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MinnesotaCare

Health Care Access Fund Status Report

February 1994

Department of Human Services
MinnesotaCare Project

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Executive Summary

The MinnesotaCare health benefit program is funded by the Health Care Access Fund. If projected enrollment, including enrollment of adult-only households, is allowed to continue without intervention, accrual-basis costs will exceed revenues as early as FY 1995, with an accumulated deficit in the fund balance of $191 million at the end of FY 1997.

The $191 million deficit results from a mix of 1993 legislative changes regarding revenues ($60 million) and expenditures ($45 million), and forecast changes regarding expenditures ($69 million) and revenues ($39 million). Other changes affecting the fund balance offset these costs by $22 million. The effect of these changes is graphed on the next page.

The Department of Human Services and the Department of Health are required by Minnesota Statutes, section 256.9352, to develop a plan to ensure that expenditures for the MinnesotaCare program are contained within the two percent provider tax and the one percent HMO gross premiums tax for the 1996-1997 biennium.

In developing such a plan, several alternatives were examined, including reducing benefits, capping total enrollment, and increasing premiums.

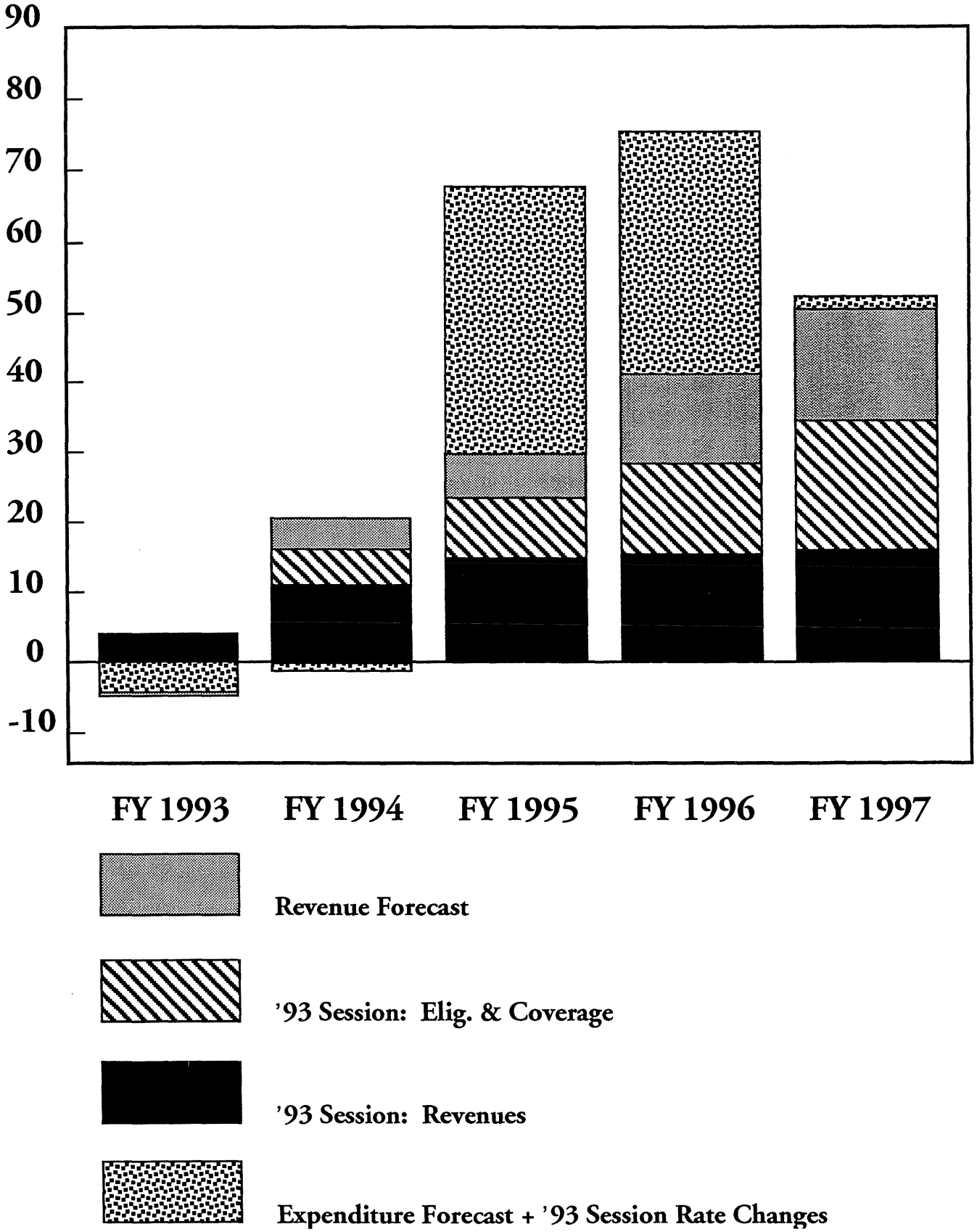
Reducing benefits is not a practical method to resolve the deficit because the level of reduction necessary to maintain a positive balance would require drastic service reductions. Coverage of pharmacy, dental, and many other services would have to be eliminated.

