Health Insurance Affordability Study

Minnesota Department of Health

January, 2009

Division of Health Policy
Health Economics Program
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January 15, 2009

The Honorable Linda Berglin
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Minnesota Senate
Room 309, State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155-1606

The Honorable Thomas Huntley
Chair, Health Care and Human Services
Finance Division
Minnesota House of Representatives
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Saint Paul, MN 55155

The Honorable John Marty
Chair, Health, Housing, and Family
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The Honorable Paul Thissen
Chair, Health and Human Services
Committee
Minnesota House of Representatives
351 State Office Building
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Saint Paul, MN 55155

To the Honorable Chairs:

The 2008 Legislature required the Minnesota Department of Health (MDH) to develop a proposal for a subsidy program to ensure that premiums and out of pocket costs are affordable for Minnesotans with incomes up to 300 percent of the Federal Poverty Guidelines (FPG) who have access to employer-sponsored health insurance (2008 Minnesota Laws, Chapter 358, Article 4, Section 14).

The enclosed report identifies alternative ways to define who would be eligible for the subsidy program and issues related to how the subsidy could be delivered. I look forward to continuing to work with you on this issue. Questions and comments on the report may be directed to the Health Economics Program at (651) 201-3560.

Sincerely,

Sanne Magnan, M.D., Ph.D.
Commissioner
P.O. Box 64975
St. Paul, Minnesota 55164-0975

Enclosure

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Executive Summary

Minnesota's 2008 health reform law requires the Minnesota Department of Health (MDH), in collaboration with the Minnesota Department of Human Services (DHS), to develop a proposal for a subsidy program to ensure that premiums and out of pocket costs are affordable for Minnesotans with incomes up to 300 percent of the Federal Poverty Guidelines (FPG) who have access to employer sponsored insurance.

MDH analyzed different approaches to designing and delivering the subsidy. The key findings from this analysis include:

- **Estimated take-up:** If the subsidy program were limited to the uninsured, an estimated 40,000 to 46,000 people would enroll. If the subsidy were available to everyone with incomes below 300 percent of FPG and access to employer coverage, it is estimated that over 500,000 people would enroll.

- **Estimated total cost:** If the program were fully implemented in 2009, the estimated annual cost of the program ranges from $159 million (if limited to the uninsured and implemented through a tax credit) to $1.8 billion (if available to everyone in the income range with access to employer coverage and delivered through direct payments).

The following issues would need to be considered in deciding how to structure a subsidy program:

Tax credits vs. direct payments: People with very low incomes would be less likely to take up the tax credit because they would have to pay expenses up front and wait for reimbursement. However, the costs of administering the subsidy through direct payments would be higher than the cost of administering a tax credit.

Cost: Making the subsidy available to everyone with access to employer coverage and spending that exceeds the affordability standards may be perceived as the fairest option, but the total cost of the program would be much lower if it were limited to people who are uninsured.

Increased health care utilization and impact on premiums: The subsidy program would pay for all health care spending above the affordability standard. Studies have shown that people use more health care when they have no cost sharing requirements. The subsidy program would cause some increase in health care utilization, and could cause premiums for employer coverage to increase.

Public program eligibility: Eighty-five percent of the people who would enroll if the program were limited to the uninsured are estimated to be already eligible for Medical Assistance (MA) or GAMC. Because of the availability of federal matching dollars in MA, it would be less expensive for the state to enroll people who are eligible for both MA and the subsidy program into MA.

Introduction

Minnesota's 2008 health reform law requires the Minnesota Department of Health (MDH), in collaboration with the Minnesota Department of Human Services (DHS), to develop a proposal for a subsidy program to ensure that premiums and out of pocket costs are affordable for Minnesotans with incomes up to 300 percent of the Federal Poverty Guidelines (FPG) who have access to employer sponsored insurance.[1] Many of these families have incomes that might make them eligible for MinnesotaCare, but they cannot enroll because they have access to employer coverage where the employer pays more than 50 percent of the premium.

In developing this proposal, MDH must evaluate different potential mechanisms for delivering the subsidy, including direct payments to individuals, tax deductions, tax credits (including refundable credits), or a combination of methods. MDH contracted with Mathematica Policy Research to estimate the impact on cost and coverage that would result from different approaches to designing and delivering the subsidy.

The first section of this report provides background information on how rising health care costs have affected lower-income Minnesotans and how a subsidy program of the type envisioned by the Legislature might address this problem. The next section presents information on the number of people who would be affected by the program and the estimated costs. The final section of the report discusses issues related to administering the subsidy program.

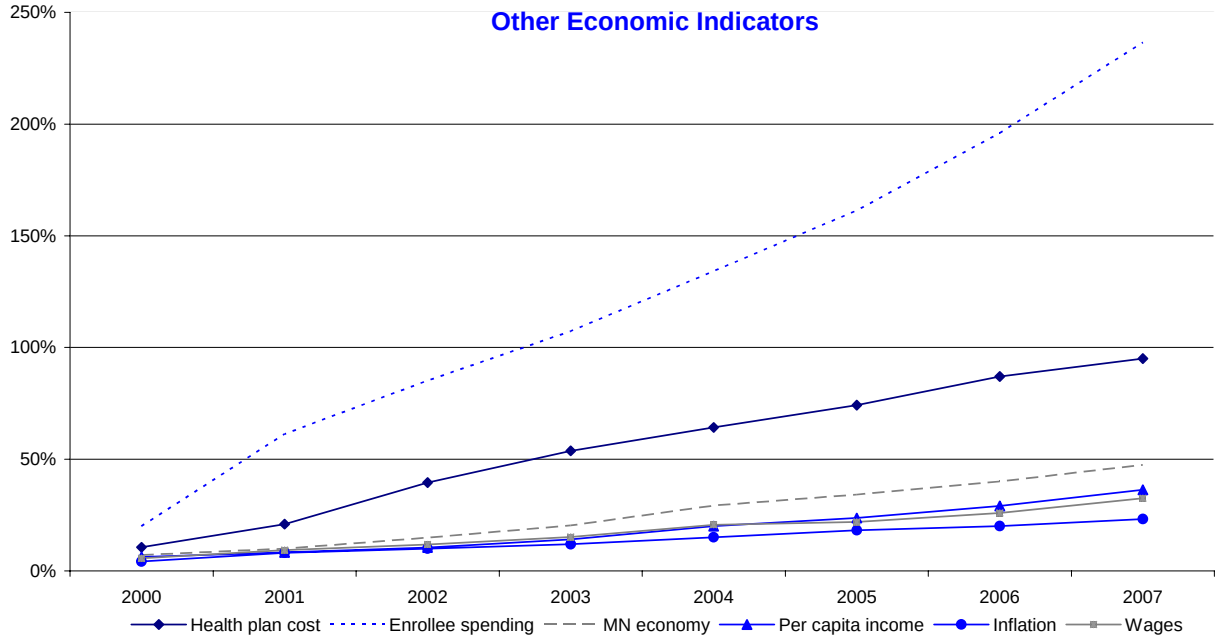
Background

Health care costs have increased substantially in recent years, in Minnesota and nationally. Figure 1 compares growth in private health care costs per enrollee to other economic indicators in Minnesota from 2000 through 2007. As shown in the figure, both health plan costs and enrollee out of pocket spending have outpaced growth in the economy, wages, and overall inflation by a large margin. Health plan costs nearly doubled from 2000 to 2007, while wages and income increased by only 30 to 40 percent. The growth in the amount that enrollees are paying out of pocket for expenses such as copayments and deductibles is even larger. Out of pocket spending for private insurance increased by nearly 240 percent from 2000 to 2007. One reason for this increase in enrollee out of pocket cost is that many employers have shifted to policies with greater cost sharing in order to control growth in premiums. In Minnesota's small group market, for example, deductibles have gone up considerably in the past few years. After remaining flat at $500 from 2002 to 2005, the median per-person deductible for people with coverage through small group policies doubled to $1,000 in 2008.[2]

[1] 2008 Minnesota Laws, Chapter 358, Article 4, Sec. 14

[2] Minnesota Department of Health, Health Economics Program, unpublished analysis of small group and individual market survey data from 2002, 2005, and 2008.

Figure 1
Cumulative Growth in Minnesota Private Health Plan and Enrollee Costs vs. Other Economic Indicators



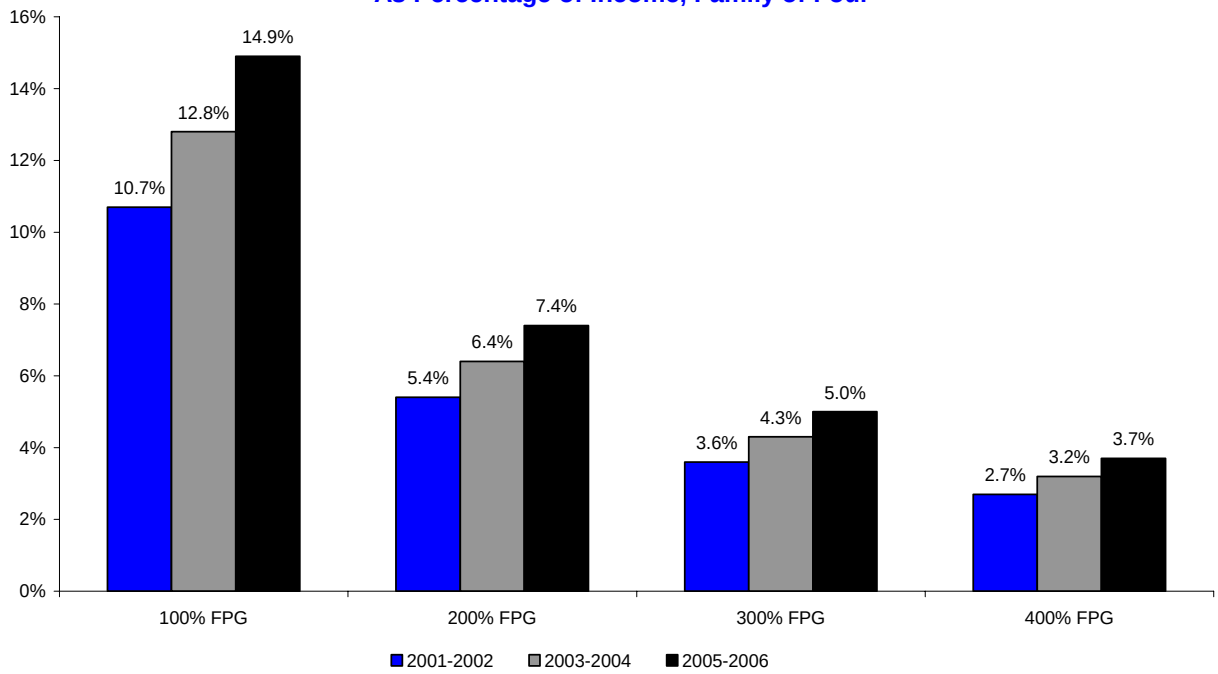
Sources: Minnesota Department of Health, Health Economics Program ; U.S. Department of Commerce, Bureau of Economic Analysis; U.S. Bureau of Labor Statistics, Minnesota Department of Employment and Economic Development

Note: Health plan cost is MN private health plan spending on health care services per person, and does not include enrollee out of pocket spending for deductibles, copayments, coinsurance, and services not covered by insurance. Enrollee spending includes payments for deductibles, copayments, coinsurance and other out of pocket costs.

The increasing cost of health care is a concern for all Minnesotans, but its impact has been larger for lower-income families and individuals. To illustrate this, Figure 2 shows, over time and for different income levels, the average employee contribution to premiums for a family policy in Minnesota as a percentage of income. The average employee contribution for family coverage increased by over 50 percent from 2001 to 2006, from $1,915 to $2,923. In 2006, this average contribution represented over 7 percent of income for a family of four with income at 200 percent of FPG, compared with less than 4 percent of income for a family at 400 percent of FPG.[3] Since most people with employer based coverage face additional payments (such as copayments and deductibles) when they use health care services, total health care spending would represent an even larger share of income in most cases.

[3] 100 percent of the Federal Poverty Guidelines for a family of four in 2008 was $21,200. (U.S. Department of Health and Human Services)

Figure 2
Average Employee Premiums for Family Coverage,
As Percentage of Income, Family of Four



Source: Minnesota data from the Medical Expenditure Panel Survey, Insurance Component (MEPS-IC)
Note: FPG refers to the Federal Poverty Guidelines, U.S. Department of Health and Human Services

Why subsidize employer coverage?

This report analyzes different approaches to help lower-income Minnesotans afford increasingly expensive health care. The Legislature has specifically directed MDH to consider strategies to assist lower-income families with access to employer coverage. There are several reasons to focus on this group:

- People with access to employer coverage are usually ineligible for subsidized health care programs like MinnesotaCare, unless their incomes are low enough to qualify them for Medical Assistance or General Assistance Medical Care.
- Many MinnesotaCare enrollees are better protected from high health care spending because the program caps premiums based on income and limits other cost sharing requirements.[4] People with access to employer coverage are excluded from MinnesotaCare in order to avoid crowd-out, which happens when people drop private coverage in order to enroll in public programs.
- Employer coverage has eroded in recent years.[5] A subsidy program could help stabilize employer coverage and reduce demands on public programs by leveraging employer contributions to coverage.

[4] Single adults and higher-income parents (except pregnant women) have a $10,000 limit on inpatient care and so have substantially less protection from high out of pocket costs than other enrollees in the program. Some of these adults also face 10 percent copayments (up to $1,000) for each hospitalization. These provisions are intended to limit crowd-out.

[5] 2001, 2004, and 2007 Minnesota Health Access Surveys, Minnesota Department of Health, Health Economics Program and the University of Minnesota School of Public Health

- As costs continue to increase, it is likely that some lower-income Minnesotans find themselves ineligible for MinnesotaCare but also unable to afford their employer coverage.

What is affordable coverage?

The standard of affordability used in this study was defined by the Legislature, and was adapted from the 2008 MinnesotaCare premium schedule. This scale establishes, for different income levels, an affordable percentage of income to be spent on health care (premiums and out of pocket spending combined) and is shown in Table 1.

For example, according to this definition of affordability, a family with income at 200 percent of FPG could afford to spend 5.6 percent of its income on health care. As shown earlier in Figure 2, the average employee share of premiums alone represents over 7 percent of income for this family. If Minnesota adopted a program to subsidize employer coverage, families in this situation would be eligible for a subsidy equal to the difference between their total health care expenditures and 5.6 percent of their income. In other words, once this family spent 5.6 percent of its income (about $2,400) on health care, the rest of its health care expenditures for the year would be paid for by the state.

Table 1
Affordability Scale

Income as % of Federal Poverty Guidelines	% of Income Considered Affordable
0-45%	$4 per month
46-54%	1.1%
55-81%	1.6%
82-109%	2.2%
110-136%	2.9%
137-164%	3.6%
165-191%	4.6%
192-219%	5.6%
220-248%	6.5%
249-274%	7.2%
275-300%	8.0%

Source: Minnesota Statutes, section 256L.15, subdivision 2, paragraph (d)

Table 2
Non-Elderly Minnesotans with Incomes Below 300% of FPG
Estimates for 2009

	Number	% Distribution
Total Populaton	1,717,000	100.0%
Income as % of Federal Poverty Guidelines		
0-100%	524,000	30.5%
101-200%	625,000	36.4%
201-300%	568,000	33.1%
Source of Health Care Coverage		
Public	561,000	32.7%
Employer	743,000	43.3%
Individual	138,000	8.0%
Uninsured	275,000	16.0%
Access to employer coverage	90,000	5.2%
No access to employer coverage	185,000	10.8%

Source: Mathematica Policy Research, based on Minnesota Health Access Survey
Note: Excludes persons enrolled in military coverage.

How many people would be affected?

Table 2 shows sources of insurance coverage for the approximately 1.7 million non-elderly Minnesotans with incomes below 300 percent of the Federal Poverty Guidelines in 2009. Sixteen percent of non-elderly Minnesotans with incomes below 300 percent of FPG are uninsured, which is nearly twice the statewide rate of 8.1 percent for non-elderly Minnesotans.[6]

The subsidy program could be limited to the uninsured or available to everyone with incomes below 300 percent of FPG and access to employer coverage. There are roughly 90,000 people in this group who are uninsured and have access to employer coverage (Table 2). If policymakers decided to make the subsidy available to everyone in the income range with access to employer coverage, many of those currently enrolled in employer coverage (approximately 743,000 people) and some people currently enrolled in private individual coverage would also be potentially eligible.

The relative size of these groups is important when thinking about ways to help lower-income families afford employer sponsored insurance. On the one hand, the most equitable approach might be to subsidize everyone who meets the program's income requirements and has access to employer coverage. From this perspective, people who have maintained their employer coverage but are struggling to pay their share of the costs should not be excluded from the subsidy.

[6] 2007 Minnesota Health Access Survey

Because this is such a large group, however, the cost of this approach would be high. Another option would limit eligibility for the subsidy to people who are currently uninsured. This approach would reduce the cost of the program, but could cause crowd-out. To help prevent this problem, eligibility for the subsidy could be limited to those who have been uninsured for at least four months, similar to the current eligibility rules for MinnesotaCare.

Another reason why policymakers may decide to target the uninsured is the fact that the uninsured report lower health status and worse health care outcomes on average than those with coverage. The uninsured are also much more likely than those with private coverage to receive care in more expensive settings, such as emergency rooms. These costs are often absorbed by health care providers as uncompensated care or passed on to people with private insurance in the form of higher insurance premiums.

Estimated enrollment and cost of subsidy program

MDH contracted with Mathematica Policy Research to model the effects of an employer subsidy program on state expenditures and insurance coverage in Minnesota. The analysis considered two approaches to implementing the subsidy:

- **Direct payments to employees**: Payments would be made monthly and vary based on out of pocket spending. This approach would require the development of a system to establish eligibility and track health care expenditures.

- **Refundable tax credit**: The credit would be calculated based on the previous year's income and health care spending. Enrollees would need to keep receipts and be prepared to provide proof of expenses if audited. This approach would require a new tax form and supporting documents to establish eligibility for the credit and determine the amount of the credit.

