OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA • James Nobles, Legislative Auditor

Date: August 6, 2020

To: Members, Legislative Audit Commission

From: Judy Randall, Deputy Legislative Auditor
Ryan Moltz, Senior Program Evaluator

Subject: Individual and Small-Group Market Health Insurance

Dear Members:

At the meeting of the Legislative Audit Commission on April 15, 2020, the Office of the Legislative Auditor indicated that we would provide members with information related to the proposed evaluation topic "Individual and Small-Group Market Health Insurance." In this letter, we provide background information about Minnesota's "rating areas" and how premiums for health insurance vary across the areas.

Conclusion

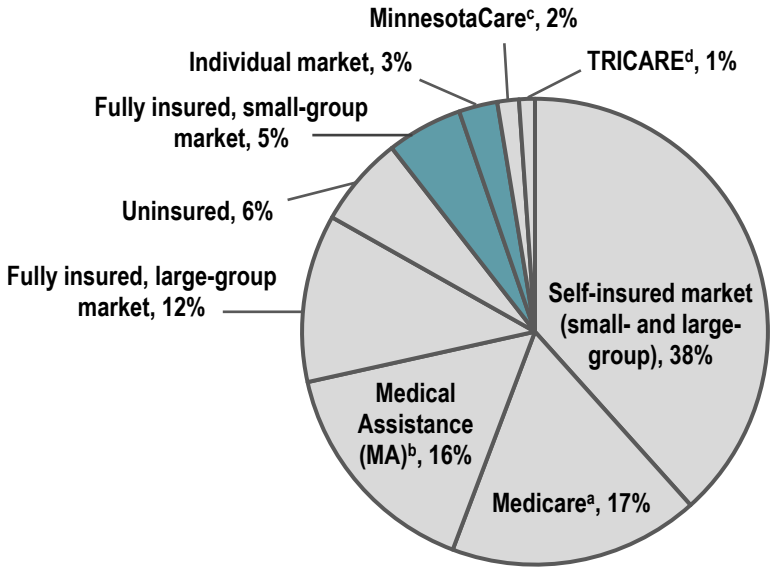
In both the individual and small-group markets, premium rates in 2020 are consistently highest in southeastern Minnesota compared with other regions of the state; premium rates are consistently lowest in the Twin Cities area compared with elsewhere in the state. This pattern holds regardless of the level of coverage purchased.

Background

As of 2017, the individual market was the source of health insurance coverage for approximately 149,000 Minnesotans. These individuals generally purchased health insurance directly from a carrier or through Minnesota's health insurance exchange, MNsure. Also in 2017, approximately 294,000 Minnesotans obtained health insurance through the portion of the small-group market that is regulated by the state.[1] Together, 8 percent of Minnesotans obtained health insurance through these markets in 2017, as seen in Exhibit 1.

[1] The group insurance markets, which typically make health insurance available through an employer, are distinguished based on the number of employees. An employer may participate in the small-group market if it has fewer than 50 full-time equivalent employees; an employer with 50 or more full-time equivalent employees may participate in the large-group market. Separately, regardless of firm size, employers that offer health insurance coverage to their employees may be either "self insured" or "fully insured." Health insurance provided by self-insured, private employers is regulated under the federal Employee Retirement Income Security Act of 1974 (ERISA). Such employers assume direct financial responsibility for the costs of enrollees' medical claims. Health insurance provided by fully insured employers and public self-insured employers, by contrast, is regulated under state law. These employers, which tend to be smaller firms, contract with a health plan that assumes financial responsibility for the costs of enrollees' medical claims.

Exhibit 1: The individual and fully insured, small-group markets were the primary source of health insurance coverage for approximately 8 percent of Minnesotans in 2017.



[a] Medicare is a federal government health insurance program that provides coverage to persons age 65 and older, to certain younger persons with disabilities, and to persons with end-stage renal disease.

[b] Medical Assistance is Minnesota's Medicaid program. In general, it provides coverage to nonelderly adults with household incomes up to 138 percent of the federal poverty level and to children with household incomes up to 275 percent of the federal poverty level.

[c] MinnesotaCare is a public program that, in general, provides coverage to adults with household incomes between 139 and 200 percent of the federal poverty level.

