Using Surveys to Inform Health Policy: Appending Premium Information to Surveys of Health Care Coverage and Access

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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS
Surveys and Health Policy

- Surveys are often used in health policy because they:
  - are the “gold standard” for determining how many people do not have health insurance
  - can detect early effects of health policy changes
  - can help sort out how people make health care decisions

- BUT Administrative data can answer other questions:
  - How much money was spent/where it was spent
  - Health plan premiums
  - Health plan benefits
  - How many people have a disease
Some Health Policy Questions Can’t Be Answered by Just One Source

- Who will this policy impact?
- Where is take-up most likely to be highest?
- How might policy that increases health insurance coverage not improve health?
Sometimes, it’s just complicated

Survey response:
I’m spending too much on prescription drugs

Survey response:
I don’t have tax credits/I didn’t qualify for tax credits

Survey Response:
I’ve had to forgo care due to cost, even though I’m on Medicaid

Administrative data:
Individuals spend an average of $200 per year on Prescription Drugs

Administrative Data:
100,000 Minnesotans are eligible for tax credits on MNsure

Administrative Data:
People on Medicaid have almost no out of pocket spending
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If Survey Data and Administrative Data are both “True”...

Let’s combine them!
1. Low enrollment in state health insurance exchange (MNsure)/forgone federal subsidies

2. Changing benchmark health plans each year – impact on premium increases and potential continuity of care

3. State spending strategies to reduce premium increases in the individual market: reinsurance, subsidies, and tax credits

4. Estimating the size and impact of the “family glitch”
The Minnesota Health Access Survey (MNHA)

- General (state) population RDD telephone survey (English and Spanish)
- Assess access to health insurance coverage in the state
- Quantify barriers to getting health insurance and receiving health care services

2017 Stats:
- 12,436 completed interviews
- Fielding period: June through early October 2017
- Response rate (RR3): Overall=29%/Cell=25%
- Weighted to MN population using 2016 American Community Survey (ACS)
Types of Data collected by the MNHA

**Demographics**
- Income ($/ FPG)
- Age
- County
- Gender
- Employment
- Internet
- Bank account
- Home ownership
- Marital status

**Health Insurance**
- Health insurance coverage for all HH members
- Access to employer coverage through self/spouse/parent
- Holder of coverage
- HDHP enrollment

**Health Care Access**
- Forgone care due to cost
- Problems with Medical bills
- Discrimination
- Provider access

**Health & Utilization**
- ER and Clinic visit/inpatient stay in the past 12 months
- Healthy days/health status
- Chronic disease
Administrative Data (all public data sources)

- Individual Health Plans available in each county
- Premiums by age, for each county
- Equations to calculate federal premium subsidies
- Eligibility criteria for federal premium subsidies
Example 1: Low Enrollment in State Health Insurance Exchange (MNsure)/forgone federal subsidies
Step 1: Estimate Premiums for All members of the Immediate Family with Individual Market Coverage

Administrative Data

Benchmark Silver Plan

Monthly Premium

Target Individual Market Enrollee

County

Survey Data

Benchmark Silver Plan

HH member Individual Market Enrollee

County

Premium

Age

Age

Household Premium
Step 2: Estimate the Premium amount a Family Must Pay

Applicable Percentage: Income 200%-250% FPG

Tax credit assigns a percent of income that families are responsible for paying.
- Each income range has a percentage range.
- The percentages change each year.
Step 3: See how much tax credit a person will actually receive

- If $0 or less – family is not eligible for any tax credit
- The tax credit may be applied to any plan, except catastrophic
Step 4: Adjust the Premiums and Tax credit to a per-person basis

- To do analysis, we adjust the final premiums and tax credits to a per-person basis
- This allows us to use the weights to provide estimates statewide, and for specific demographics
We know this method works, because we get estimates pretty close to what is actually paid out.