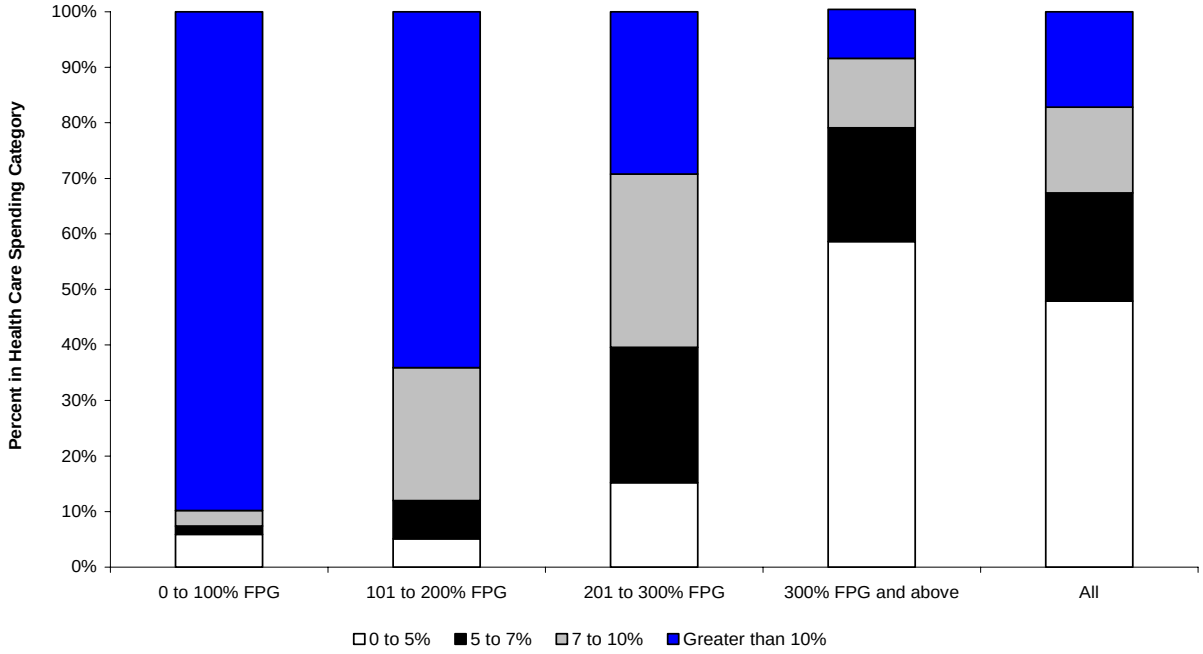
For each approach, the program's impact was modeled for two groups:

- **Waiting period group**: People uninsured for at least four months with incomes below 300 percent of FPG and access to employer coverage where the employer pays at least 50 percent of the premium (qualified employer coverage).[7]

- **No waiting period group**: Everyone with incomes below 300 percent of FPG and access to qualified employer coverage. This would include everyone in the waiting period group.

[7] Approximately 80% of the currently uninsured in Minnesota have been uninsured four months or longer. Approximately 78% of those with incomes below 300% FPG and access to employer coverage have been uninsured four months or longer. (Estimates from the 2007 Minnesota Health Access Survey).

Figure 3
Distribution of Health Care Spending As Percentage of Income
Minnesotans with Employer Coverage



Source: Mathematica Policy Research, estimates for 2009. Includes employee share of premium and out of pocket spending.

How much are people with employer coverage spending on health care now?

Figure 3 shows the distribution of health care spending as a percentage of income for Minnesotans with employer coverage. This distribution varies considerably by income. For example:

- Nearly 90 percent of those with incomes below 100 percent of FPG spent 10 percent or more of income on health care.

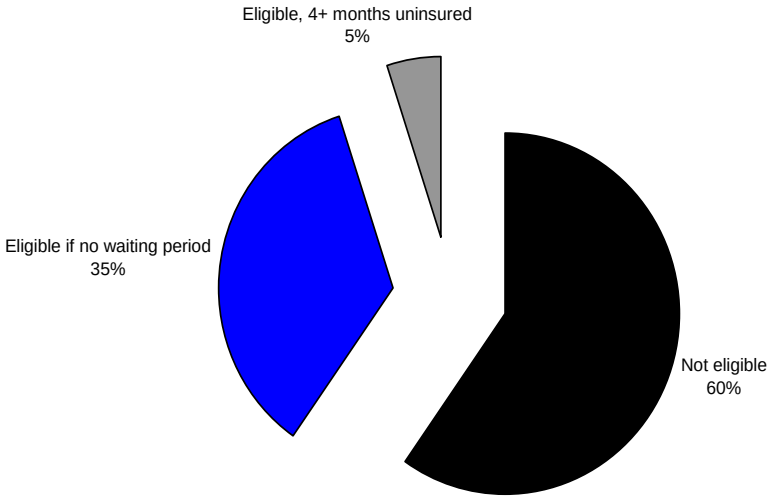
- In comparison, only 9 percent of Minnesotans with incomes above 300 percent of FPG spent more than 10 percent of their income on health care.

How many people are potentially eligible for the program?

As shown earlier, there are approximately 1.75 million non-elderly Minnesotans with incomes below 300 percent of the Federal Poverty Guideline in 2009 (Table 2). Of these, approximately 40 percent (roughly 708,000 people) have access to employer coverage where the employer pays at least 50 percent of the premium (Figure 4).

- If policymakers chose to limit the subsidy to people who have been uninsured for at least four months (the "waiting period" group), approximately 90,000 people or 5 percent of the total non-elderly population with incomes below 300 percent of FPG would be potentially eligible for the program (Figure 4).

Figure 4
1.75 Million Non-Elderly Minnesotans with Incomes Below 300% of FPG



Source: Mathematica Policy Research, estimates for 2009

- If there were no waiting period and the subsidy were available to all lower-income Minnesotans with access to qualified employer coverage, an additional 35 percent or 618,000 people would be potentially eligible for the program (Figure 4).

Sixty percent of non-elderly lower-income Minnesotans (just over 1 million people) would not be eligible for the subsidy program for one or more of the following reasons:

- They are currently enrolled in public coverage. The analysis assumes that people will not drop public coverage in order to enroll in the subsidy program.

- They are not workers or family members of workers.

- They work for a firm that does not offer coverage.

- They work for a firm where the employer pays less than 50 percent of the premium. The analysis excludes these people because many of them could enroll in MinnesotaCare and the legislation that called for this study specified that the subsidy program would be available only to people whose employer pays more than 50 percent of premiums.

Those potentially eligible for the program would only qualify for subsidy payments if their health care spending exceeded the limits in Table 1. This issue is discussed in more detail in the next section.

How many of those potentially eligible would qualify for subsidy payments?

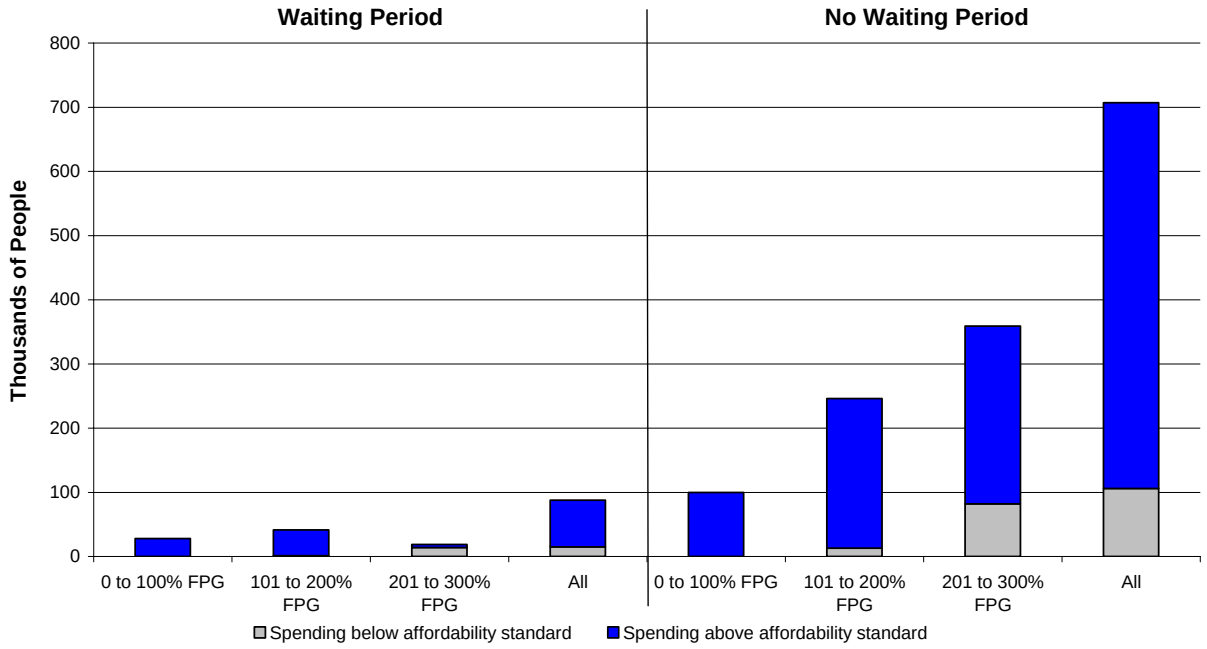
The subsidy program would cap health care spending according to a sliding scale based on income. Families and individuals would only qualify for subsidy payments if their annual health care spending exceeded the affordability standard shown in Table 1. As a result, not everyone with incomes below 300 percent of FPG and access to employer coverage would necessarily qualify for subsidy payments.

Figure 5 shows the estimated number of potentially eligible people who would qualify for subsidy payments based on their health care spending. Key results of this analysis include the following:

- Of the roughly 90,000 people who meet the eligibility requirements in the waiting period group, 81 percent (or just over 73,000) would qualify for subsidy payments based on their level of health care spending.

- With no waiting period for the subsidy, 85 percent (or approximately 601,000 of the 708,000 Minnesotans potentially eligible for the subsidy) would qualify for subsidy payments.

Figure 5
Number Spending Above Affordability Standard
Non-Elderly Minnesotans with Incomes Below 300% of FPG and Access to Employer Coverage



Source: Mathematica Policy Research, estimates for 2009

Figure 5 also shows that the number of people who would qualify for subsidy payments varies by income. In the waiting period group, nearly all (97 percent) of the people with incomes below 200 percent of FPG have health care spending above the affordability standard. A much smaller share (25 percent) of people with incomes between 200 and 300 percent of FPG would qualify for subsidy payments. This is because the standard for affordability varies by income and people with lower incomes would need to spend smaller shares of their income on health care in order to qualify for subsidies (see Table 1).

With no waiting period, a larger share of the potentially eligible population has incomes above 200 percent of FPG, roughly 50 percent (approximately 360,000 people) compared to 21 percent when there is a waiting period. Nearly 77 percent (roughly 277,000 people) of those potentially eligible with incomes above 200 percent of FPG would qualify for subsidy payments when there is no waiting period, compared to just 25 percent of people in this same income group when there is a waiting period. The reason for this difference is that most people in this income group would have to incur out of pocket costs beyond premium payments before their spending exceeded the affordability standard. With a waiting period requirement, the analysis assumes that the uninsured only consider the subsidy program if their premium costs would be reduced. As a result, many of the uninsured in this group who spend less than the affordability standard would continue to do so, because they would not take up insurance coverage. On the other hand, without a waiting period, most in this income group are already insured and spending above the affordability standard.

How many people would take up the subsidy?

Estimated take-up of the subsidy depends on both who is eligible (only the uninsured or everyone with incomes below 300 percent FPG and access to employer coverage) and the delivery mechanism (tax credits or direct payments).

Table 3 shows that the percentage of people who qualify for subsidy payments and decide to take up the program is estimated to be lower when there is a waiting period, regardless of how the subsidy is delivered. With a waiting period, take-up ranges from 55 percent to 63 percent, compared to 86 percent to 88 percent when there is no waiting period. Take-up is lower when there is a waiting period because everyone in this group is currently uninsured. For some of the uninsured, the subsidy is not large enough for them to decide to enroll in employer coverage. When there is no waiting period, on the other hand, the majority of the people who qualify for subsidy payments are already insured. For this group, the subsidy represents extra income and no additional expenses. As a result, take-up would be much higher.

Table 3 also shows that people in the waiting period group are estimated to be more sensitive to how the subsidy is delivered:

- With a waiting period, implementing the subsidy through a tax credit instead of direct payments lowers the take-up rate from 63 percent to 55 percent (an eight percentage point difference).

- In comparison, delivering the subsidy through a tax credit instead of direct payments only lowers take-up from 88 percent to 86 percent (a two percentage point difference) when there is no waiting period.

Table 3
Estimated Take-up of Subsidy

	Number of People		Estimated Take-up of Subsidy Program	
	Potentially Eligible for Subsidy	Qualify for Subsidy Payments	Direct Payment (% and number of people)	Refundable Tax Credit (% and number of people)
Waiting Period	90,000	73,000	63% 46,000	55% 40,000
No Waiting Period	708,000	601,000	88% 531,000	86% 517,000

Source: Mathematica Policy Research, estimates for 2009.
Note: Potentially eligible people have incomes below 300% of FPG and access to employer insurance. Those qualifying for subsidy payments have health care spending above the affordability standard.

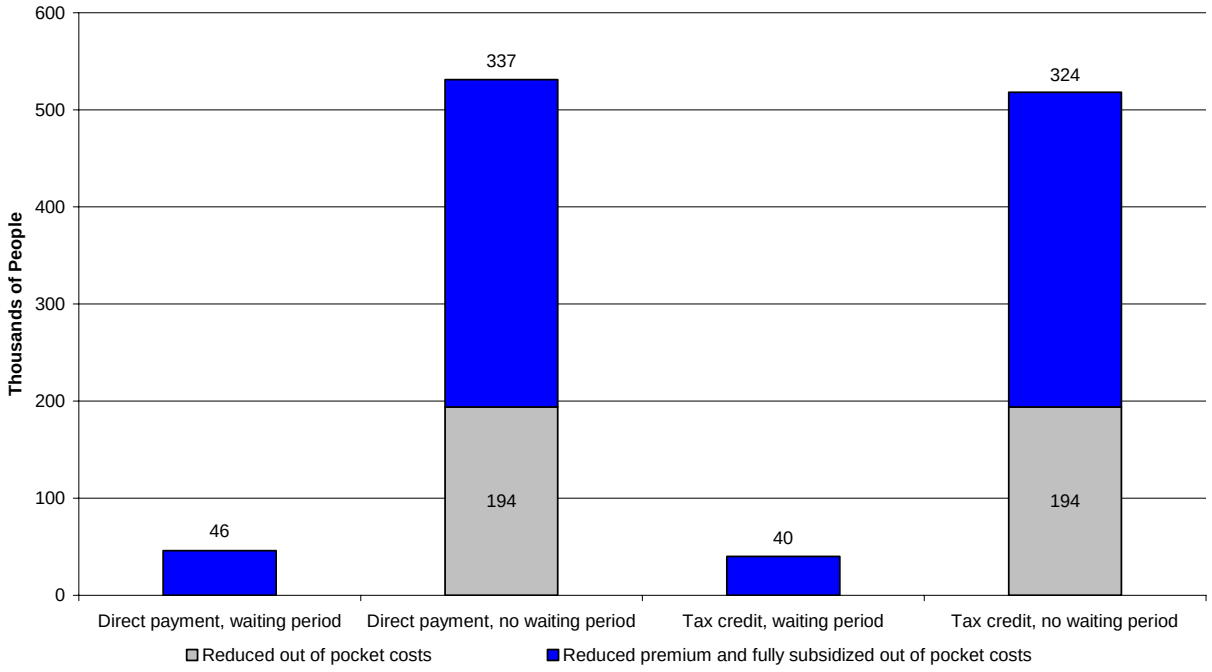
People in the waiting period group are less likely to enroll in a tax credit subsidy because this approach requires enrollees to pay for their health care costs up front and get reimbursed later. This is more difficult for the people in the waiting period group because they have lower incomes and little disposable income.

Subsidizing premium and out of pocket costs

This study considers total health care spending for premiums and out of pocket costs to determine affordability. Some people would be eligible for subsidies (i.e., their spending on health care as a percent of income would exceed the affordability standard) based on their premium payments alone. For these people, some portion of premiums and all out of pocket health care costs would be covered by the subsidy program. For others, health care spending would not exceed the affordability standard until a certain amount of out of pocket costs had been incurred in addition to premiums.

The extent to which the subsidy program would pay for premiums vs. out of pocket costs varies, depending on whether people who are currently insured would be potentially eligible for the subsidies. Figure 6 shows the number of people who would qualify for the subsidy based on premium alone or a combination of premium and out of pocket spending. Regardless of how the subsidy is delivered, everyone who takes up the subsidy in the waiting period group would qualify based on premium payments alone. If there were no waiting period, only 60 percent of those taking up the program would receive subsidies based solely on premium payments.

Figure 6
Number of People with Reduced Premium and Fully Subsidized Out of Pocket Costs vs. Number of People with only Reduced Out of Pocket Costs



Source: Mathematica Policy Research, estimates for 2009

How would the program affect insurance coverage?