[d] TRICARE is the health insurance program for uniformed service members, National Guard/Reserve members, their families, and certain others.

SOURCE: Office of the Legislative Auditor, based on data from the Minnesota Department of Health, Health Economics Program.

The federal Affordable Care Act (ACA) imposes many regulations on the individual and small-group health insurance markets. Health carriers must charge the same premium to all individuals who purchase the same health insurance product, with limited exceptions. The ACA permits exceptions based on the following four factors: age, tobacco use, whether coverage is for an individual or a family, and region of the state (known as a "rating area").[2] Persons cannot be charged different premiums for the same health insurance product on the basis of other characteristics, such as gender or health status. In general, older persons, persons who use tobacco, and persons purchasing coverage for a family, can be charged higher premiums, within limits, than others. Premiums can also vary across rating areas, but these variations must be actuarially justified and approved by the Minnesota Department of Commerce.

Prior to the enactment of the ACA, health carriers in Minnesota established their own rating areas.[3] However, the ACA required states to establish common rating areas to be used by all

[2] 42 *U.S. Code*, sec. 300gg, accessed April 30, 2020.

[3] *Minnesota Statutes* 2012, 62A.65, subd. 3 (c).

carriers participating in the individual and small-group markets. Regulations adopted under the ACA set a maximum number of rating areas each state may have, which is equal to the number of metropolitan statistical areas (MSAs) in the state plus one.[4] For Minnesota, this means a maximum of nine rating areas are allowed.

State law requires that Minnesota's rating areas consist of at least seven counties that form a contiguous region.[5] This provision was held over from the time when health carriers in Minnesota could draw their own rating areas. Federal regulations would allow drawing the rating areas on the basis of geographic boundaries other than counties, namely the first three digits of ZIP codes or metropolitan and non-metropolitan statistical areas.[6]

The ACA's provisions regarding rating areas applied to health insurance coverage beginning on January 1, 2014. To prepare for this change, the departments of Commerce and Health began a public comment process to draw Minnesota's rating areas in 2012. The process resulted in the nine rating areas shown in Exhibit 2, which were submitted to the U.S. Department of Health and Human Services for federal approval in early 2013. The rating areas received approval and have not been changed to date. Doing so would require another public comment process and federal approval.

Disparities Across Rating Areas

To analyze disparities across rating areas, we obtained 2020 rate filings from all participants in the individual and small-group markets.[7] These filings are publicly available through the System for Electronic Rates and Forms Filing (SERFF). Carriers do not necessarily offer products in all regions of the state. Moreover, a carrier does not have to offer the same products in every county in which it chooses to operate, even within a given rating area.

We compiled rate data for each plan offered by each health carrier based on age, tobacco use, and "metal level."[8] The rates available on SERFF applied only to coverage purchased for a single individual rather than for a family. To account for the fact that a particular health plan is not necessarily sold in all counties within a rating area, we first identified the cost of the lowest-cost plan by age within each metal level in each county within a rating area. Using those costs, we then calculated an average "lowest cost" for each metal level by rating area. In the

[4] MSAs are defined by the U.S. Office of Management and Budget as having at least one urbanized area of 50,000 or more inhabitants. Minnesota has eight MSAs, some of which have their principal cities in North Dakota or Wisconsin.

[5] *Minnesota Statutes* 2019, 62A.65, subd. 3 (b)(2).