- Minnesotans with coverage are using the tax credits.
- Minnesotans without coverage who are eligible could add around $100 million in tax credits.
Most people weren’t eligible for a substantial tax credit in 2015

Percent of Enrollees Eligible for Federal Tax Credits by Monthly Credit Amount

- **$0**: 64% Individual, 67% Uninsured, 72% All Eligible
- **$0 to <$50**: 5% Individual, 8% Uninsured, 14% All Eligible
- **$50 to $100**: 10% Individual, 8% Uninsured, 9% All Eligible
- **More than $100**: 21% Individual, 7% Uninsured, 15% All Eligible

Average Credit Amount – by Age and Insurance Coverage, 2015

- **Total**: $38 (All Eligible), $16 (Uninsured)
- **0 to 17**: $0 (All Eligible), $0 (Uninsured)
- **18 to 34**: $38 (All Eligible), $3 (Uninsured)
- **35 to 64**: $125 (All Eligible), $25 (Uninsured)
- **65+**: $175 (All Eligible), $75 (Uninsured)
- **Non-Group Coverage**: $49 (All Eligible), $137 (Uninsured)
- **Uninsured**: $21 (All Eligible), $74 (Uninsured)
Example 2: Changing benchmark health plans year – impact on premium increases and potential continuity of care
Step 1: Identify Current and Previous Years’ Benchmark Plan for each county in the state

- Plans could change each year
- Plans changed by county
- We also repeated the process with the lowest cost Bronze plan in the county
Step 2: Estimate premiums for each plan in each year, and tax credits for each year
Other Adjustments and Assumptions

Adjustments

- Income: using FPG values in data, with inflated incomes based on new FPG guidelines

Assumptions

- The general demographics of the market remain unchanged, including the income distribution
- The uninsurance rate is unchanged in future years
Changing plans keeps premiums low – but the impact on health is unknown

- Tax credits are based on a “benchmark” plan – which can change every year
- Subsidies help – but only if you change plans
- This isn’t looking at what actually happened – just what the market might expect to happen

<table>
<thead>
<tr>
<th>Switch Plans Every Year</th>
<th>Keep 2014 Plan All Years</th>
<th>Switch Plans Every Year</th>
<th>Keep 2014 Plan All Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benchmark Plan</td>
<td>Lowest Cost Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change (No Subsidies)</td>
<td>Change (with Subsidies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>132.4%</td>
<td>247.0%</td>
<td>155.9%</td>
<td>255.2%</td>
</tr>
<tr>
<td>26.3%</td>
<td>179.4%</td>
<td>3.3%</td>
<td>194.5%</td>
</tr>
<tr>
<td>100%</td>
<td>200%</td>
<td>50%</td>
<td>150%</td>
</tr>
</tbody>
</table>
Example 3: State spending strategies to reduce premium increases in the individual market: reinsurance, subsidies, and tax credits
Step 1: Estimate future premiums

Assumptions:

- Benchmark Plan did not change after 2019
- Reinsurance effects remained stable across years
- Cost and utilization trend was accurate for benchmark silver plan

**Premiums with reinsurance**

- 2019 Benchmark Silver Plan
- 2020 Benchmark Silver Plan: Estimate 2020 Premiums by using Cost and Utilization trend from 2018 actuarial memos (by carrier)
- 2021 Benchmark Silver Plan

**Premiums without reinsurance**

- 2019 Benchmark Silver Plan
- 2020 Benchmark Silver Plan
- 2021 Benchmark Silver Plan

15 to 30%

This amount was determined based on 2018 rates submitted with and without reinsurance, at the plan level.
Step 2: New Calculations for State Subsidy + Tax Credit

- Had to apply the subsidy to all premiums before calculating the state-based tax credit.
- State based tax credit and only for people who don’t qualify for federal credits
Other Adjustments and Assumptions

**Adjustments**

- Changing weights to account for changing enrollment in health insurance markets based on enrollment data
- Income: using FPG values in data, with updated FPG guidelines to grow incomes
- Age: we know the individual market is getting older, so we increase the age of adults 21 to ~60 to account for older individuals having higher premiums

**Assumptions**

- The general demographics of the market remain unchanged (with the exception of age)
- The uninsurance rate is unchanged in future years
Usually, policy makers get an average cost, like this:

**Total Cost with 100% Take-up, 2021**

- **Reinsurance**: $275.9
- **SBTC**: $200.4
- **Subsidy + SBTC**: $266.9

**Average Monthly Premiums, 2021**

- **Nothing**: $742
- **Reinsurance**: $593
- **State-based Tax Credit (SBTC)**: $634
- **Subsidy + State-based Tax Credit**: $535
This analysis tells them where in the state the dollars go:

- **Reinsurance focuses the about half the subsidies in the Twin Cities** – where premiums are already the lowest in the state.