The alternative approach of capping total enrollments was rejected for two reasons. First, it is contrary to the Governor's and legislators' priority of MinnesotaCare serving families and children first. Second, it treats similarly situated Minnesotans differently. That is, those lucky enough to apply before a date implementing a cap on enrollment would have coverage, while those applying a day after that date would not.

Increasing premiums was also determined to be an unacceptable approach. All premiums, including those at the highest level, would need to be more than tripled to address the deficit. Such premiums would make the program unaccessible for most Minnesotans.

Consistent with current law, the department recommends that adult-only households be enrolled January 1, 1996, instead of July 1, 1994. This eighteen-month delay will ensure that the Health Care Access Fund maintains a positive balance through FY 1997.

Sources of Health Care Access Fund Balance Deficit



Introduction

This report is written in response to Minnesota Statutes, section 256.9352 (Supp. 1993), and Laws of Minnesota 1993, chapter 345, article 9, section 2 and 17, which require the Commissioner of Human Services to make recommendations regarding the maintenance of a positive balance in the Health Care Access Fund. The report will examine the status of the Health Care Access Fund and outline measures to maintain a positive balance in the fund. A history of changes affecting MinnesotaCare enrollment and expenditure projections is contained in Appendix A of the report.

Projected Deficit in Fund

The Commissioner of Human Services is required by Minnesota Statutes, section 256.9352, to ensure that MinnesotaCare expenditures do not exceed estimates of revenues that will be deposited in the Health Care Access Fund. The March 1994 fund balance will show a deficit of $191 million by the end of FY 1997 based on projected demand for MinnesotaCare enrollment.

Table One
Health Care Access Fund Balance with
March 1994 MinnesotaCare Demand Estimates
(Thousands of Dollars)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
FUND BALANCE					
Fiscal Year	11,497	4,610	(32,620)	(73,390)	(100,658)
Accumulated Balance	11,497	16,107	(16,513)	(89,903)	(190,561)

Origins of the Projected Fund Deficit

Expenditure Changes. Changes since April 1992 in expenditure projections account for $114 million of the $191 million deficit. Legislative changes enacted in MinnesotaCare eligibility and service coverage in 1993 account for $45 million of the $114 million expenditure change; $69 million results from forecast changes. Table Two summarizes these expenditure changes by fiscal year. (Details of forecast and legislative changes are provided in Appendix A.)

Table Two
Effect of Expenditure Changes on the Fund Balance Based on March 1994 Demand Estimates

(Thousands of Dollars)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Net Expenditure Changes Since April 1992, including 1993 Session Changes	(3,246)	3,534	47,216	46,937	20,012
Running Balance	(3,246)	288	47,504	94,441	114,453
1993 Session Eligibility and Coverage Changes*	0	4,953	9,234	12,792	17,989
Running Balance	0	4,953	14,187	26,979	44,968

**See Appendix A, Table Eight*

Revenue Changes. Legislative changes in the 1993 Session account for revenue reductions of $60 million by the end of FY 1997. Revenue forecast changes subsequent to the 1993 Session account for $39 million in reductions.