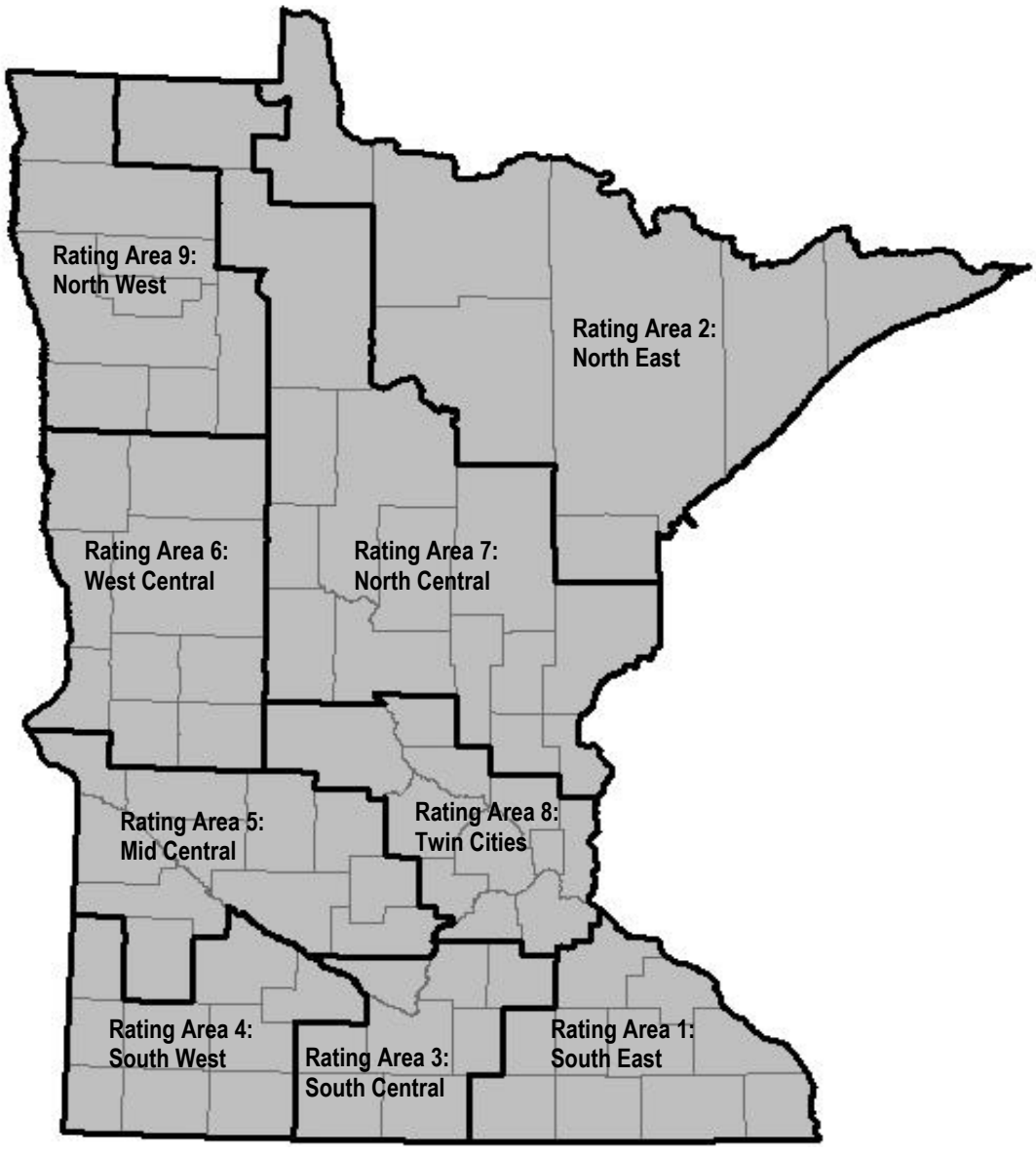
[6] 45 *CFR*, sec. 147.102(b)(3) (2018).

[7] In 2020, there are five carriers participating in the individual market: Blue Plus, Group Health, Inc. (HealthPartners), Medica, PreferredOne, and UCare. There are 11 carriers participating in the small-group market: Blue Cross Blue Shield; Blue Plus; HealthPartners, Inc.; HealthPartners Insurance Company; Medica; PreferredOne Community Health Plan; PreferredOne Insurance Company; Quartz; Sanford; UnitedHealthcare Insurance Company; and UnitedHealthcare of Illinois, Inc.

[8] Health plans sold in the individual and small-group markets are categorized by "metal level": bronze, expanded bronze, silver, gold, or platinum. Generally, there is an inverse relationship between premiums and the out-of-pocket costs an individual must pay for any care received (such as deductibles). Bronze plans have relatively low premiums with higher deductibles; platinum plans have relatively high premiums with lower deductibles. Additionally, there are "catastrophic" plans that offer limited coverage until a high deductible is met. Catastrophic plans are generally available only to persons under age 30.

case of silver plans in the individual market, we looked at both the lowest-cost silver plan and the second-lowest-cost silver plan. We did this because the latter plan is known as the "benchmark" plan. The cost of the benchmark plan in each county is used to calculate the premium tax credit available to qualified persons who purchase health insurance through MNsure.[9]

Exhibit 2: Minnesota has nine rating areas.