Here are the average monthly premiums for 2021:

- **RRs 1, 3, 4, 5**:
  - Reinsurance: $902
  - Reinsurance + SBTC: $722
  - Subsidy + SBTC: $587
  - Nothing: $531

- **RRs 2, 6, 7, 9**:
  - Reinsurance: $817
  - Reinsurance + SBTC: $653
  - Subsidy + SBTC: $573
  - Nothing: $531

- **RR 8 (Twin Cities)**:
  - Reinsurance: $624
  - Reinsurance + SBTC: $499
  - Subsidy + SBTC: $517
  - Nothing: $446

The total cost with 100% take-up in 2021 is as follows:

- **Reinsurance**:
  - RR 1, 3, 4, 5: $152.1 million
  - RR 2, 6, 7, 9: $63.7 million
  - RR 8 (Twin Cities): $446 million

- **SBTC**:
  - RR 1, 3, 4, 5: $63.7 million
  - RR 2, 6, 7, 9: $54.7 million
  - RR 8 (Twin Cities): $446 million

- **Subsidy + SBTC**:
  - RR 1, 3, 4, 5: $106.1 million
  - RR 2, 6, 7, 9: $64.3 million
  - RR 8 (Twin Cities): $446 million
But also *who* the dollars are going to

Total Cost with 100% Take-up by Age

- **Reinsurance**
  - $0 to 17: $52.5
  - 18 to 44: $61.8
  - 45+: $161.7

- **SBTC**
  - $0 to 17: $12.1
  - 18 to 44: $11.4
  - 45+: $176.9

- **Subsidy + SBTC**
  - $0 to 17: $23.1
  - 18 to 44: $25.9
  - 45+: $217.9

Average Monthly Premiums by Age, 2021

- **0 to 17**
  - Nothing: $421
  - Reinsurance: $337
  - SBTC: $362
  - Subsidy + State-based Tax Credit: $309

- **18 to 44**
  - Nothing: $436
  - Reinsurance: $349
  - SBTC: $389
  - Subsidy + State-based Tax Credit: $329

- **45+**
  - Nothing: $945
  - Reinsurance: $756
  - SBTC: $665
  - Subsidy + State-based Tax Credit: $600
We Are In “The Family Glitch”

Meet the Larson Family
2019 Income: $64,000 (300% FPG)
Employee Share of Premiums:
Single: $1,500 per year (2.3% of income)
Family: $6,800 per year (10.6% of income)

Example 4: Estimating the size and impact of the “family glitch”
Who is in the Family Glitch – and what will it cost?

- We needed to use premiums for employer sponsored insurance (MEPS)
- We need to know who the person has access through – their spouse or parent
- *The missing piece*: We only have family income, not individual income
- *The policy question*: How many people are currently buying “unaffordable” employer coverage?

<table>
<thead>
<tr>
<th>Current Health Insurance Coverage</th>
<th>Population Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Market</td>
<td>6,100</td>
</tr>
<tr>
<td>Employer Sponsored Insurance</td>
<td>170,000</td>
</tr>
<tr>
<td>Uninsured</td>
<td>10,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>186,100</strong></td>
</tr>
</tbody>
</table>

**The Price Tag of Limiting Individual Market Benchmark Premiums to 9.86% of Income in Minnesota in 2019:**

- Current Individual Market Coverage: $16.5 million
- Currently Uninsured: $5.6 million
- Current ESI Coverage: $132.3 million
Conclusions

- Our surveys have really good data – on demographics and how people experience health care
- What they are missing – actual costs – can be estimated based on other administrative data that’s available
- A lot of data that is useful is public and free!
- In places that try to estimate the future impact of health policies, this method can provide more specificity
- With funding an issue, anything that advances the usefulness of survey data is a good thing
Thank you.

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