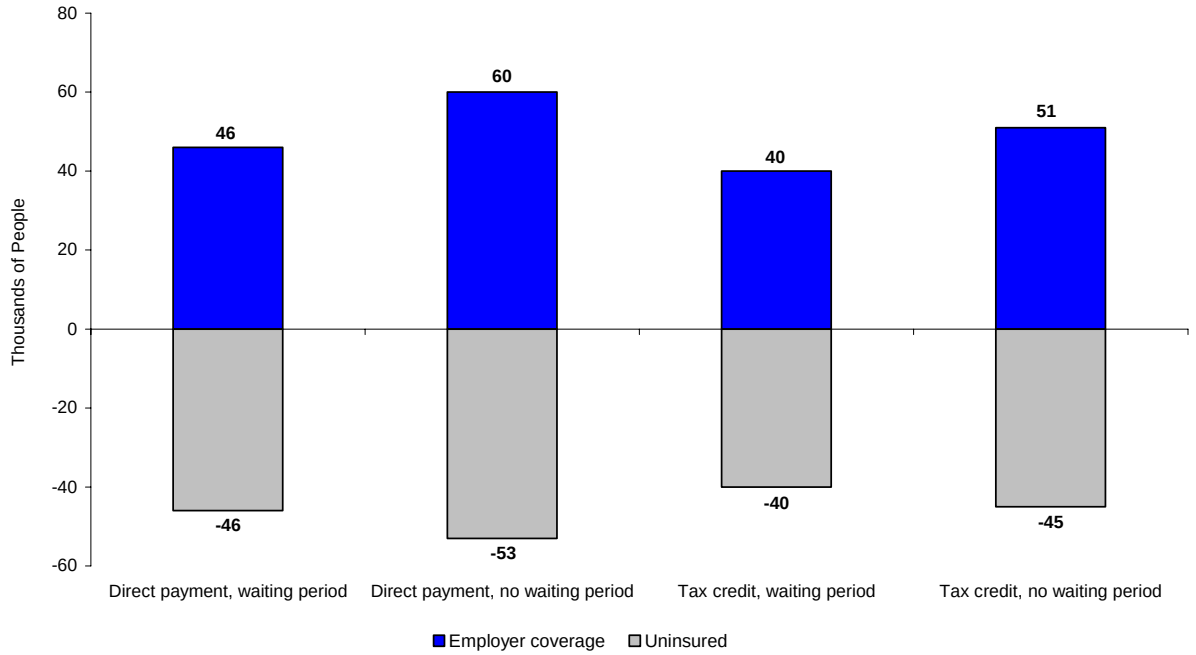
Figure 7 shows the estimated effect of enrollment in the subsidy program on coverage among people with incomes below 300 percent of FPG. As discussed previously, more people would decide to take up the program if it were delivered through direct payments. As a result, direct payments have a larger effect on coverage when compared to subsidies delivered as tax credits.

- The number of uninsured who would gain coverage ranges from 40,000 (with a waiting period and a refundable tax credit) to 53,000 (with no waiting period and direct payments).

- The number of people who would gain employer coverage ranges from 40,000 to 60,000. When there is no waiting period, some of the people who would gain employer coverage were previously insured in the individual market. These are primarily people for whom family coverage through a spouse's or parent's employer would now be more affordable than coverage in the individual market.

With no waiting period and direct payments, the uninsurance rate for non-elderly Minnesotans with incomes below 300 percent of FPG would decline from 15.7 percent to 12.7 percent. The majority (about 77 percent) of people with incomes below 300 percent of FPG who would remain uninsured are ineligible for the subsidy program.

Figure 7
Estimated Impact of Subsidy Program on Coverage
Non-Elderly Minnesotans with Incomes below 300% of FPG



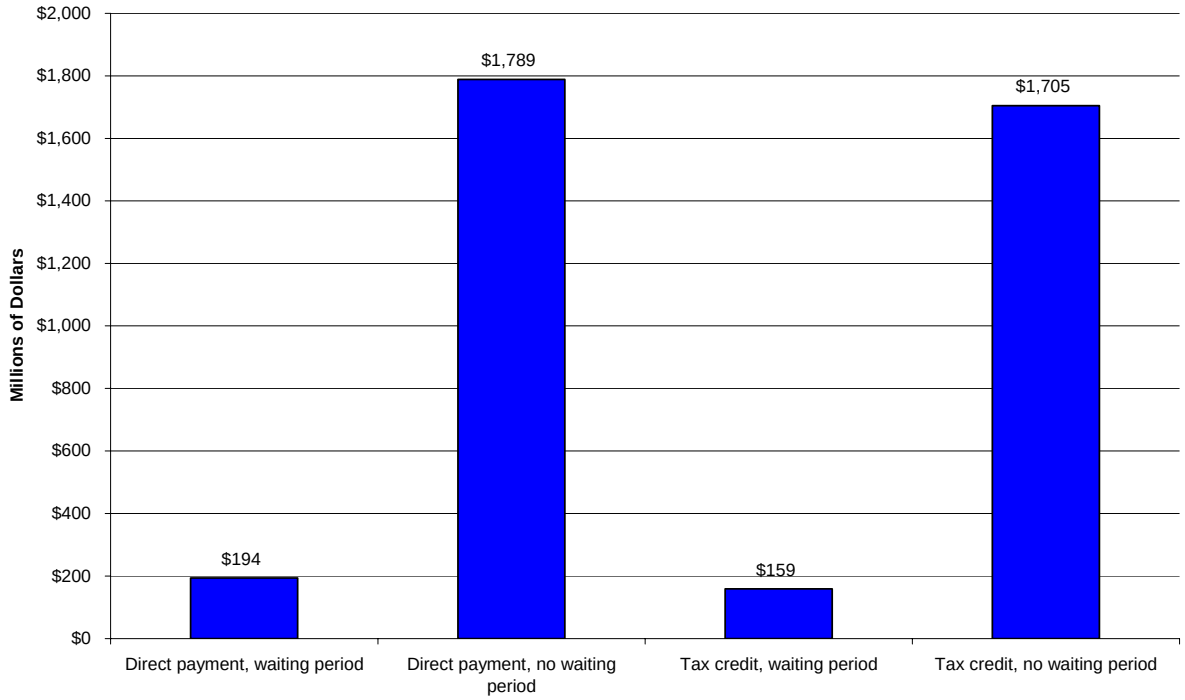
Source: Mathematica Policy Research, estimates for 2009

How much would the program cost?

If the program were fully implemented in 2009, the estimated cost of the subsidies ranges from $159 million with a waiting period and subsidies delivered as tax credits to $1.79 billion with no waiting period and direct payments (Figure 8). Costs per enrollee would be higher ($4,248 vs. $3,388 for direct payments and $4,021 vs. $3,319 for tax credits) when there is a waiting period (Table 4). This reflects the fact that people in the waiting period have lower incomes, on average, and as a result would receive larger subsidies. Similarly, costs per enrollee would be higher when the subsidy is delivered through direct payments instead of a tax credit because more low income people would enroll.

The cost estimates presented in Figure 8 and Table 4 do not include costs to administer the subsidy program. These costs would vary depending on how the subsidy is delivered. With a tax credit, enrollees would be required to track their health care spending and keep receipts for possible audits. There would be costs associated with adding a tax form to the system and processing the form. Based on information provided by the Minnesota Department of Revenue, MDH has estimated that the costs of administering a tax credit would add less than one tenth of one percent to the total cost of the program. However, costs would be higher if policymakers chose to put in place additional systems (such as eligibility verification prior to filing for the credit or additional auditing) to prevent fraud.

Figure 8
Estimated Cost of Subsidies



Source: Mathematica Policy Research, estimates for 2009
Note: Estimates assume full implementation of the program

Table 4
Estimated Cost of Subsidy Program

	Total Cost (Millions of dollars)	Estimated Cost per Enrollee
Direct Payments		
Waiting Period	$194	$4,248
No Waiting Period	$1,789	$3,388
Tax Credits		
Waiting Period	$159	$4,021
No Waiting Period	$1,705	$3,319

Source: Mathematica Policy Research, estimates for 2009

The cost of administration would be higher if the subsidy were delivered through direct payments. This type of program would require the development of a system to determine eligibility (and to confirm that enrollees continue to be eligible) and to track health care spending during the year. The system would also have to provide payments to enrollees as premiums are due and reimburse additional out of pocket spending when appropriate. The Minnesota Department of Human Services estimates that administering the subsidy program could add between 2 to 3 percent to the total cost of the program. This estimate does not include the costs associated with developing the information technology systems necessary to administer the program.

Discussion

This section summarizes issues and questions that policymakers would need to consider in deciding how to structure a subsidy program.

Eligibility for the subsidy

The subsidy program could be limited to people who had been uninsured for four months or more (the waiting period group) or available to everyone with incomes below 300 percent of FPG (the no waiting period group). In deciding who should be eligible for the subsidy, the following considerations will be important:

- **Cost:** The cost of the program will be much higher if there is no waiting period for the subsidy.

- **Equity**: Limiting the program to the uninsured with a waiting period may be perceived as unfair because people who are currently spending above affordable levels for employer coverage would not receive any assistance.

- **Targeting spending to cover the uninsured**: Without a waiting period for the subsidy, most of the people who would enroll in the subsidy program would already be insured.

Tax credits vs. direct payments

The following issues are important to consider when deciding whether to deliver the subsidy through direct payments or refundable tax credits:

- **Timing of the subsidy payment**: People with very low incomes are likely to consider the delayed payment associated with a tax credit to be much less attractive than subsidy payments as expenses are incurred. Since the majority of people in the waiting period have incomes below 200 percent of FPG, delivering the subsidy as a tax credit may limit the program's effectiveness for this population.

- **Administrative cost**: Direct payments would be more expensive to administer.

- **Cost to the state**: Direct payments could hold the possibility for federal matching payments in the future if implemented as a premium assistance program through Medicaid. Minnesota would have to apply for a new Section 1115 waiver to obtain federal match for people who are ineligible for Medical Assistance.

Additional issues

There are several additional issues associated with the subsidy program that policymakers would also need to consider. These issues are relevant regardless of who is eligible for the subsidy and how the subsidy is delivered, although the effects may vary depending on how the program is implemented:

- **Increased health care utilization**: The subsidy program would cap health care expenditures when families and individuals reach the affordability limits in Table 1. Once they reach the spending limits, the rest of their health care expenditures would be paid for by the state. Studies have shown that people use more health care services and incur higher overall costs when they have lower (or no) cost sharing.[8] Providing subsidies for out of pocket costs would limit the effectiveness of many strategies that employers and health plans have adopted to contain costs.

- **Impact on overall health care costs**: The increased utilization explained above could cause an increase in premiums for employer coverage.

- **Employer response**: Because the subsidy program would be associated with increased take-up of employer coverage and potentially higher per-person premiums, some employers may take additional steps to contain costs. For example, these measures might include tightened eligibility standards or lower employer contributions to the cost of coverage.

- **Public program eligibility:** Eighty-five percent of the uninsured people who take up the subsidy when there is a waiting period are estimated to be already eligible for either Medical Assistance (MA) or General Assistance Medical Care (GAMC). Minnesota currently requires people to enroll in available employer coverage if they want to be covered by MA or GAMC.[9] With this approach, the state already receives federal matching payments for MA enrollees and leverages employer contributions to coverage when it is cost-effective. As a result, enrolling people who might be eligible for this new subsidy program into MA instead would cost the state less than enrolling them in the subsidy program. However, people who are eligible for MA and have not enrolled may be more reluctant to enroll in MA than in this new program.

[8] For example, a key finding from the 1970s RAND Health Insurance Experiment was that higher enrollee cost sharing reduces overall use of services and health care spending. Joseph P. Newhouse, (*Free for All? Lessons from the RAND Health Insurance Experiment)*, Harvard University Press, 1993.

[9] The requirement applies when it is determined that the employer coverage would be cost-effective (in other words, when it would result in lower costs to the state).

Appendix:

Report from Mathematica Policy Research, Inc.

MPR Reference No.: 6392

MATHEMATICA
Policy Research, Inc.

Analysis of Minnesota Affordability Proposal

Final Revised Report

December 22, 2008

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EXECUTIVE SUMMARY

Enacted in 2008, S.F.3780 charges the Commissioner of Health with developing a proposal to make health care affordable for individuals and workers at or below 300 percent of the federal poverty level (FPL). The law requires the proposal to target lower-income workers and their dependents who are offered job-based coverage and whose employers would pay at least 50 percent of the premium, called a qualifying offer of coverage.

The law requires that enrollees' total medical spending be capped at affordable levels. Eligible families would receive a subsidy or refundable tax credit when the sum of their premiums, cost-sharing, and out-of-pocket expenditures exceeds established affordability standards. This study considers two versions of this strategy, differing only in how they would account for current coverage, if any:

- One version would impose a waiting period for coverage. Low-income workers with a qualifying offer of coverage would be eligible for the subsidy program only if they have been uninsured for at least four months. Dependent children under age 21 become eligible through any working parent with a qualifying offer of coverage.
- A second version would require no waiting period. Low-income workers and dependents with a qualifying offer of coverage would immediately be eligible for the subsidy program. These would include workers and dependents who currently have employer-sponsored insurance.

To estimate the enrollment and cost of this proposal, we conducted a series of simulations that differ by (1) whether there is a waiting period required; and (2) whether the subsidy is paid immediately or it is delayed. The delayed subsidy payment assumes use of a refundable tax credit, so that payment of the subsidy is paid the following calendar year.

KEY ASSUMPTIONS

The estimates reflect a number of key assumptions, as follow:

- ***Administration of the subsidy.*** Workers who qualify for a subsidy based only on their contributions to premiums pay some amount toward premiums, but the program pays the balance of their contribution to premiums plus all out-of-pocket costs for health care services. Other workers pay all of their contribution to premiums, but receive a subsidy toward additional out-of-pocket costs.
- ***Motivation to take up coverage***. Uninsured workers and dependents who would face a reduced premium consider taking up employer-sponsored coverage. Those who would continue to pay the full premium (that is, their monthly premiums would be below the affordability standard) do not take up coverage in response only to the promise of a subsidy for additional out-of-pocket expenditure.

- ***Public coverage.*** Individuals with military coverage or who are currently enrolled in Medicaid, GAMC, or MinnesotaCare do not consider taking employer-based coverage even when eligible for the subsidy program.

- ***Enrollment in the subsidy program.*** All eligible Minnesotans who take employer coverage in response to the promise of a subsidy immediately enroll in the program. When no waiting period is required, eligible workers who are currently enrolled in group coverage immediately enroll in the subsidy program.

- ***Consumer rate of time preference.*** Workers with lower income discount the value of a delayed subsidy more than workers with higher income. Reflecting the relatively high likelihood of debt-financing for new expenditures, workers' rates of time preference reflect the rate of interest on consumer debt.

ELIGIBILITY FOR THE SUBSIDY PROGRAM

The proposed strategy would target a little less than half of the low- and moderate-income population under age 65. If required to wait four months to become eligible for the subsidy program, 89,000 people (5 percent of the population at or below 300 percent FPL) would be eligible. With no waiting period, 708,000 people would be eligible.

Not all of those who would be eligible for the subsidy program would have premiums and out-of-pocket expenses that exceed the affordability standard—and therefore would stand to benefit from enrolling. Families with income below 200 percent FPL are much more likely to see benefit from the program than families with greater income. Nearly all of eligible workers and dependents below 200 percent FPL would stand to benefit from the program.

EFFECTS ON COVERAGE

About half of the eligible population that have been uninsured for more than four months and have a credible offer of coverage would newly take up employer offered insurance with the subsidy program in place. At most—with an immediate subsidy and no waiting period for coverage—an estimated 60,000 Minnesotans would gain employer-based coverage. With a waiting period (and an immediate subsidy), approximately 46,000 Minnesotans would gain coverage. Most of the workers and dependents who would newly take up coverage when subsidized are currently eligible for Medicaid or GAMC, but not enrolled.

When the subsidy is delayed and a waiting period is required, approximately 6,000 fewer people who are uninsured (40,000 versus 46,000) would take up their current offer of employer coverage. With no waiting period for coverage, 9,000 fewer adults and children would take up employer coverage (51,000 versus 60,000).

Most of the estimated gain in employer-sponsored coverage would occur in firms with 51 to 100 employees or in self-insured plans, and these firms would experience the largest percentage increase in insured lives. However, even for these firms, the average increase would be small: with an immediate subsidy and no waiting period, enrollment of workers and dependents in these firms' health plans would increase by 6 percent.

IMPACT ON THE MIDDLE- AND LOW-INCOME POPULATION

Currently, nearly 16 percent of nonelderly Minnesotans with income at or below 300 percent FPL are uninsured, compared with 8 percent of the total nonelderly population. Either with or without a waiting period to become eligible, the proposed strategy would reduce the number of Minnesotans at or below 300 percent FPL who are uninsured by about three percentage points. Thirteen percent of Minnesotans with income at or below 300 percent FPL would remain uninsured. Most of those who would remain uninsured would be ineligible for the subsidy program.

IMPACT OF A WAITING PERIOD

A much larger number of workers and dependents would be immediately eligible if there were no waiting period required to claim a subsidy. In part reflecting the larger number of workers and dependents eligible for the program when no waiting period is required, over 10 times as many individuals enroll. The vast majority of those who would enroll were previously insured, almost all of them in an employer plan.

Requiring a waiting period would result not only in a much smaller program, but one that would serve nearly exclusively workers and dependents with income below 200 percent FPL. With no waiting period, many more workers and dependents would enroll, and most of the additional enrollees would have income above 200 percent FPL. As a result, in a program with no waiting period, workers and dependents with income above 200 percent FPL would account for half of total enrollment.

IMPACT OF DELAYED SUBSIDIES

When the payment of subsidies is delayed, the value to those who might benefit from the program is reduced. Most of the families eligible for the program consume all of their income, and many borrow to consume more than their income. Therefore, the prospect of paying for premiums would in effect mean taking on additional consumer debt.

Most of those who would enroll in the program with an immediate subsidy would also enroll with a delayed subsidy. In a program that would require a waiting period to enroll, 13 percent of those who would enroll with immediate payment would no longer enroll if payment were delayed. All of those who would no longer enroll would be in families with income below 200 percent FPL.

In a program with no waiting period, delayed payment of the subsidy would have much less relative impact on enrollment. In large part, this is because most additional enrollees who would enter the program are currently insured, and delaying payment would affect neither their coverage status nor their decision to enroll in the program. Just 3 percent of eligible workers and dependents would no longer enroll, of whom 60 percent are currently uninsured.

STATE EXPENDITURES

Estimated State expenditures for subsidies (excluding the cost of administering the program) would range from $194 million for a program with a waiting period, to $1.8 billion for a program with no waiting period, if subsidies were made immediately to enrollees. If subsidies were delayed, estimated State expenditures would range from $159 million (with a waiting period) to $1.7 billion (with no waiting period). Both cost estimates include the additional expenditures associated with induced demand when (1) workers and dependents who were uninsured become insured; and (2) those who are either currently or newly insured pay reduced (or no) out of pocket costs for care.

In a program with a waiting period and an immediate subsidy, the estimated average (per capita) subsidy would be 25 percent higher than in a program that does not requires a waiting period ($4,248 compared with $3,388), although many fewer workers and dependents would enroll. If the subsidy is delayed, the estimated average subsidy would be 21 percent higher ($4,021 compared with $3,319).

IMPLEMENTATION ISSUES

Implementing a program to limit total health care spending relative to income for workers with an employer offer of coverage would raise a number of issues relating both to the broader and unintended effects of the program and to the administration of the subsidies.