Table Three
Effect of Revenue Changes on the Fund Balance

(Thousands of Dollars)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
1993 Session Changes Affecting Revenue	(3,200)	(10,463)	(14,886)	(15,286)	(16,886)
Running Balance	(3,200)	(13,663)	(28,549)	(43,835)	(60,721)
Revenue Forecast Changes After 1993 Session	4	(4,138)	(6,609)	(12,451)	(15,895)
Running Balance	4	(4,134)	(10,743)	(23,194)	(39,089)

Transfers to General Fund. An earlier report, required by Laws of Minnesota, 1993, chapter 345, article 9, section 17, documented that the MinnesotaCare health benefit plan does not have a significant impact on Medical Assistance and General Assistance Medical Care enrollment beyond that which occurred under the Children's Health Plan. This finding has caused a re-evaluation of the transfer of the full amount identified in statute. Fund balance references in this section of the report anticipate that the fund balance will be modified by using the forecasted values for transfer to the General Fund for costs related to MinnesotaCare in Medical Assistance and GAMC. This single change improves the fund balance in FY 1997 by $16 million, reducing the deficit from $191 million to $175 million.

Table Four compares the forecasted transfers with no limitation on MinnesotaCare enrollment with the amounts in statute.

Table Four
Transfers to the General Fund and Health Care Access Fund with Forecasted Transfers
(Thousands of Dollars)

	FY 1994	FY 1995	FY 1996	FY 1997
Transfer Values in Statute	10,907	25,842	25,842	25,842
Forecasted Transfer Values	3,963	13,503	23,914	31,253
Fund Balance Using Forecasted Transfers	23,051	2,771	(68,691)	(174,760)

Under current law, the remaining fund balance deficit requires action to bring projected expenditures in line with projected revenues. The statute sets forth the following hierarchy of actions to be taken by the Commissioner to balance the fund:

1. Stop enrollment of single adults and households without children;

2. Stop coverage of single adults and households without children already enrolled;

3. Decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines;

4. Decrease the premium subsidy by ten percent for families with gross annual income at or below 200 percent;

5. Require applicants to be uninsured for at least six months (increased from four months) prior to eligibility in MinnesotaCare.

Alternatives

Delay enrollment. Delaying the enrollment of adult-only households by eighteen months will balance the fund through FY 1997 without taking other actions. Table Five shows the projected effect on the fund balance of using delayed start dates for the enrollment of adult-only households. It is assumed that enrollment for families with children remains open.

Table Five
Fund Balance with Delayed Enrollment for Adult-only Households
(Thousands of Dollars)

	FY 1994	FY 1995	FY 1996	FY1997
Six-Month Delay Fund Balance	22,985	40,858	(11,796)	(104,942)
Twelve-Month Delay Fund Balance	22,985	59,940	40,885	(39,360)
Eighteen-Month Delay Fund Balance	22,985	59,940	80,492	7,004
Twenty-four-Month Delay Fund Balance	22,985	59,940	99,931	71,673

Current law appears to require delaying enrollment of adult-only households for eighteen months. Shorter delays will not resolve the forecasted fund balance deficit.

Based on the level of interest in MinnesotaCare displayed by adult-only households through telephone inquiry and applications for benefits, it is anticipated that many more adults will continue to apply for MinnesotaCare even if coverage is delayed. Between June 1, 1993, and January 17, 1994, a total of 7,928 adults without children called the Interactive Voice Response (IVR) telephone number seeking information about MinnesotaCare. In addition, 3,848 adults without children mailed in applications between October 1, 1992, and December 6, 1993.

As a result of this significant level of interest from adult-only households, the Department of Human Services anticipates a substantial workload to process these applications and continue to respond to inquiries. This additional workload will occur whether or not adult-only households are added on July 1, 1994, because applications will need to be denied and the delay explained.

Delayed enrollment for adult-only households would leave GAMC coverage in place for the poorest of these households, including GAMC coverage through spenddown for large medical bills. GAMC maximum income eligibility limits for adult-only households range from 64-69 percent of the federal poverty guideline. Enrollment in GAMC has grown by 49 percent between FY 1988 and FY 1993. GAMC expenditures during that same period have doubled.

Decrease Premium Subsidies by Ten Percent. Premiums pay approximately 12 percent of the cost of MinnesotaCare coverage. Therefore, a 10 percent decrease in the 88 percent subsidy would amount to a 75 percent increase in premiums charged to enrollees. That is, enrollees would pay 21 percent of the cost instead of 12 percent.

