DEPARTMENT OF HEALTH

Understanding Health Insurance Transitions and Public Health Insurance Coverage in Minnesota

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There are a number of primary pathways to getting health insurance coverage in the United States: the majority of people obtain coverage through employer-sponsored group coverage, while others qualify for public programs based on age, income or disability status. People without access to employer or public coverage may purchase their own coverage in the non-group (individual) market, while some remain without coverage.

With access to insurance coverage in Minnesota and the U.S. tied to socioeconomic factors, transitions in health insurance happen as a result of job or family changes, fluctuations in income, or aging. These transitions in health insurance coverage, including gaining or losing coverage, are sometimes referred to as "health insurance churn." Churn can have financial and health implications for those who experience it.

Key Findings

Among non-elderly Minnesotans:

- Approximately 355,000 Minnesotans experienced a health insurance transition in 2015, similar to previous years.
- Fewer transitions were from people losing coverage than in previous years.
- The number of Minnesotans who had the same coverage all year increased in 2015.
- People enrolled in public health insurance programs experienced more churn than those enrolled in private health insurance.
- Enrollees who went on or off public coverage were more likely to experience barriers to health care access than those enrolled all year.

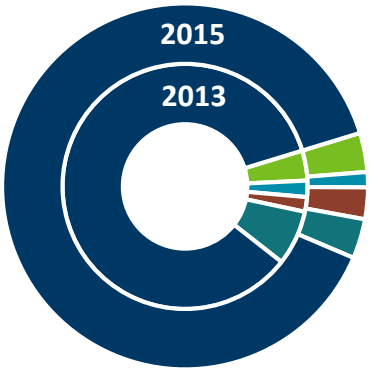
This brief provides an analysis of the volume and distribution of health insurance transitions for non-elderly (under 65) Minnesotans using data from the 2015 Minnesota Health Access Survey.[1,2] Because of the role of public programs to bridge gaps in coverage, this brief also takes a closer look at those who transition into and out of public programs.

How Much Transition in Health Insurance Takes Place in Minnesota?

In 2015, approximately 355,000[3] Minnesotans under 65 (7.6 percent) experienced some type of health insurance transition (Figure 1). These transitions took the form of:

- Changes between types of coverage (e.g., shifting from group insurance through an employer to non-group coverage) [4] (2.8 percent);
- Gaining health insurance coverage after being uninsured (3.5 percent); or
- Becoming uninsured (losing coverage) (1.4 percent).

Figure 1. Prevalence of Health Insurance Transitions



- Same Insurance Type All Year
  2013, 84.7%
  2015, 88.9%*
- Gained Coverage
  2013, 4.0%
  2015, 3.5%
- Lost Coverage
  2013, 2.2%
  2015, 1.4%*
- Changed Insurance Type
  2013, 1.9%
  2015, 2.8%
- Uninsured All Year
  2013, 7.3%
  2015, 3.5%*

Source: Minnesota Health Access Survey
*Indicates statistically significant difference from previous year shown at the 95% level

People who gained or lost coverage were similar demographically to people who were uninsured, including having lower incomes, a high school diploma or less, and were adults aged 26 to 34.

People who experienced a transition in coverage *type* tended to be more similar to people who were insured all year. They had higher incomes, were more likely to have a college degree than people who gained or lost coverage, and were more likely to be between 55 and 64; they were also less likely to be people of color or American Indians.

Similar to people who held the same coverage all year, over 91 percent of people who changed coverage type during the year reported they were in excellent, very good or good health. However, this group was far from uniform, as it represented people moving from private to public coverage, from public coverage to private coverage, and between types of private coverage.

Definitions in this Brief

- **Insurance Type:** Public, Group or Non-Group health insurance.
- **Public Insurance**: State income-based Medical Assistance[5] and MinnesotaCare[6] programs as well as federal Medicare and Veterans' Affairs programs.
- **Group Insurance**: Coverage through employer.
- **Non-Group Insurance:** Coverage purchased on one's own, also called individual insurance.
- **Health Insurance Transitions/Churn:** Includes gain or loss of health insurance as well as changes among insurance types. Changes within an insurance type (e.g., changing from one employer plan to another, changing from Medical Assistance to MinnesotaCare) are not classified as churn for this brief.