Unintended effects

Most of the people who would enroll in the program would reach the affordability cap solely on the basis of their contributions to premiums. For these people, all cost sharing that otherwise would constrain their use of care is reimbursed, and it is likely that they would respond by using more care. In turn, induced spending for health care services would increase premiums for group coverage, specifically in the mid-sized and larger group plans that would experience the greatest increase in enrollment. Although enrollment in employer coverage would increase by a relatively small amount (less than 2 percent across all firm sizes), the increased cost of the plan to any one employer could be greater.

Employers could respond to the prospect of higher premiums related to subsidized enrollees in a number of ways. For example, the surest way for employers to avoid the prospect of higher premiums would be to reduce their contributions so that they no longer pay at least 50 percent of the premium. However, several alternative responses might in fact be more likely.

For example, employers might review their plan eligibility rules to disqualify at least some workers who might be eligible for the subsidy. This response would further reduce the rate of employer offer, especially to low-wage workers—an outcome that would be the opposite of what the program intends. Alternatively, employers might turn to health plans with stricter cost management—especially for rank-and-file workers who would be most likely to qualify for the subsidy program. By paying for no care obtained outside a specified provider network, employers might limit (if not entirely avoid) paying for more services. However, to the extent

that employers would limit their own exposure to induced demand, the state's cost for subsidies might increase further.

Finally, employers might simply increase cost sharing for all workers to constrain growth in premiums. While this response would not affect utilization and cost among subsidized workers, it would reduce utilization and cost for all other workers—helping to hold the line on plan costs overall. In this case, out-of-pocket costs among workers who do not qualify for the subsidy program would increase.

Administration of the subsidy

States that have implemented subsidy programs to buy into group coverage—including Medicaid buy-ins—have accumulated experience that could be useful in considering how to subsidize workers directly for premiums as well as out-of-pocket costs for covered services. In general, enrollment in these programs is very low, and the states therefore have no real experience with managing high volume. However, programs with relatively high enrollment may offer some guidance about how to deliver premium assistance and subsidies to cover cost sharing directly.

For example, Rhode Island's RIteShare program offers premium assistance for Medicaid-eligible individuals and families with access to employer-sponsored health insurance that meets the state's coverage and cost-effectiveness criteria. In RIteShare, the state pays the employee's share of premiums, copayments, and wrap-around coverage for Medicaid benefits not in the employer's health plan, and operation of the program is streamlined for enrollees. Once RIteShare receives confirmation from the employer that the individual is enrolled, the enrollees receive the subsidy checks on or about when they are paid by their employers. Copayments and deductibles are billed to Medicaid as the secondary payer.

In Minnesota, a program that would directly subsidize workers could be operated along the same lines. The program would need to (1) initially and then periodically confirm that the employee is enrolled in coverage and the amount of the employee's contribution; and (2) confirm how often the employee is paid in order to time reimbursement checks as closely as possible to the pay date. The program might arrange to have providers bill the program directly as the secondary payer and, to the extent that the employee has cost-sharing obligations in addition to premium payments, reconcile the amount of that obligation against the amounts sent to enrollees to cover premiums. The staff required to operate a program—and in particular to reconcile cost sharing after payment of premiums—might be somewhat larger than the small staff that the RIteShare program retains solely to manage reimbursement for employee premium contributions.

Alternatively, the program could make payments to employers, avoiding the need for payroll deductions so that workers would not see a reduced paycheck to cover premiums before they are reimbursed. However, the level of employer cooperation that this requires can impede enrollment in the program.

To encourage employers to participate, states have found it necessary to minimize the burden of enrolling eligible workers. For example, prior to Massachusetts' 2006 reforms, the

State's Insurance Partnership program subsidized both low-income workers and their small employers. However, states like Iowa, Massachusetts, and Oregon—as well as Rhode Island—have found that few employers are willing to handle subsidy funds, so their programs make subsidy payments directly to workers. Also, making payment to employers may raise privacy concerns: employers would learn which employees were eligible (in effect, learning their level of family income), and potentially also the amount of their expenditures for health care.

The strategy proposed in Minnesota would subsidize both eligible workers' contribution to premiums and their out-of-pocket costs for health care. Funding out of pocket costs, especially, through employers would impose a significant administrative burden. However, in addition, it might violate workers' HIPAA privacy protections. Consequently, as in states like Rhode Island, it seems likely that Minnesota would need to pay eligible workers' out-of-pocket costs for health care services directly through the program, not through their employers.

Refundable tax credits

Refundable tax credits have been a feature of many proposals to reform national health care. In general, the principal argument against their use as the cornerstone of a health insurance system applies here: a delay in payment for premiums and cost sharing diminishes the value of the subsidy, and it diminishes value most for the lowest-income workers.

Experience with paying refundable tax credits in "real time" has been largely unsuccessful and also very costly. Specifically, the federal Health Care Tax Credit (HCTC) program for workers whose jobs are displaced by trade adjustments has attempted to make the HCTC available at the time individuals pay their monthly premiums—a feature known as advance payment. However, in the HCTC program, administrative costs consume roughly 34 percent of all national spending related to HCTC advance payment. If Minnesota attempted to develop a system of advance payment for out-of-pocket costs (in addition to premiums), the administrative cost would likely be still higher. Because out-of-pocket costs are not known at the beginning of the year, such a system would entail estimation of workers' out-of-pocket costs in advance, as well as reconciliation of expenditures at the end of the year, attempting to recapture overpayments.

Alternatively (accepting the negative effect of delayed payment on take up of coverage), implementation and administration of a refundable tax credits without advance payment could be relatively straightforward and inexpensive to administer. At least in principle, such a system could entail relatively little burden for either employers or employees.

I. INTRODUCTION

Enacted in 2008, S.F.3780 charges the Commissioner of Health with developing a proposal to make health care affordable for individuals and workers at or below 300 percent of the federal poverty level (FPL). Specifically, the law requires the proposal to target lower-income workers and their dependents who are offered job-based coverage and their employers pay at least 50 percent of the premium—in this report, called a qualifying offer of coverage.

The law requires that enrollees' total medical spending be capped at affordable levels. Eligible families would receive a subsidy or refundable tax credit when the sum of their premiums, cost-sharing, and out-of-pocket expenditures exceeds established affordability standards. These affordability standards are displayed in Table 1.

TABLE 1

PROPOSED AFFORDABILITY GUIDELINES

Family Income as a Percent of Poverty	Affordable Percent of Income for All Medical Expenditures
0 - 45%	$4 per person[a]
46 - 54%	1.1%
55 - 81%	1.6%
82 - 109%	2.2%
110 - 136%	2.9%
137 - 164%	3.6%
165 - 191%	4.6%
192 - 219%	5.6%
220 - 248%	6.5%
249 - 274%	7.2%
275 - 300%	8.0%

Source: 2008 Minnesota Laws, Chapter 358, Article 4, Sec. 14.

[a] By assumption, these workers would pay no premium. Out of pocket expenses are capped at the level of the minimum premium for MinnesotaCare.

This study considers two versions of the strategy outlined in S.F.3780. The versions differ only in how they would account for current coverage, if any:

- One version would impose a waiting period for coverage. Low-income workers with a qualifying offer of coverage would be eligible for the subsidy program only if they

have been uninsured for at least four months. Dependent children under age 21 become eligible through any working parent with a qualifying offer of coverage.[1]

- A second version of the proposal would require no waiting period. Low-income workers and dependents with a qualifying offer of coverage would immediately be eligible for the subsidy program. These would include workers and dependents who currently have employer-sponsored insurance.

The Minnesota Department of Health contracted with Mathematica Policy Research to provide estimates of the impact on coverage of these two proposals, as well as the fiscal impact on the state. The estimates provided in this report are based on a microsimulation model previously developed for the Minnesota Department of Health to estimate proposals to expand health coverage in Minnesota.[2]

To estimate the enrollment and cost of this proposal, we conducted a series of simulations, as follows:

- Simulation 1 estimates changes in coverage and the state cost assuming that a waiting period would be required to become eligible for the subsidy program. In this simulation, workers and dependents are eligible for the program only if they have been uninsured at least 4 months.

- Simulation 2 estimates changes in coverage and the state cost assuming that no waiting period would be required. This simulation allows eligible workers who are either enrolled in private coverage or uninsured to enroll in the subsidy program immediately. In addition, all workers currently enrolled in employer-based coverage would enroll in the subsidy program if their contribution to premiums exceeds the affordability standard or their out-of-pocket costs would be reduced.

Both simulations (1 and 2) assume that workers would receive a subsidy immediately. The subsidy might be administered as a program to which workers could apply for month-to-month reimbursement of expenditures for premiums and out-of-pocket costs. Alternatively, premium assistance could be administered through employers, although (as discussed in Chapter V) a separate program would likely be needed to pay eligible workers' other out-of-pocket costs.

A third alternative for administering subsidies could be through refundable tax credits. In this case, workers would pay all premiums and other medical expenses out-of-pocket, and then be reimbursed the following tax year. However, for low-income workers, this raises a particular problem. Nationally, low-income families have very low or negative rates of saving: that is, they

[1] The definition of a child for this provision parallels the MinnesotaCare statute in general (256L.01): "Child" means an individual under 21 years of age, including the unborn child of a pregnant woman, an emancipated minor, and an emancipated minor's spouse.

[2] The data and methods underlying this model are described in Appendix 1.

consume all (or nearly all) of their income and often borrow to finance additional consumption. Therefore, they are likely to finance any additional expenditure for insurance as consumer debt in the current year, either directly or indirectly. To estimate the effects of delayed payment, we developed a second set of simulations (3 and 4). This set of simulations discounts the perceived value of subsidies to workers who are not already enrolled in employer coverage, accounting for their current high rate of consumption relative to income.

II. KEY ASSUMPTIONS

Modeling the strategies entailed making a number of assumptions. Among these, the most important in terms of their effects on the results of the simulation are as follows:

- ***Administration of the subsidy.*** Some workers qualify for a subsidy based only on their contributions to premiums. When enrolled in the program, these workers pay some amount toward premiums, but the program pays the balance of their contribution to premiums plus all out-of-pocket costs for health care services. For other workers, the amount of their contribution to premiums alone does not qualify them for a subsidy. These workers pay all of their contribution to premiums, but receive a subsidy toward additional out-of-pocket costs.
- ***Motivation to take up coverage***. Uninsured workers and dependents who would face a reduced premium consider taking up employer-sponsored coverage. Those who would continue to pay the full premium (that is, their monthly premiums would be below the affordability standard) do not take up coverage in response only to the promise of a subsidy for additional out-of-pocket expenditure.[3]
- ***Public coverage.*** Individuals with military coverage or who are currently enrolled in Medicaid, GAMC, or MinnesotaCare do not consider taking employer-based coverage even when eligible for the subsidy program. However, individuals who are eligible but not enrolled in public programs do consider taking up employer-based coverage when eligible for the subsidy program.
- ***Enrollment in the subsidy program.*** All eligible Minnesotans are aware of the subsidy program, and those who take employer coverage in response to the promise of a subsidy immediately enroll in the program. Also, when no waiting period is required, eligible workers who are currently enrolled in group coverage immediately enroll in the subsidy program.
- ***Consumer rate of time preference.*** The rate at which workers discount the value of a delayed subsidy varies by family income: workers with lower income have a higher rate of time preference and, therefore, discount a delayed subsidy more than workers with higher income. Reflecting the relatively high likelihood of debt-financing for new expenditures, workers' rates of time preference reflect the rate of interest on consumer debt. We assume that the prospect of consumer debt-financing reduces workers' perceived value of the subsidy from 29 percent (for workers with income

[3] Assuming that only a reduction in premiums would trigger new take-up of an employer offer is consistent with the research literature, which shows no significant increase in worker take-up of coverage when cost sharing is lower, after controlling for premiums. See Daniel Polsky, Rebecca Stein, Sean Nicholson, and M. Kate Bundorf (October 2005). Employer Health Insurance Offerings and Employee Enrollment Decisions. Health Services Research 40(5), Part I: 1259-1277.

between 201 and 300 percent FPL) to 34 percent (for workers with income below 100 percent FPL).[4]

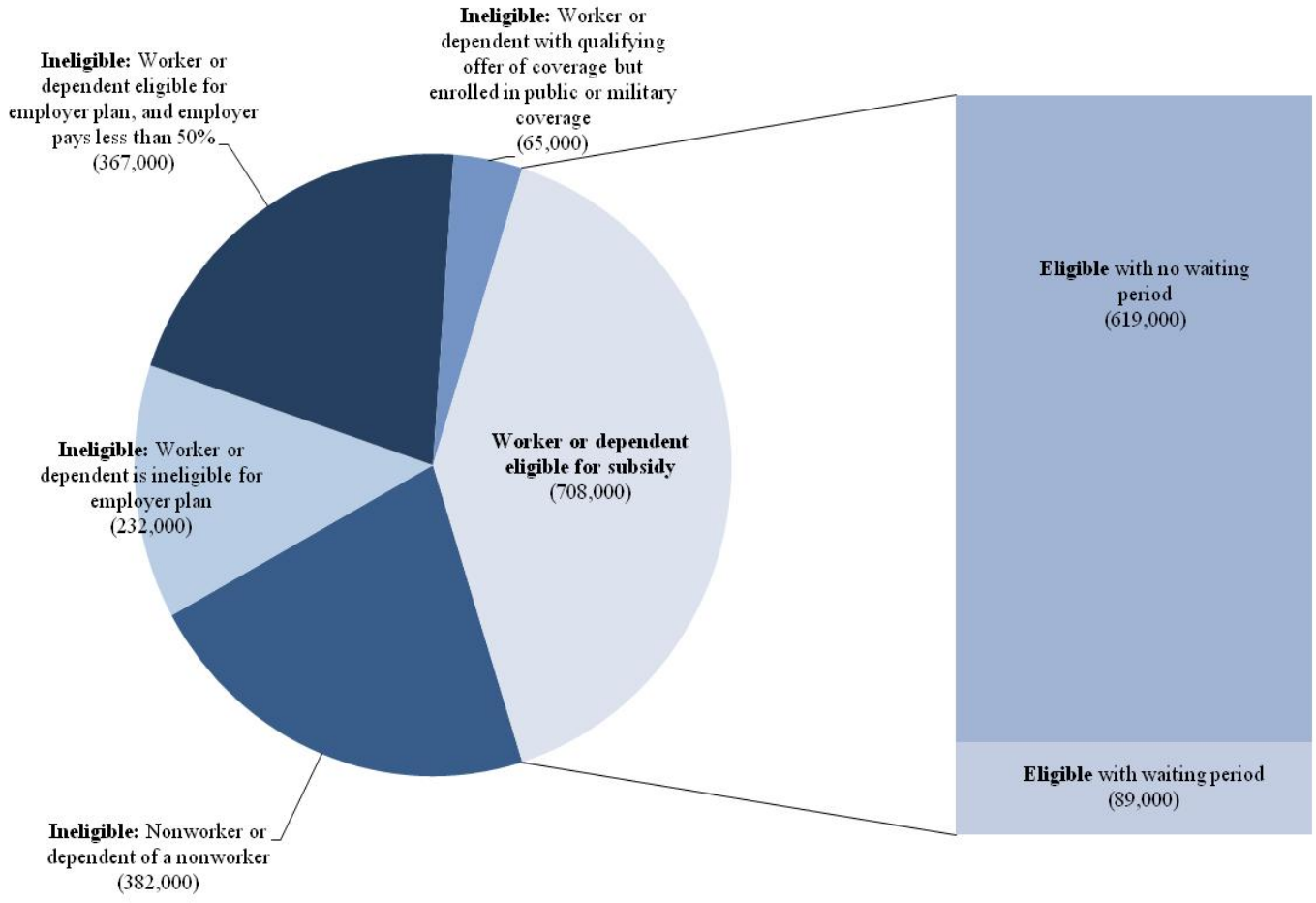
[4] These calculations are reported in Appendix A. Estimated rates of time preference by level of income were derived from: Emily C. Lawrence (1991), Poverty and the Rate of Time Preference: Evidence from Panel Data. Journal of Political Economy 99(1): 54-77. The rate of interest on consumer debt was derived from: Federal Reserve Statistical Release G.19: Consumer Credit, released October 7, 2008 (http://www.federalreserve.gov/releases/g19/Current/, accessed November 6, 2008).

III. ELIGIBILITY FOR THE SUBSIDY PROGRAM

The proposed strategy would target a little less than half of the low- and moderate-income population. Approximately 708,000 people (40 percent of the population at or below 300 percent of poverty) have a qualifying offer of coverage from an employer (Figure 1). If required to wait four months to become eligible for the subsidy program, 89,000 people (5 percent of the population at or below 300 percent FPL) would be eligible. With no waiting period, 708,000 people would be eligible.

FIGURE 1

ELIGIBILITY FOR SUBSIDY PROGRAM AMONG NON-ELDERLY MINNESOTANS AT OR BELOW 300 PERCENT FPL, FY 2009



Source: Mathematica Policy Research.

Notes: Details may not add to total due to rounding. Supporting tables are provided in Appendix B. Each category is mutually exclusive. The order of selection is: (1) nonworkers and dependents; (2) workers or dependents ineligible for employer plan; (3) workers or dependents eligible for employer plan with contribution less than 50 percent; (4) other workers or dependents with public or military coverage, if not included in earlier categories; (5) subsidy-eligible workers or dependents.

Not all of those who would be eligible for the subsidy program would have premiums and out-of-pocket expenses that exceed the affordability standard—and therefore would stand to benefit from enrolling. If a waiting period were required (so that all eligible people would have been uninsured for at least 4 months), 82 percent of eligible workers and dependents would stand to benefit from enrolling in the program (Table 2). With no waiting period (that is, also allowing recently uninsured or currently insured eligible workers and dependents to enroll in the program), 85 percent of eligible workers and dependents would stand to benefit.

TABLE 2

ESTIMATED NUMBER OF ELIGIBLE WORKERS AND DEPENDENTS BY FAMILY INCOME AND PERCENT WITH EXPENSES ABOVE THE AFFORDABILITY STANDARD, FY 2009

	Waiting period	No waiting period
Number eligible (thousands)		
Total	89	708
0-200 percent FPL	70	348
201-300 percent FPL	19	360
Number with premiums or out-of-pocket costs above the affordability standard (thousands)		
Total	73	601
0-200 percent FPL	68	324
201-300 percent FPL	5	277
Percent with premiums or out-of-pocket costs above the affordability standard		
Total	82%	85%
0-200 percent FPL	98%	93%
201-300 percent FPL	25%	77%

Source: Mathematica Policy Research.

