and sicker individuals make up the bulk of the population served by MNsure. Second, the Board must consider the continued financial viability of MNsure when reviewing the majority's recommendation. Artificially increasing the premiums of plans offered through MNsure will make these plans too expensive for those who are not eligible for an APTC subsidy. As a result, only those in the individual market with incomes between 200% and 400% of the FPL will use the exchange, and it is not clear that there are sufficient numbers of these consumers in the individual market to ensure MNsure's financial viability going forward, given the premium withhold mechanism used to fund the exchange. This concern is only strengthened by the findings of the recent study commissioned by MNsure which found the consumers who are not eligible for subsidies largely purchased low premium PreferredOne plans in 2014.<sup>8</sup> As these plans are now no longer available through MNsure, artificially raising the premiums of the plans that are still available through the exchange will put even greater pressure on these consumers to look elsewhere for health insurance.

The MNsure Board should not pursue the option of Active Purchaser. Whether as an attempt to address concerns about affordability or to dictate plan offerings or network requirements, using Active Purchaser to establish additional requirements on health plan design will only serve to limit competition and choice through MNsure. Last year, the Board wisely chose not to use Active Purchaser for MNsure's 2015 plan offerings. Instead, it decided to devote its energy and MNsure's resources to improving the

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<sup>6</sup> *Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums*, The Commonwealth Fund, December 22, 2014

<sup>7</sup> *Health Care Coverage and Plan Rates for 2015: A Snapshot of 2015 Premiums and Tax Credits*, MNsure

<sup>8</sup> *Consumer Impact Analysis: Minnesota Individual Exchange Renewals*, Wakely Consulting Group, December 2014

functionality of the exchange to make it a more reliable and useful tool for consumers. This was a wise decision, and it's one that should be repeated.

Much of what Active Purchaser promises to deliver can and should be accomplished through improved usability, functionality, and comparability of the MNsure website. MNsure and the MNsure Board should focus all available time, energy, and resources on developing and perfecting these aspects of the exchange first, before considering any move toward active purchaser, because until these are firmly in place, it cannot be known whether there is any need for active purchaser.