The number of people experiencing transitions in coverage did not change significantly from 2013 (Figure 1), when 378,000[7] (8.1 percent) of Minnesotans under 65 experienced a transition in coverage. Fewer people lost coverage or were uninsured all year in 2015, while more people held the same coverage all year. These specific changes related to lower uninsurance and more consistent coverage were likely related to the Patient Protection and Affordable Care Act (ACA), and also a continually improving economy and job

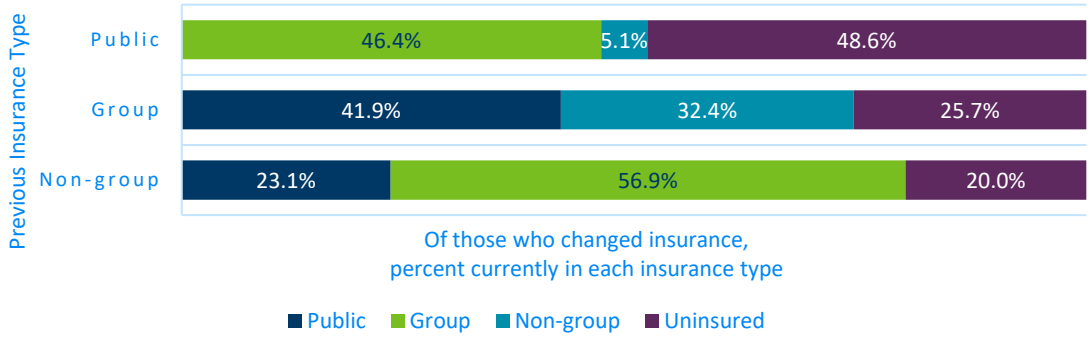
market. Nonetheless, the consistency in the number of Minnesotans who experienced a transition in coverage speaks to the importance of the topic when we are discussing health care and health insurance coverage.

Public Health Insurance Transitions

Transitions in coverage also vary by health insurance type. As shown in Figure 2, in 2015 nearly half of people who had public coverage became uninsured, while people with private coverage were more likely to experience changes in coverage, rather than losing coverage. The role of public coverage as a safety net, but also its strict income requirements, may be related to why people were more likely to lose coverage as compared to other types of coverage. Further, because public coverage is regulated at the state or federal level, these programs tend to be more sensitive to changes in laws than private coverage. While certain conditions of private coverage are regulated, private insurers have greater flexibility to develop options for enrollees, such as modifying benefit packages and negotiating networks and reimbursement rates with providers.

For the remainder of this brief we focus on Minnesotans who had some form of public insurance coverage at some point in the year. This includes people who gained public coverage, lost public coverage, transitioned between public coverage and private coverage during the year, or had public coverage for the entire year.[8]

Figure 2. Distribution of Current Insurance Coverage Among Previously Insured Who Experienced a Transition



Compared to people with continuous public programs coverage, people who experienced a transition involving public programs were:

- More likely to be aged 26 to 34; and
- More likely to live in the Twin Cities metro area.

Due to changes in regulations under the ACA, which allowed young adults to stay on their parents' health insurance policy until age 25, more transitions may have been experienced by young adults 26 to 34 as they "aged off" dependent coverage. While a larger proportion of

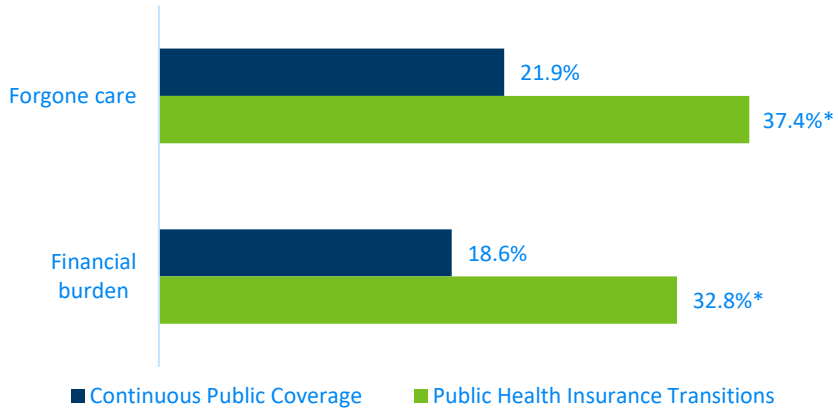
public program enrollees were people of color or American Indians, they were not more likely than other public program enrollees to experience churn.