Note: Detail may not add to totals due to rounding. Supporting tables are provided in Appendix B.

Families with income below 200 percent FPL are much more likely to see benefit from the program than families with greater income. Nearly all of eligible workers and dependents below 200 percent FPL would stand to benefit from the program (93 to 98 percent), regardless of whether the program was restricted to those who are uninsured (with a waiting period) or extended also to people who are recently uninsured or have coverage (no waiting period).

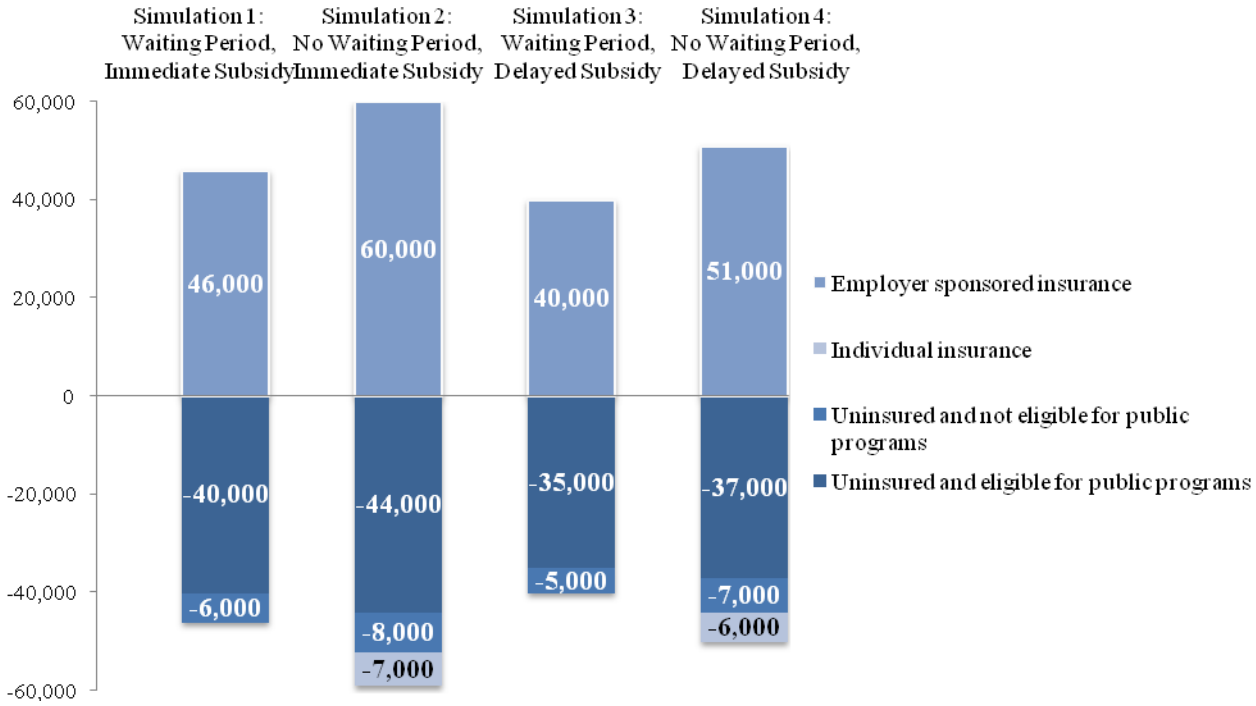
However, many fewer eligible workers and dependents with income above 200 percent FPL would stand to benefit. If the program is restricted to those who are uninsured (with a waiting period), just 19,000 people above 200 percent FPL would be eligible, and of these just 25 percent would see a benefit. If there was no waiting period, nearly twenty times more middle-income workers and dependents would be eligible (360,000), and a much larger percentage of them (77 percent) would stand to benefit if they enrolled.

IV. EFFECTS ON COVERAGE

Under this program, about half of the population that have been uninsured for more than four months and have a credible offer of coverage would newly take up employer offered insurance. At most—with an immediate subsidy and no waiting period for coverage (Simulation 2)—an estimated 60,000 Minnesotans would gain employer-based coverage (Figure 2). With a waiting period (Simulation 1), approximately 46,000 Minnesotans would gain coverage.

FIGURE 2

ESTIMATED CHANGE IN THE NUMBER OF MINNESOTANS WITH PRIVATE INSURANCE OR UNINSURED, FY 2009



Source: Mathematica Policy Research.

Notes: Detail may not add to totals due to rounding. Supporting tables are provided in Appendix B.

With no waiting period, some of those who would take up subsidized employer coverage currently have individual coverage. As a result, the increase in the number of Minnesotans with employer coverage would exceed the reduction in the number who are uninsured. However, the number of uninsured individuals newly taking up coverage far exceeds the number switching from individual to employer coverage.

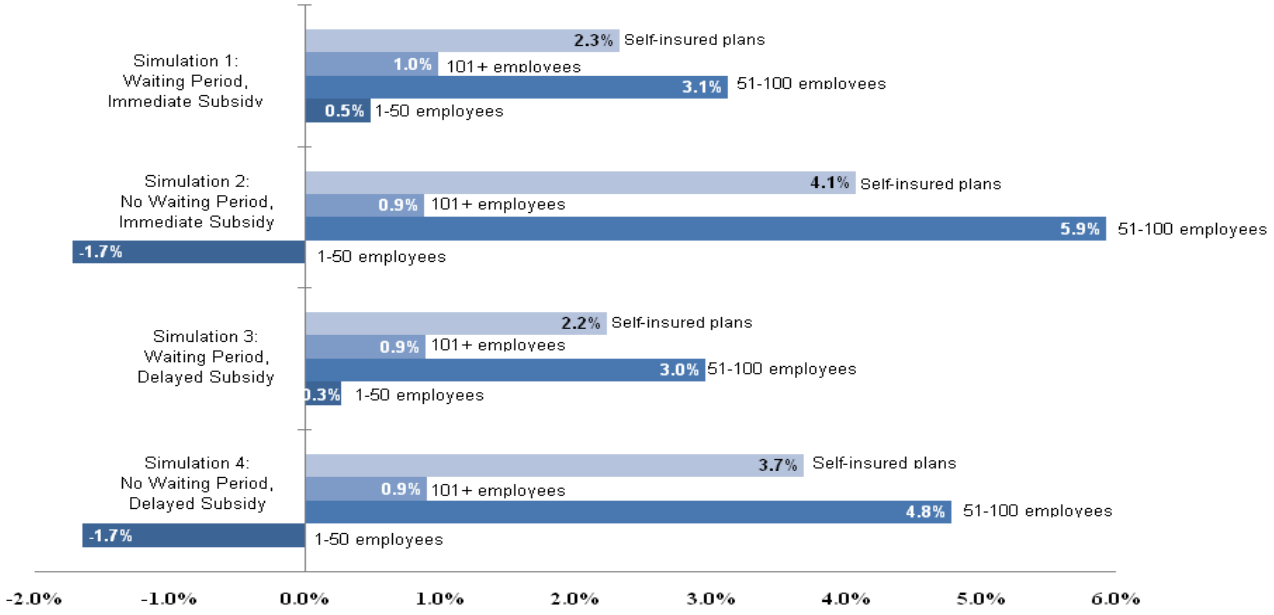
Note that most of the workers and dependents who newly take up coverage when subsidized are currently eligible for Medicaid or GAMC, but not enrolled. With a waiting period, more than 85 percent were eligible for Medicaid or GAMC but not enrolled (40,000 of the 46,000 newly covered); with no waiting period, 75 percent (44,000 of 60,000) were eligible but not enrolled.[5]

When the subsidy is delayed (that is, paid as a refundable tax credit in the year following coverage), fewer people who are uninsured would take up their current offer of employer coverage. Approximately 6,000 fewer workers and dependents would gain employer-based coverage (40,000 versus 46,000), when—in addition to a delayed subsidy—a waiting period is required (Simulation 3). With no waiting period for coverage (Simulation 4), 9,000 fewer adults and children would take up employer coverage (51,000 versus 60,000) when the subsidy is delayed than when a subsidy is immediately available.

Most of the estimated gain in employer-sponsored coverage would occur in mid-sized firms (with 51 to 100 employees) or in self-insured plans; and these firms would experience the largest percentage increase in insured lives (Figure 3). However, even for these firms, the average increase would be small: with an immediate subsidy and no waiting period, enrollment of workers and dependents in these firms' health plans would increase by 6 percent.

FIGURE 3

ESTIMATED PERCENTAGE CHANGE IN EMPLOYER-BASED COVERAGE BY SIZE OF FIRM, FY 2009



Source: Mathematica Policy Research.

Note: Supporting tables are provided in Appendix B.

[5] These estimates assume that workers and dependents who are eligible but not enrolled in public coverage may respond to the availability of the subsidy by enrolling in employer coverage but do not change decisions about whether to enroll in public coverage.

In addition, when there is no waiting period, some workers and their dependents would leave small-group coverage to enroll in the plan offered by a spouse's larger employer—increasing the take-up of coverage in larger and self-insured plans. In general, this result reflects employer contributions to family coverage that are lower as a percent of premiums than contributions to single coverage, even in plans where employers pay more than half of the premium.[6]

For workers and dependents who enroll in the program, their premiums and out-of-pocket costs would be significantly reduced. In the current case, workers pay an estimated average contribution to premiums of $123 per month for single coverage and $250 per month for family coverage (Table 3). Nearly one-third of group-insured workers (32 percent) pay more than 7 percent of family income for health care—including premium contributions and out-of-pocket expenses for medical care. Seventeen percent of workers pay more than 10 percent of their income for health care.

[6] Specifically, in families with two workers, each with an offer of coverage from their employer, each worker may take single coverage (or single plus children) rather than family coverage. However, under the proposed subsidy program (which caps medical expenditures only for those covered by the subsidized policy), these families would prefer family coverage—and to the extent that larger employers offer more comprehensive coverage, they would drop small-group coverage to take family coverage from a larger employer.

TABLE 3

ESTIMATED AVERAGE MONTHLY CONTRIBUTIONS TO COVERAGE AND TOTAL PAYMENTS AS A PERCENTAGE OF INCOME, FY 2009

		Immediate Subsidy				Delayed Subsidy			
		Simulation 1: Waiting period		Simulation 2: No waiting period		Simulation 3: Waiting period		Simulation 4: No waiting period	
	Current case	Workers with subsidy	Workers with no subsidy	Workers with subsidy	Workers with no subsidy	Workers with subsidy	Workers with no subsidy	Workers with subsidy	Workers with no subsidy
Average monthly employee contribution to premiums									
Single coverage	$123	$49	$123	$69	$126	$45	$123	$68	$126
Family coverage	$250	$74	$250	$167	$249	$78	$250	$168	$249
Average monthly out-of-pocket costs									
Single coverage	$78	$34	$78	$76	$82	$26	$78	$75	$82
Family coverage	$193	$86	$193	$146	$199	$86	$193	$146	$199
Percent of persons in families with contributions to premiums that are:									
Less than 7 percent of income	91%	94%	91%	95%	93%	93%	91%	95%	93%
7 to 10 percent of income	4%	--	4%	3%	4%	--	4%	3%	4%
More than 10 percent of income	5%	--	5%	--	4%	--	5%	--	4%
Income unknown [a]	--	6%	--	2%	--	7%	--	2%	--
Percent of persons in families with contributions to premiums and out-of-pocket costs that are: [a]									
Less than 7 percent of income	67%	94%	67%	84%	75%	93%	67%	84%	75%
7 to 10 percent of income	15%	--	15%	14%	14%	--	15%	14%	14%
More than 10 percent of income	17%	--	17%	--	11%	--	17%	--	11%
Income unknown [a]	1%	6%	1%	2%	--	7%	1%	2%	--

Source: Mathematica Policy Research.

Notes: Dashes indicate an estimate of fewer than 500 persons. Details may not add to total due to rounding.

[a] Persons who reported a qualifying offer of coverage and zero household income are reflected in the estimates as percentage unknown. These persons are assumed to have income less than 45 percent FPL for the purpose of defining their subsidy level.

With a waiting period, none of the workers who enroll in the program would pay more than 7 percent of family income for medical costs—a result that reflects the low family incomes of workers who would enroll and the subsidy schedule, which caps medical expenditures at a lower percentage of income when income is lower. When there is no waiting period, 14 percent of families would pay more than 7 percent of income, and 3 percent of families would pay more than 7 percent of their income towards premiums alone (before they pay additional out-of-pocket costs).

Among workers enrolled in the subsidy program, net average contributions to premiums (after subsidy) would range from approximately $45 for single coverage (in Simulations 1 and 3,

with a waiting period) to $69 (in Simulations 2 and 4, with no waiting period). Net average contributions to family coverage would range from approximately $75 per month (in Simulations 1 and 3) to $168 (in Simulations 2 and 4). When a waiting period is required, average contributions would be lower because only workers who qualify for premium assistance would enroll. In contrast, when no waiting period is required, some enrollees would qualify for premium assistance but others would receive subsidies toward only other out-of-pocket costs.

A. IMPACT ON THE MIDDLE- AND LOW-INCOME POPULATION

Currently, nearly 16 percent of nonelderly Minnesotans with income at or below 300 percent FPL are uninsured, compared with 8 percent of the total nonelderly population. Either with or without a waiting period to become eligible, the proposed strategy would reduce the number of Minnesotans at or below 300 percent FPL who are uninsured by 14 to 17 percent—equal to about three percentage points (Table 4).

TABLE 4

ESTIMATED NUMBER OF NON-ELDERLY MINNESOTANS AT OR BELOW 300 PERCENT FPL BY SOURCE OF COVERAGE AND PERCENTAGE CHANGE, FY2009

		Immediate subsidy		Delayed subsidy	
	Total	Simulation 1: Waiting period	Simulation 2: No waiting period	Simulation 3: Waiting period	Simulation 4: No waiting period
		Percent change in number of persons:			
Total population (thousands)	**1,754**	-	-	-	-
Employer coverage	743	6%	8%	5%	7%
Private employer	621	31%	23%	28%	21%
Public employer	96	5%	9%	2%	6%
COBRA	62	-	- 3%	-	- 3%
Individual insurance or MCHA	287	-	- 2%	-	- 2%
Uninsured	275	-17%	-19%	-14%	-16%
Medicaid eligible	196	-20%	-23%	-18%	-19%
Not Medicaid eligible	79	- 7%	-10%	- 6%	- 9%
Percent uninsured	*16%*	*13%*	*13%*	*13%*	*13%*
Percent uninsured and eligible for the subsidy program	-	*2.5%*	*3.1%*	*2.8%*	*3.6%*

Source: Mathematica Policy Research.

Notes: Supporting tables are provided in Appendix B. Dashes indicate no change.

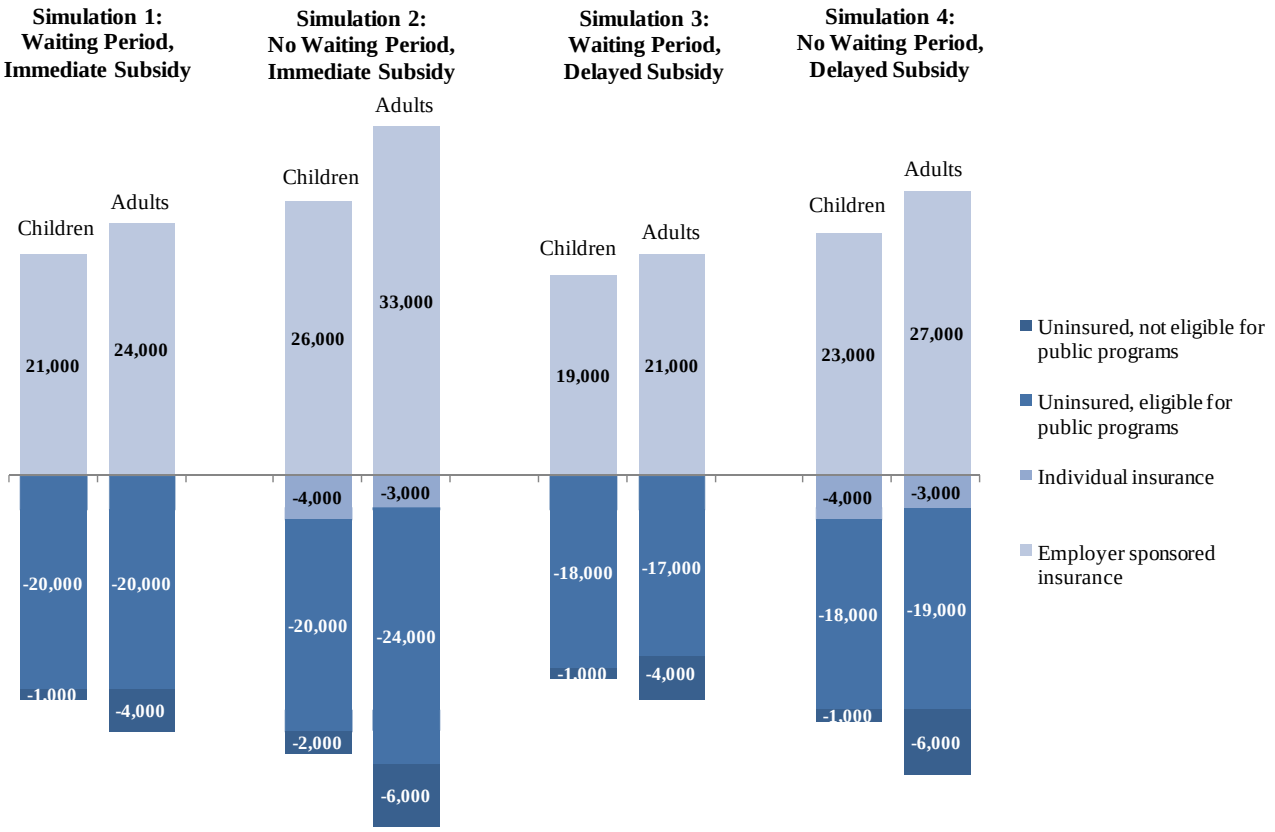
Thirteen percent of Minnesotans with income at or below 300 percent FPL would remain uninsured. Most of those who would remain uninsured would be ineligible for the subsidy program. Others would be eligible for the program, but the amount of the subsidy would not be sufficient to induce them to take up coverage. If the subsidy were large enough to induce everyone eligible to take up coverage, the uninsured population at or below 300 percent FPL

would fall an additional 2 to 4 percentage points—to about 10 percent of the population under age 65.