Only 10 percent of MinnesotaCare enrollees are families with incomes above 200 percent of the federal poverty guideline. If a 10 percent subsidy decrease were applied only to these enrollees, the effect on the fund balance would be very small; that is, $5-$10 million for the period from FY 1995 through FY 1997. If a 10 percent subsidy decrease were applied to all MinnesotaCare enrollees, the gross effect on premium revenue would be about $70 million for the same period.

Enrollment experience to date indicates that families with incomes above 200 percent FPG represent the highest rate of cancellation for nonpayment of initial premiums: over 15 percent compared to 3.6 percent for families between 150 and 185 percent of FPG and 1.8 percent for families below 150 percent of FPG. Families in the 150 to 275 percent of FPG categories cancel for nonpayment at two to three times the rate of families below 150 percent of FPG.

Increase Uninsured Period to Six Months. Increasing the mandatory pre-enrollment uninsured period from four to six months would have a small effect on the level of new enrollment in the program; possibly a 5-10 percent decrease in new enrollment. The effect on the fund balance deficit would be between $10 and $20 million for the period FY 1995 through FY 1997.

Cap Total Enrollment. This option requires repeal of the hierarchy of cost containment options in current law and substitution of a single method: a limit on total MinnesotaCare enrollment to be administered by the Department of Human Services in order to keep MinnesotaCare spending within the amount of available funds.

Capping total enrollment would permit adult-only households to enroll beginning in July 1994. Total enrollment would need to be limited to approximately 110,000 people; 80,000 in families with children and 30,000 in households without children. This level is expected to be reached in December 1994 but could happen earlier or later depending on the rate of enrollment.

Capping enrollment would involve significant administrative difficulty for both the applicant and the Department, because of the need for a waiting list. More importantly, it is contrary to the legislative priority of providing MinnesotaCare coverage to families with children first. It also compromises a standard of fairness. Whether a Minnesotan would (or would not) be covered by MinnesotaCare would depend solely on whether he or she applied before or after the date the cap was implemented.

Reduce Benefits. The $175 million fund balance deficit at the end of FY 1997 equals 28 percent of projected MinnesotaCare medical payments for the three-year period FY 1995 to FY 1997. Drastic cuts in benefits will be required to balance the fund through reduced coverage. For example, in order to address a deficit of this magnitude, MinnesotaCare would have to either eliminate all inpatient coverage effective July 1, 1994, or limit coverage to hospital, physician, clinic, lab, and x-ray services, while eliminating pharmacy, dental, and several other covered services.

Increase Premiums. In order to deal with a deficit of this size, premiums would have to be more than tripled. Because most MinnesotaCare enrollees are in the lowest income group (below 150 percent of federal poverty guidelines) this would make the program unaffordable for many current enrollees.

Recommendation

Delaying MinnesotaCare enrollment of adult-only households by eighteen months is the preferred action for remedying the projected deficit. This option, which is consistent with current law, is the least disruptive to families with dependent children, as it allows benefits and premium contributions to continue without change. It retains the historical focus of MinnesotaCare on the long-range reduction of health care costs by providing low-cost health care coverage to minor children and their families.

Table Six
Impact of Eighteen-Month Delay on MinnesotaCare Enrollment and Health Care Access Fund Balance

(Thousands of Dollars)

	FY 1994	FY 1995	FY 1996	FY 1997
Adult-Only Households	0	0	9,757	52,604
Family Enrollment	62,305	81,147	97,527	110,897
Total Enrollment	62,305	81,147	107,284	163,501
Health Care Access Fund Balance	22,985	59,940	80,492	7,004

Although there has been a high level of interest expressed by adult-only households in MinnesotaCare, GAMC continues to serve the poorest members of this group. Delaying adult-only enrollment appears to be the best alternative to preserve the integrity and the goals of the MinnesotaCare program.