The strict income requirements around public programs are one reason why people in these programs may have experienced transitions. The median income for people who were currently enrolled in a public program was approximately 147 percent of the Federal Poverty Guidelines (FPG), while those who transitioned out of state public programs had a median income of about 187% FPG. This reflects the difference in income someone would experience if they went from working 30 hours per week to 40 hours per week at $11 per hour.[9]

This small difference in income can lead to substantial changes in covered benefits and affordability in coverage for people buying insurance on their own; for people who become uninsured, they no longer have any covered benefits. Private coverage tends to have higher out-of-pocket costs than public coverage, and people who are uninsured often bear the full costs of whatever medical care they receive. This increase in costs (including higher premiums, deductibles, and co-pays for those with insurance) has become known as a financial cliff.[10]

Evidence of financial strain can be seen in the percent of people who experienced forgone care due to cost and financial burden. As shown in Figure 3, in 2015 nearly twice as many people who were on public coverage part of the year (37.4 percent) did not get needed health care due to cost, compared to those that had public coverage all year (21.9 percent). Similarly, people with a transition were more likely to report problems with medical bills (32.8 percent compared to 18.6 percent). These results are consistent with previous research, and illustrate how increased exposure to health care costs (whether through increased cost sharing, or uninsurance) can directly impact the ability to receive needed health care.[11]

Figure 3. Financial Strain



Source: 2015 Minnesota Health Access Survey
*Indicates statistically significant difference from continuous public coverage at the 95% level

There are also potential fiscal implications for the state when people churn on and off public programs. Around 10,000 people (32.3 percent of those who lost public program insurance and became uninsured) reported they lost coverage because they did not submit their paperwork in time. This reported loss of coverage, but not necessarily eligibility, means that some public program enrollees may have experienced brief periods of uninsurance and then re-enrolled. Some studies have noted potential increases in costs to the state for processing multiple new enrollments, compared to a

single enrollment and renewal; however these studies do not necessarily account for costs to the state for ineligible enrollees.[12,13]

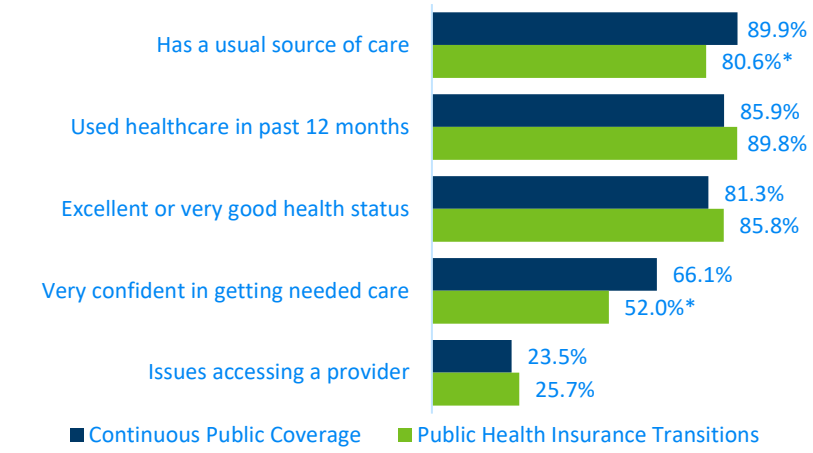
Health Status and Access to Health Care

Transitions off of state public programs increase patient responsibility for health care costs and lead to changes in available providers, which may lead to disruptions in care and potentially affect patients' overall health status.[14,15] This portion of the analysis focuses specifically on differences in access to health care that people who transition on or off of public programs may have experienced.

People with inconsistent public program coverage experienced more barriers to accessing health care in 2015. As shown in Figure 4, people who churned in or out of public programs were less likely (80.6 percent) to have a usual source of care than people who remained on public programs (89.9 percent). They were also less likely to be very confident in getting the care they needed. There were no differences in their use of health care, or problems finding a provider. Although people experiencing health insurance transitions were not more likely to have problems accessing a provider, it is unknown whether they had to change to a new provider in order to receive care.

These results align with other research that has shown retention of health insurance coverage can help build relationships between patients and their health care providers, increasing the likelihood of having a usual source of care.[16] Without a usual place for patients to receive care and with possible shifts in networks between insurance types, it is not surprising that those who experienced transitions around public programs were not as confident that they would be able to get the care they needed.

Figure 4. Health Status and Access to Health Care



Source: 2015 Minnesota Health Access Survey
*Indicates statistically significant difference from continuous public coverage at the 95% level

Summary & Conclusions

This issue brief examined the prevalence of health insurance transitions in Minnesota in 2015 using data from the Minnesota Health Access Survey, with a focus on people with a period of

public program coverage. We found that in total around 355,000 Minnesotans experienced a transition in 2015, similar to the number in 2013.

People with public program coverage were more likely to experience a gain or loss in coverage, while people with private health insurance (group or individual) were more likely to transition between types of coverage. People with public program transitions were more likely to experience financial barriers to care, and also appear to have been more likely to experience disruptions in care, than those who were enrolled in public coverage all year.