The impact of the program would be greater for adults than for children (Figure 4). At most, about 33,000 uninsured adults at or below 300 percent FPL would take up employer coverage (in Simulation 2), compared with 26,000 uninsured children. More than three-quarters of both children and adults who newly enroll in employer coverage under each simulation are currently eligible for Medicaid or GAMC but are not enrolled. The number of newly enrolled adults who were uninsured and *not* already eligible for a public program ranges from 4,000 (with a waiting period) to 6,000 (with no waiting period). Among newly enrolled children, just 1,000 to 2,000 were previously uninsured and also not eligible for a public program.

FIGURE 4

ESTIMATED CHANGE IN THE NUMBER OF CHILDREN AND ADULTS WITH COVERAGE: FAMILIES AT OR BELOW 300 PERCENT FPL, FY 2009



Source: Mathematica Policy Research.

Note: Supporting tables are provided in Appendix B.

B. IMPACT OF A WAITING PERIOD

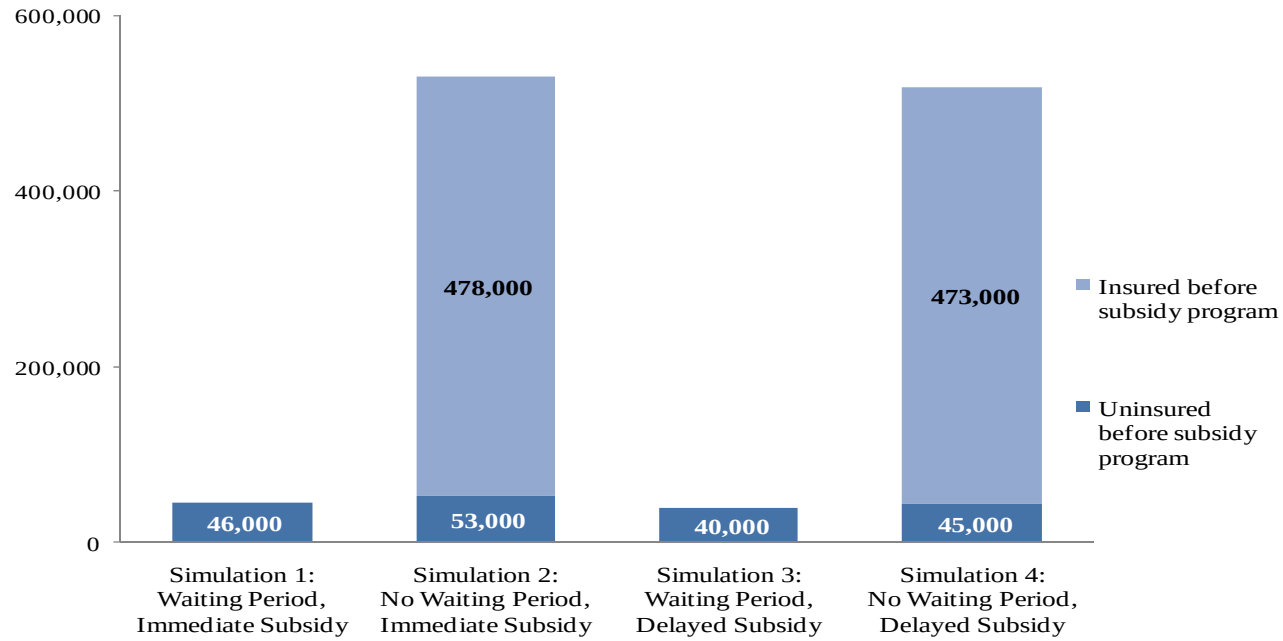
As noted already, a much larger number of workers and dependents would be immediately eligible if there were no waiting period required to claim a subsidy. These would include three categories of people:

- People who currently are uninsured, but have been uninsured less than 4 months.
- People with individual coverage—typically, a dependent who would enroll in a spouse's or parent's employer plan if the subsidy were available.
- People already enrolled in a qualifying employer plan and would qualify for a subsidy to help pay their contribution to premiums, out-of-pocket expenses for care, or both.

In part reflecting the larger number of workers and dependents eligible for the program when no waiting period is required (Simulations 2 and 4), over 10 times as many individuals enroll (Figure 5). The vast majority (478,000 of the 531,000 who enroll in Simulation 2) were previously insured, almost all of them in an employer plan (99 percent). Of course, when a waiting period is required, all of those who enroll (46,000 in Simulation 1) are currently uninsured.

FIGURE 5

ESTIMATED NUMBER OF ENROLLEES IN THE SUBSIDY PROGRAM BY PREVIOUS COVERAGE STATUS, FY 2009



Source: Mathematica Policy Research.

Note: Supporting tables are provided in Appendix B.

A program that would require a waiting period also would have a very different mix of enrollees by income level than a program with no waiting period. In large part, this is because relatively few workers and dependents above 200 percent FPL are currently uninsured and would be eligible for a program with a waiting period.

Requiring a waiting period would result not only in a much smaller program, but one that would serve nearly exclusively workers and dependents with income below 200 percent FPL. Nearly all (99 percent) of enrollees would have income below 200 percent FPL (Table 5). With no waiting period, many more workers and dependents would enroll, and most of the additional enrollees would have income above 200 percent FPL. As a result, in a program with no waiting period, workers and dependents with income above 200 percent FPL would account for half of total enrollment.

TABLE 5

ESTIMATED NUMBER AND PERCENT OF ENROLLEES BY FAMILY INCOME AS A PERCENT OF POVERTY, FY 2009

	Immediate Subsidy		Delayed Subsidy	
	Simulation 1: Waiting period	Simulation 2: No waiting period	Simulation 3: Waiting period	Simulation 4: No waiting period
Number enrolled (thousands)				
Total	46	531	40	517
0-200 percent FPL	45	267	39	258
201-300 percent FPL	--	264	--	260
Percent of enrollees				
Total	100%	100%	100.0%	100%
0-200 percent FPL	99%	50%	99%	50%
201-300 percent FPL	1%	50%	1%	50%

Source: Mathematica Policy Research.

Notes: Supporting tables are provided in Appendix B. Dashes indicate an estimate of fewer than 500 persons. Details may not add to totals due to rounding.

C. IMPACT OF DELAYED SUBSIDIES

When the payment of subsidies is delayed, the value to those who might benefit from the program is reduced. Most of the families eligible for the program consume all of their income, and many borrow to consume more than their income. Therefore, the prospect of paying for premiums would in effect mean taking on additional consumer debt.

The impact of a subsidy delayed for one year—approximating the impact of a refundable tax credit—versus immediate payment of the subsidy is summarized in Table 6. Most of those who would enroll in the program with an immediate subsidy would also enroll with a delayed subsidy. In a program that would require a waiting period to enroll, 13 percent of those who would enroll with immediate payment would no longer enroll if payment were delayed. All of those who would no longer enroll would be in families with income below 200 percent FPL.

TABLE 6

ESTIMATED NUMBER OF ENROLLEES AND PERCENT CHANGE WITH DELAYED SUBSIDY, FY 2009

	Number enrolled (thousands)		
	Immediate Subsidy	Delayed Subsidy	Percent change
Waiting period (Simulations 1 and 3)			
Total	46	40	-13%
0-200 percent FPL	45	39	-13%
201-300 percent FPL	--	--	--
No waiting period (Simulations 2 and 4)			
Total	531	517	-3%
0-200 percent FPL	267	258	-3%
201-300 percent FPL	264	260	-2%

Source: Mathematica Policy Research.

Notes: Supporting tables are provided in Appendix B. Dashes indicate an estimate of fewer than 500 persons or change less than 0.5 percent. Details may not add to totals due to rounding.

In a program with no waiting period, delayed payment of the subsidy would have much less relative impact on enrollment. In large part, this is because most additional enrollees who would enter the program would be insured already. Therefore, delaying payment would not affect their coverage status or their decision to enroll in the program. Just 3 percent of eligible workers and dependents would no longer enroll, of whom 60 percent are currently uninsured.

IV. STATE EXPENDITURES

Estimated State expenditures for subsidies (excluding the cost of administering the program) would range from $194 million for a program with a waiting period, to $1.8 billion for a program with no waiting period, if subsidies were made immediately to enrollees (Table 7). If subsidies were delayed, estimated State expenditures would range from $159 million (with a waiting period) to $1.7 billion (with no waiting period). Both cost estimates include the additional expenditures associated with induced demand when (1) workers and dependents who were uninsured become insured; and (2) those who are either currently or newly insured pay reduced (or no) out of pocket costs for care.

TABLE 7

ESTIMATED ANNUAL TOTAL AND PER CAPITA STATE EXPENDITURES, FY 2009

	Immediate Subsidy		Delayed Subsidy	
	Simulation 1: Waiting period	Simulation 2: No waiting period	Simulation 3: Waiting period	Simulation 4: No waiting period
State Expenditures (in millions)				
Total, all enrollees	$193.7	$1,789.0	$159.3	$1,705.0
0-100% FPL	$107.7	$460.0	$93.8	$425.0
101-200% FPL	$85.7	$752.0	$64.7	$725.0
201-300% FPL	$0.7	$570.0	$0.7	$554.0
Enrollees with premium assistance and OOP subsidies	$193.7	$1,468.0	$159.3	$1,384.0
Enrollees with OOP subsidies only	-	$321.0	-	$321.0
State Expenditure Per Enrollee				
Total, all enrollees	$4,248	$3,388	$4,021	$3,319
0-100% FPL	$5,286	$5,565	$5,321	$5,395
101-200% FPL	$3,443	$4,090	$3,006	$4,046
201-300% FPL	$1,578	$2,196	$1,578	$2,168
Enrollees with premium assistance and OOP subsidies	$4,248	$1,733	$4,021	$1,664
Enrollees with OOP subsidies only	-	$1,655	-	$1,655

Source: Mathematica Policy Research.

Notes: Dashes indicate an estimate that would be based on fewer than 500 persons.

The difference in the estimated cost of the program with or without a waiting period relates to the number of workers and dependents who would enroll as well as to differences in the per capita cost of subsidies. In a program with a waiting period and an immediate subsidy, the estimated average (per capita) subsidy would be 25 percent higher than in a program that does not requires a waiting period ($4,248 compared with $3,388), although many fewer workers and dependents would enroll. Of course, the higher per capita subsidy amount in a program with a

waiting period reflects the lower average family income of workers and dependents who would enroll in the program.

If the subsidy is delayed, the estimated average subsidy would be 21 percent higher ($4,021 compared with $3,319). This estimate reflects the reduced value of the subsidy especially to workers at the lowest income levels and, therefore, lower participation among those workers when the program has a waiting period. Because higher-income workers account for a slightly greater proportion of enrollment in the program when there is a waiting period (as well as when there is not), the per capita subsidy amounts are not as different as when the subsidy is immediate.

V. IMPLEMENTATION ISSUES

Implementing a program to limit total health care spending relative to income for workers with an employer offer of coverage would raise a number of issues relating both to the broader and unintended effects of the program and to the administration of the subsidies. The following sections briefly explore some of these issues.

A. SECOND-ORDER EFFECTS

The estimates presented in this report include the "induction" effects of insurance. Specifically, we assume that workers and dependents who would newly gain coverage use care in patterns that are similar to people with similar socioeconomic and health status characteristics who are currently insured.

In addition, the estimates reflect the induction effects on demand of eliminating enrollees' out-of-pocket costs for care. Most of the people who would enroll in the program would reach the affordability cap solely on the basis of their contributions to premiums. For these people, all cost sharing that otherwise would constrain their use of care is reimbursed, and it is likely that they would respond by using more care. Indeed, even people whose contributions to premiums are below the cap might respond to the prospect of a cap on expenditures by increasing their use of care. If so, induced health care expenditures would exceed our estimates, as would the state cost of subsidies.

Induced spending for health care services, in turn would increase premiums for group coverage. With a waiting period, the impact on premiums would be moderated only by the relatively small effect of the program on coverage: because enrollment would increase by a relatively small amount (less than 2 percent across all firm sizes), employers' cost exposure would be limited. However, even so, the increased cost of the plan to any one employer could be greater than the increase in enrollment overall. With no waiting period, as many as 20 percent of group-insured workers and dependents might enroll in the program and receive a subsidy, and the likely impact on premiums would be virtually unavoidable.

Employers could respond to the prospect of higher premiums related to subsidized enrollees in a number of ways. For example, the surest way for employers to avoid the prospect of higher premiums would be to reduce their contributions so that they no longer pay at least 50 percent of the premium. As a result, none of their workers would qualify for the subsidy. However, this might involve restructuring compensation for all workers. In addition, for many employers, reducing contributions below 50 percent of premiums might be infeasible. In the mid-sized market, especially, insurers may apply small-group rules, requiring a minimum employer contribution (as well as a minimum level of participation among eligible workers) for the group to qualify for coverage.[7]

[7] Minnesota defines minimum participation and contribution rules for small groups in statute. See: Minnesota Statutes 62L.03, subd. 3 (https://www.revisor.leg.state.mn.us/statutes/?year=2008&id=62L.03, accessed 11/29/08).

Consequently, several alternative responses might in fact be more likely. For example, employers might review their plan eligibility rules to disqualify at least some workers who might be eligible for the subsidy. This response would further reduce the rate of employer offer, especially to low-wage workers—an outcome that would be the opposite of what the program intends.

Alternatively, employers might turn to health plans with stricter cost management—especially for rank-and-file workers who would be most likely to qualify for the subsidy program. Such plans could include tightly managed care and exclusive provider organizations. By paying for no care obtained outside a specified provider network, employers might limit (if not entirely avoid) paying for more services. However, to the extent that employers would limit their own exposure to induced demand, the state's cost for subsidies might increase further.

Finally, employers might simply increase cost sharing for all workers to constrain growth in premiums. While this response would not affect utilization and cost among subsidized workers, it would reduce utilization and cost for all other workers—helping to hold the line on plan costs overall. In this case, out-of-pocket costs among workers who do not qualify for the subsidy program would increase.

B. ADMINISTRATION OF THE SUBSIDY

The discussion in this report assumes either of two general methods of implementation: (1) immediate payment of subsidies directly to workers or through their employers; or (2) delayed payment of subsidies, presumably as a refundable tax credit. Either method entails issues for implementation

1. Payments to workers

States that have implemented subsidy programs to buy into group coverage—including Medicaid buy-ins—have accumulated experience that could be useful in considering how to subsidize workers directly for premiums as well as out-of-pocket costs for covered services. In general, enrollment in these programs is very low, and the states therefore have no real experience with managing high volume. However, programs with relatively high enrollment may offer some guidance about how to deliver premium assistance and subsidies to cover cost sharing directly.

For example, Rhode Island's RIteShare program offers premium assistance for Medicaid-eligible individuals and families with access to employer-sponsored health insurance that meets the state's coverage and cost-effectiveness criteria. In RIteShare, the state pays the employee's share of premiums, copayments, and wrap-around coverage for Medicaid benefits not in the employer's health plan.[8] There is no minimum or maximum employer contribution.[9]

[8] Families with incomes up to 133 percent FPL receive RIteShare at no cost. Families with incomes between 133 percent and 250 percent FPL pay a monthly premium of $45, $86, $106 or $114 per month, depending on their income (http://www.dhs.state.ri.us/dhs/reports/rc_rs_fact_sheet_eng_10_08.pdf, accessed 11/10/08).

Operation of the program is streamlined for enrollees. Once RIteShare receives confirmation from the employer that the individual is enrolled, the program reimburses employees weekly, biweekly, or monthly, depending on the frequency of the employer's payroll. Enrollees receive the subsidy checks on or about when they are paid. Copayments and deductibles are billed to Medicaid as the secondary payer.[10]

In Minnesota, a program that would directly subsidize workers could be operated along the same lines. The program would need to (1) initially and then periodically confirm that the employee is enrolled in coverage and the amount of the employee's contribution; and (2) confirm how often the employee is paid in order to time reimbursement checks as closely as possible to the pay date. The program might arrange to have providers bill the program directly as the secondary payer and, to the extent that the employee has cost-sharing obligations in addition to premium payments, reconcile the amount of that obligation against the amounts sent to enrollees to cover premiums. The staff required to operate a program—and in particular to reconcile cost sharing after payment of premiums—might be somewhat larger than the small staff that the RIteShare program retains solely to manage reimbursement for employee premium contributions.[11]

2. Payments to employers

Payments to employers potentially would offer one major advantage to workers eligible for the program: it would avoid the need for payroll deductions so that workers would not see a reduced paycheck to cover premiums before they are reimbursed. However, the level of employer cooperation that this requires can impede enrollment in the program.

For example, Rhode Island's RIteShare program initially paid enrollees' premiums directly to their employers, who then paid the premium over to the health plan. However, employers perceived this process as burdensome, and RIteShare had only 275 enrollees at the end of the first year of operation. In late 2001, the state began to reimburse employees directly for the family's share of cost of the coverage, removing the burden from employers. Subsequently,

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(continued)

[9] Enrollment in RIteShare is mandatory for Medicaid-eligible individuals whose employers offer an approved health plan. As of July 2007, 1,572 employers had some history of an approved, cost-effective health plan and 781 employers had current employees who were participating in RIteShare, with 7,190 workers and dependents enrolled in the program. See: Gary D. Alexander, Rhode Island Department of Human Services, Annual Report on the Department of Human Services' Implementation of Programs to Address Uninsurance Among Rhode Islanders, February 15, 2008 (http://www.ritecare.ri.gov/documents/reports_publications/Annual%20Report%20re%20 uninsurance%20in%20RI.pdf, accessed 11/10/08).

[10] Claudia Williams, A Snapshot of State Experience Implementing Premium Assistance Programs, National Academy of State Health Policy, April 2003 (http://www.statecoverage.net/statereports/multi19.pdfm, accessed 11/10/08).