Appendix A

The Health Care Access Fund Balance: Developments Since End of 1993 Session

The 1992 Legislative Session funded MinnesotaCare (then called Health Right) so that projected revenues were sufficient to fund the program through FY 1997. The fund began to have a projected deficit for FY 1997 with the November 1992 MinnesotaCare forecast, although this fact was not evident because projections at the time only extended through FY 1995. When fund balance statements showing FY 1996 and FY 1997 were prepared at the end of the 1993 Legislative Session to update enrollment and incorporate legislative policy changes, it became evident that the Health Care Access fund would not sustain a positive balance through the biennium. (The 1992 MinnesotaCare law, which requires quarterly forecast assessments of the fund balance, requires consideration of the forecast for the current fiscal year and the two following years. During FY 1993, therefore, the prescribed forecast horizon for the quarterly assessments extended only to FY 1995.)

The 1993 end-of-session fund balance statements showed a deficit beginning in FY 1996, with an accumulated deficit of $236 million at the end of FY 1997. The December 1993 fund balance statement was somewhat worse: the deficit began in FY 1995 and accumulated to $246 million by the end of FY 1997. The March 1994 demand estimates show a deficit beginning in FY 1995, accumulating to $191 million by the end of FY 1997. (Table One provides summary information on the bottom line figures of these statements.)

Table One
Comparison of Fund Balance Positions
(Thousands of Dollars)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
MARCH 1994 (Demand Est.)					
Year Balance	11,497	4,610	(32,620)	(73,390)	(100,658)
Accumulated Balance	11,497	16,107	(16,513)	(89,903)	(190,561)
DECEMBER 1993					
Year Balance	11,538	2,726	(35,641)	(90,725)	(134,122)
Accumulated Balance	11,538	14,264	(21,377)	(112,102)	(246,224)
SEPTEMBER 1993					
Year Balance	10,215	6,223	(8,334)	(80,901)	(160,799)
Accumulated Balance	10,215	16,438	8,104	(72,797)	(233,596)
END OF '93 SESSION					
Year Balance	5,668	3,538	(5,696)	(78,948)	(160,845)
Accumulated Balance	5,668	9,206	3,510	(75,438)	(236,283)

History of the MinnesotaCare Expenditure Forecast

Developments Since April 1992

This section provides an account of the forecast changes and the 1993 legislative changes which contributed to the change in the expenditures forecasted for the program. Table Two shows that accumulated changes in the MinnesotaCare expenditure forecast account for $114 million of the $191 million deficit in the fund balance by the end of FY 1997. A net cost of $46 million for benefit and eligibility increases made by the 1993 Legislature is contained within the $114 million figure.

Table Two
Effect of Forecast Changes on the Fund Balance Since April 1992
(Thousands of Dollars)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
CHANGES IN FORECASTED EXPENDITURES					
By Fiscal Year	(3,246)	3,534	47,216	46,937	20,012
Accumulated Effect	(3,246)	288	47,504	94,441	114,453

Late in the winter of 1992, legislators who were negotiating health care reform decided that health care coverage for the uninsured would be provided by expanding upon the eligibility and the coverage provided by the Children's Health Plan (CHP). They called upon the Department of Human Services (DHS) staff responsible for forecasting Medical Assistance (MA) and General Assistance Medical Care (GAMC) expenditures to provide estimates for the costs of the new program. DHS provided estimates which were intended to have approximately equal risk of being high or low.

The risks of forecasting the enrollment and expenditures of a new health care coverage program are large. In this instance, these risks were increased by the extended forecast horizon (one additional biennium) used for MinnesotaCare projections from the beginning in April 1992. In other areas of state government these extended projections are called "planning estimates," rather than "forecasts," in recognition of the great difficulty of forecasting several years ahead.

Forecast Changes

Significant forecast changes occurred in November 1992, March 1993, December 1993, and February 1994. The May 1993 changes represent only legislative changes made in the 1993 Session. The September 1993 changes represent little change beyond updating to actual FY 1993 figures. Tables Three and Four summarize the history, respectively, of the MinnesotaCare enrollment forecast and the MinnesotaCare expenditure forecast from the end-of-session 1992 (April 1992) estimates to the March 1994 demand estimates.