Though the majority of health insurance transitions involved gaining or losing coverage, new pathways to coverage provided by the ACA likely helped to reduce the number of people losing coverage. Increased income eligibility levels for public programs mean that children and adults who previously could not afford coverage on the non-group market but whose income did not permit them to enroll in public program coverage may now qualify. Those who lose coverage after loss of a job no longer have to be concerned about being denied coverage in the non-group market due to the presence of a pre-existing condition, and may be eligible for premium subsidies to reduce costs in that market.

Although health insurance coverage transitions can be disruptive to patients in terms of access, continuity, and affordability of care, there is little empirical information available about these impacts. Thus, availability of population data from the Minnesota Health Access Survey permitted us for the first time to study the level of health insurance transitions in Minnesota, changes over time, and their relationship with barriers to health care access. While our analysis shows that transitions appeared to be associated with barriers in access to health care, we also understand that changes in health insurance coverage are a part of life transitions, and as such, cannot be eliminated. As state and federal reforms evolve, monitoring their association with gaps in coverage, movement between types of coverage, and cliffs at transition points may help to identify harmful or inefficient levels of churn in coverage experienced by Minnesota residents.

Endnotes

[1] This brief focuses on the non-elderly (under age 65) population, since over 95 percent of Minnesotans age 65 and over have health insurance coverage through Medicare.

[2] The MNHA is a biennial survey of health insurance coverage in Minnesota. All measures and percentages presented have been weighted to the Minnesota non-elderly, non-institutional population. Additional information is available online at: http://www.health.state.mn.us/divs/hpsc/hep/hasurvey/about.html.

[3] Minnesota population estimate for 2015 of 5,482,435: U.S. Census Bureau, Population Division; Table 1. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2016 (NST-EST2016-01). December 2016. Estimate is based on population estimate as of July 1. Percentage of

Minnesotans who were non-elderly in Minnesota estimated to be 85.3 percent: American Community Survey, 1-year ACS estimates for 2015 report S0101. Accessed on April 5, 2017. Based on reporting percentages.

[4] Changes between public programs (e.g., Medical Assistance to MinnesotaCare) or between employer plans (e.g., different employer coverage as a result of a new job) are not considered transitions for the purpose of this brief.

[5] Medical Assistance eligibility extends up to 283% FPG for infants under age two, to 278% FPG for pregnant women, and up to 275% FPG for children ages two to eighteen. Additional income eligibility rules apply under other special circumstances, such as disability.

[6] MinnesotaCare is a Basic Health Plan (BHP) with eligibility for adults with incomes between 138% FPG and 200% FPG.

[7] Minnesota population estimate for 2013 of 5,418,521: U.S. Census Bureau, Population Division; Table 1. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2016 (NST-EST2016-01). December 2016. Estimate is based on population estimate as of July 1. Percentage of Minnesotans who were nonelderly in Minnesota estimated to be 86.1 percent: American Community Survey, 1-year ACS estimates for 2013 report S0101. Accessed on April 5, 2017. Based on reporting percentages.

[8] While it would be ideal to separate these groups, income levels will be somewhat similar due to income requirements.

[9] For a single person, this would be an income change from $17,150 to $21,800. For a family of four, this would be an income change from $35,721 to $45,441.

[10]Minnesota Health Care Financing Task Force. (2016). Health care financing task force final report. Retrieved from: http://mn.gov/dhs-stat/images/final-materials-final-report_01-28-2016.pdf.

[11] For a more complete description of financial burden and forgone care, see: Minnesota Department of Health, Health Economics Program and University of Minnesota, School of Public Health, "Health Care Access in Minnesota, Baseline Analysis for Assessing the Impact of the Health Reform in the State," Issue Brief, February 2014; http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/acaissuebrief2014.pdf

[12] Buettgens, M., Nichols, A. and Dorn, S. (2012). Churning Under the ACA and State Policy Options for Mitigation. Washington, DC: Urban Institute.

[13] Rosenbaum, D. (2015). Lessons Churned: Measuring the Impact of Churn in Health and Human Services Programs on Participants and State and Local Agencies. Washington, DC: Center on Budget and Policy Priorities.

[14] Sommers, B.D., Graves, J. A., Swartz, K., and Rosenbaum, S. (2013). Medicaid and marketplace eligibility changes will occur often in all states; Policy options can ease impact. *Health Affairs,* 33(4), 700-7.

[15] Ginde, A.A., Lowe, R.A. and Wiler, J.L. (2012). Health Insurance Status Change and Emergency Department Use Among US Adults. *Archives of Internal Medicine*, 172(8), 642-47.

[16] Ku, L. & Steinmetz, E. 2013. The Continuity of Medicaid Coverage: An Update. Washington, DC: George Washington University.

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