[11] Tricia Leddy, Rhode Island Department Human Service Center for Child and Family Health, Premium Assistance: Opportunities and Challenges Implementing Rhode Island's RIteShare Program, August 5, 2002 (http://www.statecoverage.net/statereports/ri21.pdf, accessed 11/11/08.

employer participation increased sharply; enrollment jumped to more than 2,000 from January to June 2002 and doubled to 4,000 by May of 2003.[12]

To encourage employers to participate, states have found it necessary to minimize the burden of enrolling eligible workers: in general, payroll management is complicated, and attempting to build in special treatment for premium assistance recipients makes it more so. To the extent they have succeeded, states that make payments to the employer have needed to find ways to make the program streamlined for participating employers.[13]

For example, prior to Massachusetts' 2006 reforms, the State's Insurance Partnership program subsidized both low-income workers and their small employers. For employers that went through a "billing and enrollment intermediary" (BEI) to obtain coverage, the State paid the subsidy to the BEI, which then adjusted its billing to the employer. Other employers received a check directly from the State through an Insurance Partnership contractor; these employers adjusted the health insurance payroll deduction for the employee to reflect the subsidy payment.[14] States like Iowa, Massachusetts, and Oregon—as well as Rhode Island—have found that few employers are willing to handle subsidy funds, so their programs make subsidy payments directly to workers.

Finally, making payment to employers may raise privacy concerns: employers would learn which employees were eligible (in effect, learning their level of family income), and potentially also the amount of their expenditures for health care. In transitioning from paying employers to paying workers, Rhode Island's RIteShare program noted the advantage of making individual employee participation invisible to employers, thereby preserving workers' confidentiality.

The strategy proposed in Minnesota would subsidize both eligible workers' contribution to premiums and their out-of-pocket costs for health care. Funding out of pocket costs, especially, through employers would impose a significant administrative burden. However, in addition, it might violate workers' HIPAA privacy protections. Consequently, as in states like Rhode Island, it seems likely that Minnesota would need to pay eligible workers' out-of-pocket costs for health care services directly through the program, not through their employers.

[12] National Health Policy Forum, Doing It RIte: Exploring a Decade of Health Coverage Innovation, May 2003 (http://www.statecoverage.net/statereports/ri26.pdf, accessed 11/10/08).

[13] In addition to the prospect of administrative complexity and burden, businesses may be concerned about aspects of premium assistance that may seem unfair to them or to their workers. For example, they may object to a program that would provide assistance only to uninsured workers who turned down employer coverage, and deny or delay assistance to otherwise-identical workers who have been paying to participate in the employer's plan. See: Ed Neuschler and Rick Curtis, Premium Assistance: What Works? What Doesn't? Institute for Health Policy Solutions, April 2003 (http://www.statecoverage.net/statereports/multi20.pdf, accessed 11/10/08).

[14] See: Ed Neuschler and Rick Curtis, *Ibid.*

3. Refundable tax credits

Refundable tax credits have been a feature of many proposals to reform national health care. In general, the principal argument against their use as the cornerstone of a health insurance system applies here: a delay in payment for premiums and cost sharing diminishes the value of the subsidy, and it diminishes value most for the lowest-income workers.

Experience with paying refundable tax credits in "real time" has been largely unsuccessful and also very costly. Specifically, the federal Health Care Tax Credit (HCTC) program for workers whose jobs are displaced by trade adjustments has attempted to make the HCTC available at the time individuals pay their monthly premiums—a feature known as advance payment. Advance payment is intended to ensure that individuals do not have to pay the full premiums themselves and wait to be reimbursed until they file their tax returns the following year. Despite the availability of advance payment, take up has been low—in part due to implementation rules that, if replicated in Minnesota's proposed subsidy program for employed workers, might have a less chilling effect on health plan enrollment.[15]

However, one aspect of the HCTC experience is an important consideration for any program that would attempt advance payment of refundable tax credits: the administrative cost can be high. In the HCTC program, administrative costs consume roughly 34 percent of all national spending related to HCTC advance payment. If Minnesota attempted to develop a system of advance payment for out-of-pocket costs (in addition to premiums), the administrative cost would likely be still higher. Because out-of-pocket costs are not known at the beginning of the year, such a system would entail estimation of workers' out-of-pocket costs in advance, as well as reconciliation of expenditures at the end of the year, attempting to recapture overpayments.

Alternatively (accepting the negative effect of delayed payment on take up of coverage), implementation and administration of a system of refundable tax credits without advance payment could be relatively straightforward and inexpensive to administer. At least in principle, such a system could entail relatively little burden for either employers or employees. For employers, it likely would entail some new reporting to both employees and to the State. Both would need to receive information about employer and employee contributions to health insurance during the calendar year. Employers typically report payroll deductions to employees, but they often do not report the amount of the employer contribution to premiums. Nor do they report to the State the amount that either the employer or employee contributes to premiums. For employees to obtain reimbursement for out-of-pocket expenses, it would be necessary to retain all medical bills and proof of payment in order to claim the refundable credit.

[15] The Internal Revenue Service created a significant barrier to the effective use of advance payments by requiring individuals (who qualify for the HCTC by virtue of having been displaced from employment) to pay at least one month's premium out-of-pocket before receiving any advance payment. This rule—in addition to the HCTC covering just 65 percent of premiums—has resulted in very low take up. In 2007, just 16,000 workers claimed the HCTC; no more than 15 percent of eligible workers and their families participate. See: Stan Dorn, Health Coverage Tax Credits: A Small Program Offering Large Policy Lessons, February 2008 (http://www.urban.org/UploadedPDF/411608_health_coverage_tax.pdf, accessed 11/10/08).

APPENDIX A: DATA AND METHODS

The estimates of the impact of the proposed policies on coverage are based on a microsimulation model developed for the state of Minnesota in 2008. The model uses data from the 2004 Minnesota Health Access Survey (MNHA), which are reweighted to reflect key results of the 2007 MNHA survey. These data are "aged" to FY 2009 by adjusting weights to reflect likely changes in the population; contributions to health insurance are rescaled to reflect the projected cost of health insurance in FY 2009.[16] The MNHA data consist of survey responses obtained from a "target" in each household, as well as a limited information obtained about other family members. The microsimulation is conducted at the target-level, but information from other family members is used to describe demographic characteristics of the household and insurance coverage (for example, a target's spouse or parent may be the insurance policy-holder in the family).

For the current simulations, additional data from the Medical Expenditure Panel Survey (MEPS) on out-of-pocket expenditures for each family member was matched to each target record controlling for the target's (or family member's) age, race, gender, firm size, income, and coverage type (single or family), as well as the costs experienced by other family members.[17] These MEPS records represent the expenditure experiences of individuals who had employer-based coverage for the entire year. The average monthly out-of-pocket expenditures per family member was calculated by summing the out-of-pocket costs for everyone covered by the policy, and distributing the total cost equally across family members, including the target.

For Simulations 1 and 3 (the program with a waiting period), an eligibility flag indicating whether they had been uninsured for 4 months or longer was assigned to (1) each uninsured adult target (age 21 or older) with family income at or below 300 percent FPL, and (2) children between 150 and 300 percent FPL. The assignment was random, controlling for estimates provided by the Minnesota Department of Health measuring the percentage of adults and children (by FPL) that were uninsured less than 4 months or 4 months or longer in the 2007 MNHA. Targets aged 0 to 20 in households with family income under 150 percent FPL were flagged as eligible, regardless of length of time uninsured; these criteria are the same as for MinnesotaCare.

[16] Creation of the microsimulation database is described in: Deborah Chollet, et al., "Health Insurance Exchange Study: Final Report," March 27, 2008 (http://www.mathematica-mpr.com/publications/PDFs/healthinsexchange.pdf, accessed 11/29/08). The database was updated to control totals derived from the 2007 MNHA, as documented in: Deborah Chollet, et al., "Updated Simulation Estimates," Memorandum, June 30, 2008.

[17] The set of all MEPS records that represented individuals with 12 months of employer coverage was divided into tertiles based on total medical spending during the year. The ratio of out-of-pocket spending to total medical spending was rank-ordered, and each tertile was further divided to create 9 cells, reflecting combinations of high, medium, and low total and out-of-pocket spending, respectively. The random assignment was constrained to selecting MEPS records for each family member from within the same cell as the target.

The model estimates the effect of the policy change by predicting how the subsidy would affect the price of premiums among the eligible population. The premium change, in turn, drives a changes in the probability that individuals will take-up employer coverage. The difference between the number of low-income individuals who take up employer coverage in the current case and the number who take up coverage in each simulation is the impact of each proposed policy on coverage. The fiscal impact of the policy to the state is calculated as the difference between the capped level of spending for each enrolled individual (based on family income) and the sum of premiums and out-of-pocket expenditures they would face without the subsidy. Administrative costs associated with implementing and running the subsidy program are not included in the cost estimates.

The estimates include the "second order" effects of (1) uninsured individuals gaining coverage; and (2) both newly and currently insured individuals confronting reduced (or no) cost-sharing once their expenditures relative to income reached the affordability cap. For every dollar reduction in out-of-pocket costs for individuals receiving a subsidy, we assume an additional $0.62 in demand for medical services is induced. This estimate was calculated as the weighted average of induction factors by type of service derived from the RAND Health Insurance Experiment.[18] Weights were calculated as the proportion of national medical spending among people under 65 by type of service (excluding vision and dental) as reported in the Household Component of the 2005 MEPS.

In preparing the microsimulation database, we estimated for each potential policy-holder (i.e., those workers who were offered and eligible for employer coverage) a required premium contribution; the price-elasticity of demand for employer coverage was estimated on this premium contribution, controlling for employment and demographic characteristics. The same estimates were used in the simulations for this report.

The essential logic of the simulations is as follows: The maximum affordable medical expenditure per month was calculated for each eligible target, based on the affordability standard in Table 1. If the target's premium contribution exceeded the affordable monthly medical expenditure, his premium contribution was reduced to that value. No change in premium contribution was calculated if the target's premium contribution was less than the affordable monthly medical expenditure. Take-up was re-estimated only for targets whose premium contributions were reduced.

The first set of simulations assumes that the subsidies to reduce the employee's share of the premium are paid immediately, either directly to workers or through their employers. Simulation 1 allowed the target to take a subsidy only if: (1) he had been uninsured for at least 4 months; or (2) was an otherwise-eligible child in a family at or below 150 percent FPL. In Simulation 2, all

[18] See: Edwin C. Hustead et al., "Medical Savings Accounts: Cost Implications and Design Issues." Washington, DC: American Academy of Actuaries, May 1995 (http://www.actuary.org/pdf/health/msa_cost.pdf, accessed 11/29/08). Some services, such as those delivered in an inpatient hospital, are less sensitive to cost sharing, and are estimated to increase demand by $0.30 for each dollar reduction in out-of-pocket costs. However, services such as prescription drugs are more sensitive to cost sharing and are expected to increase demand for services by $1.00 for each $1.00 reduction in out-of-pocket costs.

targets who meet the income and employment requirements, or live in a family with an employed family member who meets the requirements, can take the subsidy.

Simulations 3 and 4 assume that subsidies are received the following calendar year, in the form of a refundable tax credit to employees. Under this assumption, the value of the subsidy is reduced to account for the rate of time preference, as well as the fact that households will need to finance premium costs through consumer credit during the year before receiving the tax rebate in the following year.[19, 20] The reduced value of the subsidy is used to re-estimate the probability that eligible individuals without employer-based insurance will take it up. Targets already covered by employer-based insurance are assumed to be unaffected by the timing of the subsidy.

[19] The value of the discount factor for rate of time preference is drawn from Lawrence (1991), *Ibid*. Families at or below 100 percent FPL were assigned the discount rate of households at the 10th income percentile, while families between 101 and 200 percent FPL were assigned the discount rate of households at the 25th income percentile, and households between 201 and 300 percent FPL were assigned the discount rate of households at the 50th income percentile..

[20] Nationally, households below 300 percent FPL have a negative savings rate (Cashell 2005). As a result, the model presumes that households who cannot afford premiums under the base case will only take up employer insurance under the simulations if they are able to finance the premiums that would be paid by the subsidy on consumer credit. The average national rate of interest in August 2008 for interest-bearing credit card accounts was 13.6 percent (Federal Reserve Board 2008), or roughly double the cost of borrowing assumed in Lawrence (1991), *Ibid*. To account for this increase in the cost of borrowing, the discount rates for rate of time preference were all multiplied by 2.3. The adjusted time preference discount was 34 percent for households below 100 percent FPL, 32 percent for households between 101 and 200 percent FPL, and 29 percent for households between 201 and 300 percent FPL.

APPENDIX B

TABLES B.1 – B.7

Table B1. Estimated Number of Insured and Uninsured Non-Elderly Minnesotans, by Source of Coverage: Current Case and Policy Simulations, FY2009

		Immediate Subsidy				Delayed Subsidy			
		Simulation 1: Waiting Period		Simulation 2: No Waiting Period		Simulation 3: Waiting Period		Simulation 4: No Waiting Period	
	Current Case (thousands)	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case
Total Population	**4,597**	**4,597**	**-**	**4,597**	-	**4,597**	-	**4,597**	-
Employer sponsored insurance	**3,205**	**3,250**	**1.4%**	**3,264**	**1.9%**	**3,244**	**1.2%**	**3,255**	**1.6%**
Private employer									
Self-insured Plans	1,070	1,094	2.3%	1,113	4.1%	1,093	2.2%	1,109	3.7%
Insured Plans									
Self-employed	48	48	-	47	- 2.7%	48	-	48	- 1.6%
2-10 employees	180	180	0.4%	176	- 2.1%	180	-	175	- 2.5%
11-50 employees	287	289	0.6%	284	- 1.3%	289	0.5%	284	- 1.1%
51-100 employees	194	200	3.1%	206	5.9%	200	3.0%	204	4.8%
101 or more employees	741	748	1.0%	747	0.9%	747	0.9%	747	0.9%
Unknown firm size	106	106	-	106	-	106	-	106	-
Government employee plan[a]	516	522	1.0%	525	1.7%	519	0.4%	522	1.2%
COBRA	62	62	-	60	- 3.1%	62	-	60	- 3.1%
Individual private insurance	**287**	**287**	**-**	**280**	**- 2.4%**	**287**	**-**	**280**	**- 2.2%**
MCHA	29	29	-	28	- 1.2%	29	-	29	- 0.8%
Other private insurance	258	258	-	251	- 2.5%	258	-	252	- 2.4%
Public program	**639**	**639**	**-**	**639**	**-**	**639**	**-**	**639**	**-**
Medicaid or GAMC	511	511	-	511	-	511	-	511	-
MinnesotaCare	129	129	-	129	-	129	-	129	-
Military	**99**	**99**	**-**	**99**	**-**	**99**	**-**	**99**	**-**
Uninsured	**368**	**323**	**-12.4%**	**316**	**-14.3%**	**329**	**-10.7%**	**324**	**-12.1%**
Medicaid/MinnesotaCare eligible	196	156	-20.4%	152	-22.7%	161	-17.8%	159	-19.0%
Not Medicaid/MinnesotaCare eligible, at or below 300% FPL	79	73	- 7.2%	71	-10.5%	74	- 6.0%	72	- 9.2%
Not Medicaid/MinnesotaCare eligible, over 300% FPL	93	93	-	93	-	93	-	93	-

Source: Mathematica Policy Research.

Notes: Dashes indicate an estimate of fewer than 500 persons or change less than 0.05 percent. Details may not add to totals due to rounding.

Table B2. Estimated Number of Insured and Uninsured Non-Elderly Minnesotans At or Below 300 Percent FPL by Source of Coverage: Current Case and Policy Simulations, FY2009

		Immediate Subsidy				Delayed Subsidy			
		Simulation 1: Waiting Period		Simulation 2: No Waiting Period		Simulation 3: Waiting Period		Simulation 4 No Waiting Period	
	Current Case (thousands)	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case
Total Population	**1,754**	**1,754**	**-**	**1,754**	-	**1,754**	-	**1,754**	-
Employer sponsored insurance	**743**	**789**	**6.1%**	**803**	**8.0%**	**783**	**5.3%**	**794**	**6.8%**
Private employer									
Self-insured Plans	211	236	11.7%	255	20.6%	235	11.3%	251	18.6%
Insured Plans									
Self-employed	12	12	0.0%	11	-10.6%	12	0.0%	12	-6.1%
2-10 employees	52	53	1.4%	49	-7.1%	52	0.0%	48	-8.6%
11-50 employees	73	75	2.3%	69	-5.2%	74	1.8%	70	-4.4%
51-100 employees	52	58	11.6%	64	22.0%	58	11.0%	62	17.8%
101 or more employees	181	188	4.0%	187	3.6%	187	3.6%	187	3.6%
Unknown firm size	39	39	0.0%	39	0.0%	39	0.0%	39	0.0%
Government employee plan	96	101	5.4%	105	9.3%	98	2.3%	102	6.2%
COBRA	26	26	0.0%	24	-7.4%	26	0.0%	24	-7.4%
Individual private insurance	**138**	**138**	**0.0%**	**131**	**-5.0%**	**138**	**0.0%**	**132**	**-4.6%**
MCHA	15	15	0.0%	14	-2.3%	15	0.0%	15	-1.6%
Other private insurance	123	123	0.0%	117	-5.3%	123	0.0%	117	-4.9%
Uninsured	**275**	**229**	**-16.6%**	**222**	**-19.2%**	**235**	**-14.4%**	**231**	**-16.2%**
Medicaid/MinnesotaCare eligible	196	156	-20.4%	152	-22.7%	161	-17.8%	159	-19.0%
Not Medicaid/MinnesotaCare eligible	79	73	-7.2%	71	-10.5%	74	-6.0%	72	-9.2%

Source: Mathematica Policy Research.

Notes: Dashes indicate an estimate of fewer than 500 persons or change less than 0.05 percent. Details may not add to totals due to rounding.