Table Three
Comparison of MinnesotaCare Enrollment Forecasts

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
TOTAL ENROLLMENT					
April 1992	9,333	49,706	74,204	121,540	158,210
November 1992	3,198	53,915	85,317	133,040	170,207
March 1993	4,418	57,776	97,355	141,736	179,705
1993 Session Changes	4,418	62,864	102,243	146,463	184,148
September 1993	4,896	62,864	102,056	146,103	183,549
December 1993	4,896	63,532	113,923	155,546	83,277
March 1994 (Est. Demand)	4,896	62,305	111,450	153,104	80,775
March 1994 (Current Law)	4,896	62,305	81,147	107,285	163,501
ENROLLMENT FORECAST CHANGES					
November 1992	(6,135)	4,209	11,113	11,500	11,997
March 1993	1,220	3,861	12,038	8,696	9,498
1993 Session Changes	0	5,088	4,888	4,727	4,443
September 1993	478	0	(187)	(360)	(599)
December 1993	0	668	11,867	9,443	(272)
March 1994 (Est. Demand)	0	(1,227)	(2,473)	(2,442)	(2,502)
March 1994 (Current Law)	0	0	(30,303)	(45,819)	(17,274)
Net Change from April 1992 to March 1994 (Est. Demand)	**(4,437)**	**12,599**	**37,246**	**31,564**	**22,565**

Appendix A

This table summarizes successive forecasts of MinnesotaCare medical payments net of enrollee premium payments. Forecasts are on an accrual basis.

Table Four
Comparison of MinnesotaCare Net Cost Forecasts
(Thousands of Dollars)

	FY 1993	FY 1994	FY 1995	FY 1996	Y 1997
NET COST FORECASTS					
April 1992	5,355	35,556	67,373	$135,839	$209,177
November 1992	3,289	33,035	74,546	143,991	219,305
March 1993	4,645	45,434	100,967	188,719	276,759
1993 Session Changes	4,645	42,469	94,557	174,876	257,157
September 1993	3,432	42,469	94,311	174,356	256,195
December 1993	2,109	41,095	144,153	196,921	260,811
March 1994 (Demand Est.)	2,109	39,091	114,589	182,776	229,189
March 1994 (Current Law)	2,109	39,091	66,066	106,225	201,100
NET COST FORECAST CHANGES					
November 1992	(2,066)	(2,521)	7,173	8,152	10,128
March 1993	1,356	12,399	26,421	44,728	57,454
1993 Session Changes	0	(2,965)	(6,410)	(13,843)	(19,602)
September 1993	(1,213)	0	(246)	(520)	(962)
December 1993	(1,323)	(1,374)	19,842	22,565	4,616
March 1994 (Demand Est.)	0	(2,005)	436	(14,145)	(31,622)
March 1994 (Current Law)	0	0	(48,523)	(76,551)	(28,089)
Net Change from April 1992 March 1994 (Est. Demand)	**(3,246)**	**3,535**	**47,216**	**6,937**	**20,012**
Running Total of Forecast Changes through March 1994 (Est. Demand)	**(3,246)**	**288**	**47,504**	**94,441**	**114,453**

The November 1992 forecast increased enrollment projections for families with children based on application and enrollment activity through October 1992. The average cost per person for families with children was adjusted downward for FY 1994, producing a decrease in the net cost forecast in spite of the increased enrollment projection.

FY 1993 projections were cut because DHS administrative capacity was constraining enrollment growth and because the Children's Health Plan (CHP) had adequate funds to permit children to remain in the $25 per year CHP enrollment option.

Table Five
Effect of November 1992 Forecast Changes
MinnesotaCare Net Cost and Enrollment
(Thousands of Dollars)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Change in Net Costs	(2,066)	(2,521)	7,173	8,152	10,128
Percentage Change	-38.6%	-7.1%	10.6%	6.0%	4.8%
Change in Enrollment	(6,135)	4,209	11,113	11,500	11,997
Percentage Change	-65.7%	8.5%	15.0%	9.5%	7.6%

The March 1993 forecast again increased enrollment projections for families with children based on application activity through January 1993. A faster start of enrollment for adult-only households was also assumed.

