MINNESOTA COUNCIL OF HEALTH PLANS

"MINNESOTACARE BUY-IN" ANALYSIS

1. IT'S NOT TODAY'S MINNESOTACARE.

Governor Dayton proposed a "buy-in" so people who now buy health insurance from MNsure or directly from an insurance company could get a public option—no matter how much money they make. The proposal has more in common with private health insurance than with MinnesotaCare as we know it. Here's a quick comparison:

	Today's Minnesota Care	MNsure Today Gold | Silver Plan ex. Morrison County 40-year-old	Proposed Public Options 2019 Gold | Silver
Monthly premium	Up to $80	$493 Gold | $415 Silver	Gold tbd | $659 Silver
Person's maximum share of expenses*	6 percent	20 percent Gold | 30 percent Silver	20 percent Gold | 30 percent Silver
Deductible, per year	up to $38	$750 Gold | $2,000 Silver	*to be determined*
Price of generic prescriptions	$6	$5 Gold|40% of generic cost Silver	*to be determined*
Cap on what an individual pays for care	None	$6,000 Gold | $6,500 Silver	*to be determined*
Network of doctors and hospitals	Determined by insurance company		*to be determined*
Plan administration	Private insurance company		Private insurance companies

*Technically called actuarial value

2. HEALTH INSURANCE COMPANIES WELCOME COMPETITION. THIS ISN'T COMPETITION.

The proposed public option would be administered by private health insurers, just as most insurance is today. The state is not creating new competition for insurers—it's changing the rules on how much doctors, hospitals and clinics get paid for providing care. Payment rates for your doctor, clinic and hospital services would be set by the state. In the most recent proposal, payments would be paid at Medicare rates, which are roughly 40 percent less than what private insurance pays.

3. THE NEW PROGRAM LOWERS PAYMENTS TO CLINICS AND HOSPITALS.

Asking doctors and hospitals to accept lower fees will make it even harder for people to get the care they need. The best clinic in the world can't help you if you can't get an appointment there. The public option assumes people who provide care will take lower payments—*without* increasing their prices for patients who get their health insurance through work. History suggests that this isn't likely. Typically, hospitals, doctors and clinics raise prices on privately insured patients to make up for lower payments from people who get insurance from government programs.

We asked experts to estimate how this might work using Medicare payment rates, and found that the proposal would reduce payments to doctors, clinics and hospitals nearly $700 million each year if just people who buy insurance on their own now buy from the state. If people who provide care do not absorb those expenses, premiums would go up for everyone else in the state—about $500 for a family of four. As more people buy from the state, premiums people pay through work will go up even more.

4. WHAT'S NEEDED IS TO LOWER THE PRICE OF HEALTH CARE FOR *EVERYONE*.

Mandating lower prices for some people will make premiums more expensive for everyone else. There's a lot we don't know about the proposed public option, and the Council is committed to helping fill in the details. In doing so, we need to make sure the proposal brings health care within reach for *all* Minnesotans.

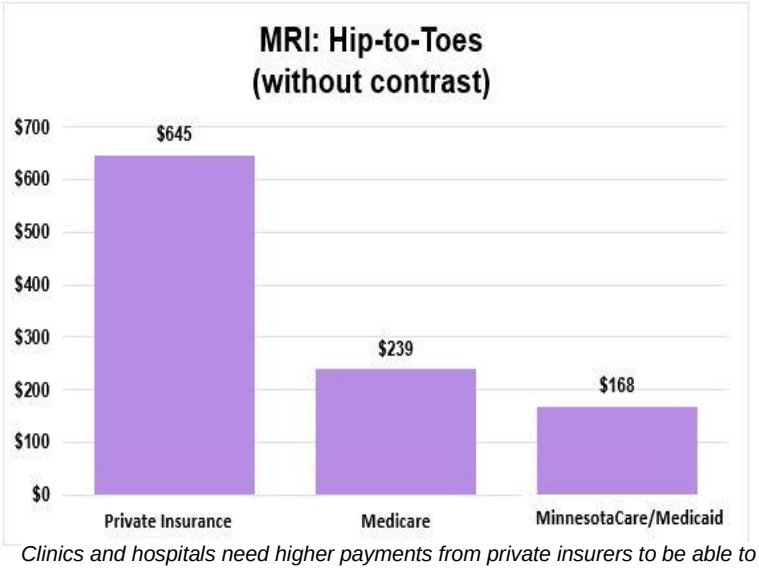
MINNESOTA COUNCIL OF HEALTH PLANS

ANALYSIS OF THE PUBLIC OPTION PROPOSAL

To understand the proposed public insurance option, we need to start with a few basic questions:

- **Who will sign up?** The effect of the proposal depends on how many people sign up. Will it be just Minnesotans who buy their own insurance right now, or will people who now get insurance through work sign up as well?
- **Who will take on the expense?** The goal is to lower the premiums people pay each month to bring care within reach. Will people who sign up for the new program pay enough in premiums to cover their medical bills, or will the expense be passed on to other Minnesotans?
- **How will it work over time?** Changes in health care often have unanticipated consequences. How will the public insurance option evolve over time?

To help answer these questions we asked actuaries, who are expert insurance analysts, to investigate. What we learned was that the proposed plan lowers premiums because it would pay doctors, hospitals and clinics roughly 60 cents for every dollar of medical care, compared to how much individuals or their employers pay. That's how Medical Assistance, Medicare and MinnesotaCare work, too: they pay at lower rates for care, and doctors adjust what patients who get insurance through work pay to make up for it. At right, you'll see how much is paid for an MRI. This is example of how payment varies for the same medical service.



Clinics and hospitals need higher payments from private insurers to be able to care for all patients. Medicare and Medicaid payments simply don't cover the bills.

Data Source: MN Community Measurement

The proposed program assumes that the people who provide care will take lower payments—*without* increasing their prices for patients who get their health insurance through work. History suggests that this isn't likely. Typically, hospitals, doctors and clinics raise prices on privately insured patients to make up for lower payments from people who get insurance from government-supported programs. The table below shows three scenarios of who signs up for the public option and how much payments to doctors, hospitals and clinics go down because the state pays like Medicare.

Who Signs Up for the Public Option?	Annual Drop in Payment to Hospitals and Clinics
All people buying their own policies today	($0.7 billion)
Plus 5 percent of people who get insurance from small and large employers	($0.9 billion)
Plus 20 percent of people who get insurance from small and large employers	($1.3 billion)

Source: Minnesota Council of Health Plans 2017 actuarial study, based on statewide average of Medicare and private insurance payments.

The next table shows what happens to other Minnesotans' premiums if people who provide care pass along some or all the drop in payments for service. The amount per family varies, depending on how much of the lost payment your doctor, hospital or clinic needs to make up and how expensive care is locally. The number will be higher in areas of the state with higher medical expenses and lower where care isn't as expensive.

How doctors, clinics and hospitals deal with lower payments	Premium increase* per family if just people who buy their own insurance today bought the public option	Premium increase* per family if 5 percent of people who now get insurance at work buy the public option instead	Premium increase* per family if 20 percent of people who now get insurance at work buy the public option instead
Reduce expenses by the same amount	$0	$0	$0
Decide to make up 60 percent	$304	$368	$568
Decide to make up 80 percent	$404	$488	$760
Decide to make up 100 percent	$504	$612	$948

*Average yearly premium increase based on family of 4.

MORE INFORMATION NEEDED

People who buy insurance on their own want to know how Governor Dayton's proposal compares to what they have today. To get those answers, the state needs to provide more details. Here are some of the topics that remain.

- **How will the state set monthly premiums for the new public option?** According to current federal law, premiums can only be set by considering people's age, how expensive care is in the area where they live, and how much their insurance policy requires them to pay out of pocket (the so-called "actuarial value" of a policy, which the federal government labels with metals like Gold and Silver). What formula will the state use to set premiums?

- **What prices will people pay for prescriptions?** By current law, the state can't use its Medicaid discount to pay pharmacies for the prescriptions of people who aren't covered by Medicaid. What drug prices will people in the new public option have to pay?

- **How will people pay the out-of-pocket part of their medical bills?** The proposed public option offers Silver and Gold health insurance policies. By law, Silver policies require individuals to pay about 30 percent of their medical bills out of pocket, while the insurance policy pays the other 70 percent. For Gold policies, the split is 20 percent out of pocket and 80 percent from insurance. The state proposal isn't clear whether an individual's 20 to 30 percent of medical bills will be paid for by deductibles, copays or other options.