Table B2(A). Estimated Number of Insured and Uninsured Non-Elderly Minnesotans At or Below 300 Percent FPL, by Principal Source of Coverage: Current Case and Policy Simulations, FY2009

	Current Case		Simulation 1 Waiting Period		Simulation 2: No Waiting Period		Simulation 3: Waiting Period		Simulation 4: No Waiting Period	
	Children (age 0-20)	Adults (age 21-64)	Children (age 0-20)	Adults (age 21-64)	Children (age 0-20)	Adults (age 21-64)	Children (age 0-20)	Adults (age 21-64)	Children (age 0-20)	Adults (age 21-64)
Total Population	**714**	**1,040**	**714**	**1,040**	**714**	**1,040**	**714**	**1,040**	**714**	**1,040**
Employer sponsored insurance	**273**	**471**	**294**	**495**	**299**	**504**	**291**	**491**	**296**	**498**
Private employer										
Self-insured Plans	68	144	77	159	84	171	77	158	83	167
Insured Plans										
Self-employed	9	3	9	3	9	2	9	3	9	2
Firms with 2-10 employees	27	26	27	26	26	22	27	26	26	22
Firms with 11-50 employees	30	43	31	43	28	41	31	43	28	41
Firms with 51-100 employees	21	32	24	34	25	39	24	34	24	37
Firms with 101 or more employees	58	123	62	126	62	125	62	125	62	125
Unknown firm size	18	21	18	21	18	21	18	21	18	21
Government employee plan[a]	33	64	35	66	38	67	33	65	36	66
COBRA	10	16	10	16	9	14	10	16	9	14
Individual private insurance	**37**	**101**	**37**	**101**	**33**	**98**	**37**	**101**	**34**	**98**
MCHA	1	13	1	13	1	13	1	13	1	13
Other private insurance	36	87	36	87	32	84	36	87	32	85
Uninsured	**85**	**190**	**63**	**166**	**62**	**160**	**66**	**170**	**65**	**166**
Medicaid/MinnesotaCare eligible	67	129	47	109	47	105	49	112	49	110
Not Medicaid/MinnesotaCare eligible	17	61	16	57	15	55	17	57	16	56

Source: Mathematica Policy Research.

Table B3. Estimated Number of Insured and Uninsured Non-Elderly Minnesotans At or Below 300 Percent FPL by Selected Personal Characteristics: Current Case and Policy Simulations, FY2009

		Immediate Subsidy				Delayed Subsidy			
		Simulation 1: Waiting Period		Simulation 2: No Waiting Period		Simulation 3: Waiting Period		Simulation 4: No Waiting Period	
	Current Case (thousands)	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case
Total Population (nonmilitary coverage)	1,717	1,717	-	1,717	-	1,717	-	1,717	-
Adults age 18-64									
0-100% FPL	339	339	-	339	-	339	-	339	-
101-200%	384	384	-	384	-	384	-	384	-
201-300%	385	385	-	385	-	385	-	385	-
Children age 0-17									
0-100% FPL	186	186	-	186	-	186	-	186	-
101-200%	240	240	-	240	-	240	-	240	-
201-300%	183	183	-	183	-	183	-	183	-
Work status									
Full-time worker	652	652	-	652	-	652	-	652	-
Part-time worker	55	55	-	55	-	55	-	55	-
Unemployed/non-worker	401	401	-	401	-	401	-	401	-
Children	609	609	-	609	-	609	-	609	-
Region									
North	385	385	-	385	-	385	-	385	-
Central	253	253	-	253	-	253	-	253	-
Twin Cities	750	750	-	750	-	750	-	750	-
South	329	329	-	329	-	329	-	329	-
Health Status									
Good, fair or poor	556	556	-	556	-	556	-	556	-
Excellent or very good	1,150	1,150	-	1,150	-	1,150	-	1,150	-
Unknown	11	11	-	11	-	11	-	11	-
Private group coverage	**743**	**789**	**6.1%**	**803**	**8.0%**	**783**	**5.3%**	**794**	**6.8%**
Adults age 18-64									
0-100% FPL	72	86	19.9%	88	22.0%	86	18.6%	87	20.7%
101-200%	162	181	11.4%	185	14.3%	178	9.4%	182	11.9%
201-300%	274	274	0.1%	279	1.6%	274	0.1%	277	0.9%
Children age 0-17									
0-100% FPL	18	24	33.6%	25	40.4%	22	23.5%	23	30.3%
101-200%	91	97	7.0%	99	8.8%	97	6.9%	99	8.7%
201-300%	126	126	0.1%	127	0.7%	126	0.1%	127	0.6%

Table B3 *(continued)*

		Immediate Subsidy				Delayed Subsidy			
		Simulation 1: Waiting Period		Simulation 2: No Waiting Period		Simulation 3: Waiting Period		Simulation 4: No Waiting Period	
	Current Case (thousands)	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case
Work status									
Full-time worker	386	403	4.5%	406	5.4%	399	3.5%	402	4.4%
Part-time worker	24	26	11.7%	28	18.4%	26	11.6%	28	18.3%
Unemployed/non-worker	99	112	13.0%	118	18.5%	112	12.6%	115	15.7%
Children	234	247	5.3%	251	6.9%	245	4.5%	249	6.0%
Region									
North	135	144	7.3%	148	9.6%	142	5.5%	145	7.7%
Central	133	142	6.6%	146	9.4%	142	6.6%	146	9.1%
Twin Cities	324	341	5.5%	346	7.1%	338	4.4%	341	5.3%
South	152	161	6.2%	163	7.4%	161	6.1%	163	7.3%
Health Status									
Good, fair or poor	192	199	3.6%	207	7.9%	199	3.4%	205	6.6%
Excellent or very good	550	589	7.0%	594	8.1%	583	6.0%	588	6.9%
Unknown	1	1	-	1	6.1%	1	-	1	6.1%
Pvt. individual coverage (incl. MCHA)	**138**	**138**	**-**	**131**	**- 5.0%**	**138**	**-**	**132**	**- 4.6%**
Adults age 18-64									
0-100% FPL	23	23	-	23	- 0.5%	23	-	23	- 0.5%
101-200%	47	47	-	44	- 7.0%	47	-	44	- 6.0%
201-300%	38	38	-	37	- 1.8%	38	-	37	- 1.7%
Children age 0-17									
0-100% FPL	4	4	-	2	-33.7%	4	-	2	-33.7%
101-200%	14	14	-	13	- 6.2%	14	-	13	- 6.2%
201-300%	13	13	-	12	- 5.8%	13	-	12	- 5.0%
Work status									
Full-time worker	59	59	-	57	- 3.5%	59	-	57	- 3.5%
Part-time worker	9	9	-	9	- 0.6%	9	-	9	- 0.6%
Unemployed/non-worker	39	39	-	37	- 5.0%	39	-	38	- 3.8%
Children	31	31	-	28	- 9.2%	31	-	28	- 8.9%
Region									
North	30	30	-	29	- 5.1%	30	-	29	- 4.7%
Central	27	27	-	24	- 9.2%	27	-	25	- 7.5%
Twin Cities	57	57	-	55	- 2.5%	57	-	55	- 2.4%
South	24	24	-	23	- 6.1%	24	-	23	- 6.1%

Table B3 *(continued)*

		Immediate Subsidy				Delayed Subsidy			
		Simulation 1: Waiting Period		Simulation 2: No Waiting Period		Simulation 3: Waiting Period		Simulation 4: No Waiting Period	
	Current Case (thousands)	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case
Health Status									
Good, fair or poor	29	29	-	26	-10.0%	29	-	26	- 9.9%
Excellent or very good	109	109	-	105	- 3.7%	109	-	106	- 3.1%
Unknown	-	0	-	0	-	0	-	0	-
Public program	**561**	**561**	-	**561**	-	**561**	-	**561**	-
Adults age 18-64									
0-100% FPL	166	166	-	166	-	166	-	166	-
101-200%	83	83	-	83	-	83	-	83	-
201-300%	29	29	-	29	-	29	-	29	-
Children age 0-17									
0-100% FPL	144	144	-	144	-	144	-	144	-
101-200%	113	113	-	113	-	113	-	113	-
201-300%	27	27	-	27	-	27	-	27	-
Work status									
Full-time worker	99	99	-	99	-	99	-	99	-
Part-time worker	13	13	-	13	-	13	-	13	-
Unemployed/non-worker	165	165	-	165	-	165	-	165	-
Children	284	284	-	284	-	284	-	284	-
Region									
North	148	148	-	148	-	148	-	148	-
Central	63	63	-	63	-	63	-	63	-
Twin Cities	251	251	-	251	-	251	-	251	-
South	99	99	-	99	-	99	-	99	-
Health Status									
Good, fair or poor	231	231	-	231	-	231	-	231	-
Excellent or very good	328	328	-	328	-	328	-	328	-
Unknown	2	2	-	2	-	2	-	2	-
Uninsured	**275**	**229**	**-16.6%**	**222**	**-19.2%**	**235**	**-14.4%**	**231**	**-16.2%**
Adults age 18-64									
0-100% FPL	78	64	-18.4%	62	-20.2%	65	-17.2%	63	-19.0%
101-200%	92	74	-20.1%	72	-21.5%	77	-16.6%	76	-18.0%
201-300%	45	44	- 0.6%	41	- 8.6%	44	- 0.6%	43	- 4.0%

Table B3 *(continued)*

		Immediate Subsidy				Delayed Subsidy			
		Simulation 1: Waiting Period		Simulation 2: No Waiting Period		Simulation 3: Waiting Period		Simulation 4: No Waiting Period	
	Current Case (thousands)	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case	Number (thousands)	Percent Change from Current Case
Children age 0-17									
0-100% FPL	20	14	-29.4%	14	-29.4%	16	-20.6%	16	-20.6%
101-200%	22	16	-28.2%	15	-31.5%	16	-27.7%	15	-31.1%
201-300%	17	17	- 0.9%	17	- 0.9%	17	- 0.9%	17	- 0.9%
Work status									
Full-time worker	108	90	-16.3%	89	-17.4%	94	-12.7%	93	-13.8%
Part-time worker	10	7	-28.5%	5	-44.2%	7	-28.2%	5	-44.0%
Unemployed/non-worker	98	85	-13.2%	81	-16.9%	85	-12.9%	84	-14.4%
Children	60	48	-20.8%	47	-22.0%	49	-17.6%	49	-18.9%
Region									
North	72	62	-13.7%	61	-15.8%	65	-10.3%	63	-12.4%
Central	30	21	-29.1%	20	-33.5%	21	-29.1%	20	-33.5%
Twin Cities	119	102	-14.8%	98	-18.1%	105	-11.8%	104	-13.3%
South	53	44	-17.5%	44	-18.2%	44	-17.3%	44	-18.0%
Health Status									
Good, fair or poor	104	97	- 6.7%	92	-11.9%	97	- 6.4%	94	- 9.5%
Excellent or very good	163	124	-23.7%	123	-24.7%	130	-20.2%	129	-21.2%
Unknown	8	8	-	8	- 0.8%	8	-	8	- 0.8%

Source: Mathematica Policy Research.

Notes: Dashes indicate an estimate of fewer than 500 persons or change less than 0.05 percent. Details may not add to totals due to rounding.

Table B4. Number of Individuals Eligible and Enrolled in Subsidy Program, FY2009 (thousands)

	Immediate Subsidy		Delayed Subsidy	
	Simulation 1: Waiting Period	Simulation 2: No Waiting Period	Simulation 3: Waiting Period	Simulation 4: No Waiting Period
Number eligible for subsidy	89	708	89	708
0-100% FPL	28	101	28	101
101-200%	42	247	42	247
201-300%	19	360	19	360
Number with expenditure above the affordability standard	73	601	73	601
0-100% FPL	28	101	28	101
101-200%	40	223	40	223
201-300%	5	277	5	277
Number with premium assistance and full payment of out-of-pocket costs	73	408	73	408
0-100% FPL	28	101	28	101
101-200%	40	214	40	214
201-300%	5	93	5	93
Number with reduced out-of-pocket costs only	-	194	-	194
0-100% FPL	-	-	-	-
101-200%	-	9	-	9
201-300%	-	184	-	184
Number enrolled in subsidy program	46	531	40	517
0-100% FPL	20	83	18	79
101-200%	25	184	22	179
201-300%	-	264	0	260
Enrollees with premium assistance	46	337	40	324
0-100% FPL	20	83	18	79
101-200%	25	175	22	170
201-300%	-	80	0	75
Enrollees with no premium assistance	-	194	-	194
0-100% FPL	-	-	-	-
101-200%	-	9	-	9
201-300%	-	184	-	184

Source: Mathematica Policy Research.

Notes: Dashes indicate an estimate of fewer than 500 persons or change less than 0.05 percent. Details may not add to totals due to rounding

Table B5. Total and Average Annual Expenditures on Subsidy Program, FY2009

	Immediate Subsidy		Delayed Subsidy	
	Simulation 1 Waiting Period	Simulation 2: No Waiting Period	Simulation 3: Waiting Period	Simulation 4: No Waiting Period
Total State Expenditures ($ million)	$193.7	$1,789.0	$159.3	$1,705.0
On all enrollees				
0-100% FPL	107.7	460.0	93.8	425.0
101-200%	85.7	752.0	64.7	725.0
201-300%	0.7	570.0	0.7	554.0
Total State Expenditures for Enrollees with Premium Assistance	193.7	1,468.0	159.3	1,384.0
0-100% FPL	107.7	460.0	93.8	425.0
101-200%	85.7	738.4	64.7	711.4
201-300%	0.7	263.0	0.7	247.0
Total State Expenditures for Other Enrollees	-	321.0	-	321.0
0-100% FPL	-	-	-	-
101-200%	-	13.6	-	13.6
201-300%	-	307.0	-	307.0
Average State Expenditure Per Enrollee	$4,248	$3,388	$4,021	$3,319
On all enrollees				
0-100% FPL	5,286	5,565	5,321	5,395
101-200%	3,443	4,090	3,006	4,046
201-300%	1,578	2,196	1,578	2,168
Average State Expenditure per Enrollees with Premium Assistance	4,248	1,733	4,021	1,664
0-100% FPL	5,286	5,565	5,321	5,395
101-200%	3,443	2,617	3,006	2,573
201-300%	1,578	532	1,578	504
Average State Expenditure per Other Enrollees	-	1,655	-	1,655
0-100% FPL	-	-	-	-
101-200%	-	1,472	-	1,472
201-300%	-	1,664	-	1,664

Source: Mathematica Policy Research.

Notes: Dashes indicate an estimate of fewer than 500 persons or change less than 0.05 percent. Details may not add to totals due to rounding.

Table B6. Estimated Monthly Premiums for Single and Family Coverage in Employer-Sponsored Plans in the Current Case and Policy Simulations, FY2009

		Immediate Subsidy				Delayed Subsidy			
		Simulation 1: Waiting Period		Simulation 2: No Waiting Period		Simulation 3: Waiting Period		Simulation 4: No Waiting Period	
	Current Case	Workers with Subsidy	Workers with No Subsidy	Workers with Subsidy	Workers with No Subsidy	Workers with Subsidy	Workers with No Subsidy	Workers with Subsidy	Workers with No Subsidy
All Employers									
Number of workers (thousands)	1,498	6	1,498	214	1,277	5	1,498	219	1,279
Number of dependents (thousands)	1,490	40	1,490	312	1,248	35	1,490	294	1,250
Average employee contribution to premium									
Single coverage	$123	$49	$123	$69	$126	$45	$123	$68	$126
Family coverage	$250	$74	$250	$167	$249	$78	$250	$168	$249
Average employee contribution to OOP									
Single coverage	$78	$34	$78	$76	$82	$26	$78	$75	$82
Family coverage	$193	$86	$193	$146	$199	$86	$193	$146	$199
Employee contribution to premiums as a percentage of income									
Percent of persons:									
Less than 5%	84.4%	90.6%	84.4%	84.4%	68.0%	68.0%	87.3%	94.8%	95.2%
5 to 7%	6.3%	3.2%	6.3%	6.3%	27.1%	27.1%	5.5%	3.4%	2.9%
7 to 10%	4.2%	0.0%	4.2%	4.2%	3.1%	3.1%	3.6%	1.8%	1.9%
More than 10%	4.8%	0.0%	4.8%	0.0%	3.5%	0.0%	4.8%	0.0%	3.5%
Unknown	0.3%	6.2%	0.3%	1.8%	0.0%	7.2%	0.3%	1.8%	0.0%
Employee contribution to total medical costs as a percentage of income									
Percent of persons:									
Less than 5%	47.9%	90.6%	47.9%	51.7%	54.9%	89.2%	47.9%	51.3%	54.8%
5 to 7%	19.5%	3.2%	19.5%	32.5%	20.2%	3.6%	19.5%	32.6%	20.2%
7 to 10%	15.4%	0.0%	15.4%	14.1%	13.6%	0.0%	15.4%	14.3%	13.7%
More than 10%	16.6%	0.0%	16.6%	0.0%	11.0%	0.0%	16.6%	0.0%	11.1%
Unknown	0.5%	6.2%	0.5%	1.8%	0.2%	7.2%	0.5%	1.8%	0.2%

Source: Mathematica Policy Research.

Notes: Employer coverage excludes COBRA, self-employed workers, and workers and dependents in firms of unknown size. Dashes indicate an estimate of fewer than 500 persons or change less than 0.05 percent. Details may not add to totals due to rounding.

TABLE B7

ESTIMATED NUMBER OF WORKERS AND DEPENDENTS WITH EMPLOYER-SPONSORED COVERAGE, BY POVERTY LEVEL AND EXPENDITURES FOR HEALTH CARE AS A PERCENT OF FAMILY INCOME: CURRENT CASE, FY 2009

	Number (in thousands)	Percent
	2,984	**100.0%**
Expenditures as a percent of income:		
0-5%	1,429	47.9%
5-7%	582	19.5%
7-10%	460	15.4%
10%-99%	497	16.6%
More than 100%	16	0.5%
Persons at 0-100% FPL	**75**	**100.0%**
Expenditures as a percent of income:		
0-5%	4	5.9%
5-7%	1	1.5%
7-10%	2	2.8%
10%-99%	51	68.1%
More than 100%	16	21.7%
Persons at 101-200% FPL	**227**	**100.0%**
Expenditures as a percent of income:		
0-5%	12	5.1%
5-7%	16	6.9%
7-10%	54	23.9%
10%-99%	146	64.1%
More than 100%	--	--
Persons at 201-300% FPL	**363**	**100.0%**
Expenditures as a percent of income:		
0-5%	55	15.2%
5-7%	89	24.4%
7-10%	113	31.2%
10%-99%	106	29.2%
More than 100%	--	--
Persons at 300% FPL or more	**2,319**	**100.0%**
Expenditures as a percent of income:		
0-5%	1,358	58.6%
5-7%	476	20.5%
7-10%	290	12.5%
10%-99%	194	8.4%
More than 100%	--	--

Source: Mathematica Policy Research.

Notes: Dashes indicate estimates less than 500 persons or 0.05 percent. Estimates exclude approximately 221,000 workers and dependents in firms of unknown size or who reported employer coverage of unknown origin, as well as COBRA enrollees and self-employed workers.