Table Six
Effect of March 1993 Forecast Changes
MinnesotaCare Net Cost and Enrollment Changes

(Thousands of Dollars)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Reasons for Net Cost Changes					
Higher Enrollment	1,356	5,268	13,205	15,050	18,655
Technical Correction	0	2,124	0	0	0
Managed Care Schedule	0	0	3,558	13,759	16,102
Non-AFDC Inpatient Rates	0	5,007	9,658	15,919	22,697
Total Net Cost Change	1,356	2,399	26,421	44,728	57,454
Percentage Change	41.2%	37.5%	35.4%	31.1%	26.2%
Change in Enrollment	1,220	3,861	12,038	8,696	9,498
Percentage Change	38.1%	7.2%	14.1%	6.5%	5.6%

Managed care had been assumed in the forecast to produce a ten percent savings on that portion of the business which was in managed care. The April 1992 assumption that the program would be 50 percent managed care in FY 1995 and 100 percent managed care in FY 1996 was revised to five percent in FY 1994, rising to 55 percent in FY 1997. This reduced the amount of managed care savings assumed in the forecast. The revised schedule was based on the managed care plan submitted to the Legislature by DHS in February 1993.

The April 1992 estimates were based on a composite of MA inpatient hospital rates. MA has two distinct sets of inpatient rates: one for AFDC and one for all others (non-AFDC rates). It was determined that the current law implied the higher non-AFDC rates. The forecast change reflected the added cost for these higher rates.

During the 1993 Legislative Session, a number of substantial program modifications were enacted. The November 1992 forecast increase regarding inpatient hospital rates was reversed by adopting AFDC rates for inpatient services. MinnesotaCare enrollees were judged more likely to resemble AFDC families in their use of hospital services than other, more expensive, Medical Assistance clients. Service coverage was substantially increased by adding coverage of mental health and chemical dependency services. Eligibility was expanded by providing MinnesotaCare eligibility pending determination of MA eligibility (Bridge the Gap). The cost of the changes was offset by reducing dental coverage for adults to preventive services only and by expanding Medical Assistance eligibility to children under one year old with incomes up to 275% of the federal poverty guideline.

Table Seven
1993 Session Changes
MinnesotaCare Net Cost and Enrollment Projections
(Thousands of Dollars)

	FY 1994	FY 1995	FY 1996	FY 1997
Reasons for Net Cost Changes				
AFDC Inpatient Rates	(7,990)	(15,821)	(26,936)	(38,011)
Adult Dental limit	(1,560)	(3,505)	(5,102)	(6,471)
MA 275% Under 1 Year	(755)	(1,115)	(1,439)	(1,808)
CD & Mental Health Cov.	3,860	8,057	14,245	20,331
Bridge the Gap	1,958	1,972	2,077	1,888
$4/Month for Children <150% of Poverty	2,323	2,843	3,271	3,571
Pharmacy Rates	72	77	301	420
Other adjustments	(873)	982	(260)	478
Total Net Cost Change	(2,965)	(6,410)	(13,843)	(19,602)
Percentage Change	-6.5%	-6.3%	-7.3%	-7.1%
Enrollment Change	5,088	4,888	4,727	4,443
Percentage Change	8.8%	5.0%	3.3%	2.5%

The savings from adopting AFDC inpatient rates were greater than the cost projected in theNovember 1992 forecast using non-AFDC inpatient rates, because the AFDC rates are lower than the composite rates assumed in April 1992.

The increase in enrollment projections results from the $4 monthly premium for children under 150% of poverty and from "Bridge the Gap," which allows MinnesotaCare applicants who appear eligible for Medical Assistance to be enrolled in MinnesotaCare pending determination of MA eligibility.

The value of the inpatient and pharmacy rate changes is distinguished from that of other 1993 Session changes in this analysis to illustrate the net cost of the changes in eligibility and service coverage passed in the 1993 Session. The net savings resulting from the rate changes is treated as offsetting forecast changes—as indeed the inpatient change reversed a substantial portion of the November 1992 forecast increases.

Table Eight shows the calculation of the value of 1993 Session eligibility and coverage changes apart from the inpatient rate change.

Table Eight
1993 Session Changes in MinnesotaCare Eligibility and Coverage

(Thousands of Dollars)

	FY 1994	FY 1995	FY 1996	FY 1997
Value of:				
Total 1993 Session Changes	(2,965)	(6,410)	(13,843)	(19,602)
Inpatient Rate Change	7,990	15,821	26,936	38,011
Pharmacy Rate Change	(72)	(77)	(301)	(420)
1993 Session Eligibility and Coverage Changes	4,953	9,234	12,272	17,989
Running Total	4,953	14,187	26,979	44,968

The December 1993 forecast revised earlier assumptions about the rate at which adult-only households would enroll in MinnesotaCare. The rate of enrollment was projected to be faster than assumed in previous forecasts, but the level expected to be reached in FY 1997 was kept approximately the same. This change was based on the number of contacts from people inquiring about eligibility and increased DHS capacity to add new enrollees.