SOURCE: Office of the Legislative Auditor, analysis of data from the Minnesota Department of Commerce.

[9] In general, the premium tax credit is available to persons with incomes between 201 percent and 400 percent of the federal poverty level who purchase a qualified health plan (not a catastrophic plan) through MNsure. The premium tax credit reduces the amount of the monthly premium.

Exhibit 3 shows the individual-market rates for four hypothetical purchasers of health insurance; Exhibit 4 shows the same for the small-group market. Across all four individuals—who vary in age, tobacco use, and level of coverage—the rates in the individual and small-group markets are consistently the highest in rating area 1 (southeastern Minnesota) and consistently the lowest in rating area 8 (Twin Cities).

Exhibit 3: This table shows sample rates charged to persons with a particular risk profile for 2020 coverage in the individual market.

Rating Area	27-year-old, non-tobacco user, bronze	35-year-old, non-tobacco user, benchmark[a]	48-year-old, tobacco user, gold	60-year-old, non-tobacco user, platinum
1 – South East	$364	$456	$672	$1,150
2 – North East	288	307	457	1,103
3 – South Central	302	362	497	1,103
4 – South West	320	317	441	1,103
5 – Mid Central	287	318	457	1,008
6 – West Central	255	332	478	961
7 – North Central	269	279	427	1,008
8 – Twin Cities	249	242	426	779
9 – North West	267	312	445	1,008

NOTES: The rates shown are the average monthly rate for the least expensive version of a plan at that metal level, rounded to the nearest dollar, available in a given rating area during the first quarter of 2020. These rates are not necessarily what the person would actually pay, however, if the person purchases the plan through MNsure and qualifies for the premium tax credit. The rates shown are for coverage for the individual only.

[a] The benchmark plan is the second-lowest-cost silver plan available in a county.

SOURCE: Office of the Legislative Auditor, analysis of data from the System for Electronic Rates and Forms Filing (SERFF).

Exhibit 4: This table shows sample rates charged to persons with a particular risk profile for 2020 coverage in the small-group market.

Rating Area	27-year-old, bronze	35-year-old, silver	48-year-old, gold	60-year-old, platinum
1 – South East	$294	$354	$559	$1,181
2 – North East	275	336	497	1,058
3 – South Central	256	331	520	1,079
4 – South West	283	325	521	1,098
5 – Mid Central	275	352	547	1,149
6 – West Central	255	320	507	1,048
7 – North Central	257	320	514	1,054
8 – Twin Cities	250	303	489	992
9 – North West	270	311	509	1,045

NOTES: The rates shown are the average monthly rate for the least expensive version of a plan at that metal level, rounded to the nearest dollar, available in a given rating area during the first quarter of 2020. The rates shown are for coverage for the individual only. In 2020, none of the carriers in the small group market considered tobacco use when setting premiums.

SOURCE: Office of the Legislative Auditor, analysis of data from the System for Electronic Rates and Forms Filing (SERFF).

In the individual market, it is important to note that these rates are not necessarily the rate that a person would actually pay for that coverage. A person who receives a premium tax credit through MNsure would pay less.[10] In general, a higher premium translates into a higher tax credit.[11] Therefore, in the individual market, these disparities primarily affect persons who do not qualify for the premium tax credit, including those with incomes greater than 400 percent of the federal poverty level. Because premium tax credits are not available in the small-group market, disparities affect all persons insured in that market, regardless of their income.

We hope this memorandum provides useful information on rate disparities across rating areas.

[10] MNsure stopped offering small-group health insurance through its platform in 2018.

[11] Although we did not analyze the effects of premium tax credits for this memorandum, we included such an analysis in our 2015 evaluation of MNsure. At the time, the median monthly premium tax credit in the Twin Cities rating area was $116; in southeastern Minnesota, it was $344. Office of the Legislative Auditor, Program Evaluation Division, *Minnesota Health Insurance Exchange (MNsure)* (St. Paul, 2015), 68.