Enrollment and average cost projections for families with children were reduced slightly. Other changes involved adjustment in premium revenue projections and MA and GAMC projections for MinnesotaCare enrollees. These changes are summarized in Table Nine.

Table Nine
December 1993 Forecast Changes
MinnesotaCare Net Cost and Enrollment Projections

(Thousands of Dollars)

	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997
Reasons for Net Cost Changes					
Households without Child Enrollment	0	0	17,926	16,282	1,299
Families with Children Enrollment	(1,323)	(749)	(2,549)	834	731
Managed Care Schedule	0	0	4,074	6,652	3,575
Other Changes	0	(625)	391	465	473
Total Net Cost Change	(1,323)	(1,374)	19,842	22,565	4,616
Percentage Change	-38.5%	-3.2%	21.0%	12.9%	1.8%
Enrollment Change	0	668	11,867	9,443	(272)
Percentage Change	0.0%	1.1%	11.6%	6.5%	-0.1%

In preparation for the March 1994 forecast, changes were made which led to production of new estimates. These are designated "March 1994 Demand Estimates." These estimates were used to define the fund balance deficit that needed to be addressed in the March 1994 forecast.

The February 1994 forecast, shown in Table Ten, revised the claim cost rates for the two segments of the program, households without children and families with dependent children, to ensure an accurate division of costs for the two segments. The result was increased costs for households with no children. These costs were offset by decreased cost projections for families with children, but the net effect of the two changes produced increases for FY 1995 to FY 1997.

Annual trend assumptions were revised to be consistent with the MA forecast. No price inflation was assumed except as provided in current law for Medical Assistance rates. This reduced the previous ten-percent trend assumption for FY 1996 and FY 1997 to approximately four percent. The percentage discount assumed from managed care was reduced from ten percent to five percent. This was done because of uncertainty about how MinnesotaCare can continue to benefit from MA payment of expensive inpatient bills under an HMO arrangement.

Enrollment projections for families with children were reduced one-to-two percent based on experience through January 1994.

Table Ten
March 1994 Demand Estimates
MinnesotaCare Net Cost and Enrollment Projections

(Thousands of Dollars)

	FY 1994	FY 1995	FY 1996	FY 1997
Reasons for Net Cost Changes				
Claim Cost Rates	(693)	7,509	6,793	8,520
Current Law Price Inflation	0	(4,082)	(20,342)	(43,937)
Managed Care Discount	0	0	2,518	7,128
Families with Children Enrollment	(1,301)	(2,991)	(3,114)	(3,333)
Total Net Cost Change	(2,004)	436	(14,145)	(31,622)
Percentage Change	-4.9%	0.4%	-7.2%	-12.1%
Enrollment Change	(1,227)	(2,473)	(2,442)	(2,502)
Percentage Change	-1.9%	-2.2%	-1.6%	-1.4%

In recognition of the fund balance deficit implicit in the March 1994 Demand Estimates and the requirement of current law that program eligibility be managed so that expenditures would not exceed available funding, the March 1994 forecast modifies the March demand estimates by assuming that the beginning of eligibility for adult-only households would not occur until January 1996. Table Eleven summarizes the cost and enrollment effects of this change.

Table Eleven
March 1994 Forecast
MinnesotaCare Net Cost and Enrollment Projections

(Thousands of Dollars)

	FY 1994	FY 1995	FY 1996	FY 1997
Reasons for Net cost Changes				
Eligibility for adult-only Households Delayed to Jan. 1996	0	(48,523)	(76,551)	(28,089)
Total Net cost Change	0	(48,523)	(76,551)	(28,089)
Percentage change	0.0%	-42.3%	-41.9%	-12.3%
Enrollment Change	0	(30,303)	(45,819)	(17,274)
Percentage Change	0.0%	-27.2%	-29.9%	-9.6%