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Progress Toward Universal Health Coverage in Minnesota:

Annual Report



**Minnesota
Health Care
Commission**

Pursuant to 1995 Minn. Laws Chap. 234
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Progress Toward Universal Health Coverage in Minnesota:

Annual Report

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Minnesota
Health Care
Commission

January, 1996

The Minnesota Health Care Commission

The Minnesota Health Care Commission's 28 members represent consumers, labor, employers, health care providers, health plan companies, and state government. The commission was created in the original 1992 HealthRight Act (now known as "MinnesotaCare") to provide an opportunity for the major stakeholders to seek consensus on health care reform policies and programs. The commission reached consensus on a cost containment plan in 1992 and a universal coverage plan in 1993. Many of the commission's previous recommendations have been enacted into law and form the basis for the state's strategies to improve health care access, affordability, and quality.

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Progress Toward Universal Health Coverage in Minnesota: Annual Report

January, 1996

Forward

The 1995 MinnesotaCare Act directed the Minnesota Health Care Commission to report annually to the Legislature on “the extent to which the State is making progress toward the goal of universal coverage.” The report is to include findings of monitoring the uninsured, and recommendations regarding possible additional steps toward universal coverage. The Legislature also required the commission to make recommendations to improve health coverage for persons with disabilities. This reporting requirement was incorporated as part of the commission’s annual report on universal coverage, below, and as part of a separate commission planning study to improve coordination of acute and long term care.

This annual report is the commission’s third report on universal health coverage, and draws upon the considerable analysis and discussion of this issue by the commission over the past three years. The commission’s first two universal coverage reports, Universal Coverage Report (1994) and An Affordable Step Toward Universal Coverage (1995), described the importance of universal coverage to the health care policy debate, and suggested an integrated package of recommendations to reduce the number of Minnesotans without health insurance. Previous universal coverage reports also presented key findings to guide policy, including: estimates of the number and characteristics of those lacking health insurance in Minnesota; results of actuarial analyses of proposed insurance reforms; universal coverage financing options; and closer examination of the problems posed by maintaining a voluntary health insurance market in which younger, healthier persons are free to opt out of coverage until they are older or become ill, with attendant higher costs for others who continuously maintain coverage.

Executive Summary

While this annual report draws on the analytic and conceptual frameworks of our previous reports, it has been shaped by challenges and concerns unique to the current health care reform environment. The legislative and policy context for the commission's deliberations of universal coverage this year included the following developments:

- There was greater awareness and discussion of the costs of Minnesota's publicly funded health care programs, which are growing at a rate that exceeds available state funding.
- These fiscal pressures are likely to be exacerbated by anticipated reductions in the rate of growth of federal outlays for Medicare and Medicaid programs. The size and timing of these reductions have not yet been determined, creating a high level of uncertainty regarding the potential impact of these reductions for Minnesota. The Minnesota Department of Human Services (DHS) has been engaging a variety of stakeholders, including the commission, and the public in discussions of a framework for addressing the pending federal changes.
- Support generally seems to be lacking for mandates or increased taxes for new state spending on health care.

As a result, the universal coverage policy debate this year has focused not only on expanding the number of Minnesotans with health coverage, but also on maintaining gains achieved to date under the state's comprehensive health care reforms, known collectively as MinnesotaCare. These reforms have kept Minnesota's rate of uninsurance one of the lowest in the nation, while the national rate of uninsurance has steadily increased.

The commission's recommendations below are relevant to policy concerns of the upcoming legislative session. We have not proposed health-related tax increases or mandates. Our recommendations reflect the needs to address rapidly growing publicly financed health care expenditures, and to prepare for likely reductions in the federal share of health care funding. Our recommendations build on reforms which have been demonstrated to be successful, and which makes use of voluntary, market-based efforts to improve health coverage.

The body of the report also updates our previous estimates of Minnesota's uninsured, and concludes with an examination of some of the key challenges and issues to be addressed in the future to ~~continue~~ making progress toward universal coverage. Much of the review and discussion for ~~this~~ report was conducted by the commission's Universal Coverage work group, which met five times in 1995. (A list of participants on the work group is provided at the beginning of this report.)

Executive Summary

Commission Support for Universal Coverage

The Minnesota Health Care Commission supports the goals in the 1995 MinnesotaCare Act for achieving universal health coverage, and for reducing the percent of Minnesotans lacking health coverage to fewer than 4 % of the population by January 1, 2000.

Definition of Universal Coverage

According to current statute, universal coverage is achieved when:

- every Minnesotan has access to a full range of quality health care services;
- every Minnesotan is able to obtain affordable health coverage which pays for the full range of services, including preventive and primary care;
- every Minnesotan pays into the health care system according to that person's ability.

Strategies to Achieve Universal Coverage

Minnesota has successfully employed a variety of coordinated strategies to address the problem of the uninsured, and to make continued progress toward achieving universal coverage. Minnesota's strategies rely on market forces and a combination of private and public sector responses to expand opportunities for obtaining affordable, available health coverage. These strategies include:

- **Health care cost containment.** Costs are being contained, through Minnesota's cost containment efforts and competitive market forces, making health coverage more affordable. New information is being generated to help all parties – patients, providers, insurers, businesses, government – improve their health care decisions to obtain optimal health care value.
- **Assistance for low income persons.** Public programs such as Medical Assistance, General Assistance Medical Care, and MinnesotaCare, a subsidized health insurance program, have provided affordable health coverage to very-low-income persons, persons with disabilities, and low income workers who do not otherwise qualify for public assistance.

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- **Insurance reforms.** Insurance reforms in rating, underwriting, and other areas have been successfully instituted to help individuals and small employers purchase quality, affordable products.
- **Purchasing pools.** Purchasing pools potentially offer smaller groups some of the advantages of large group purchasing of health care. These advantages include greater choice among products, more negotiating power in the market, and economies of scale to reduce the costs of marketing, enrolling members, and premium collection.
- **Broad, stable financing.** General revenues are used to finance MA and GAMC. A 2 % provider tax was imposed in 1992 to fund MinnesotaCare. Additional HMO and nonprofit health plan gross premium taxes took effect on January 1, 1996.
- **Personal responsibility.** Strategies to encourage individuals to take personal responsibility for paying their share are important to achieving universal coverage.

These strategies are continued in the recommendations below.

Summary of Minnesota Health Care Commission Recommendations

The Minnesota Health Care Commission forwards the following recommendations to continue progress toward universal coverage. These recommendations are consistent with Minnesota's move toward achieving universal health coverage, and can be achieved in the current health care reform environment.

The recommendations have been grouped according to four main categories:

1. Assist low income persons and persons with disabilities
2. Insurance reforms
3. Purchasing pools
4. Personal responsibility

1. Assist low income uninsured persons and persons with disabilities

- A. **Recommendation:** Expand the MinnesotaCare subsidized health insurance program consistent with the availability of funds and maintenance of the integrity of the MinnesotaCare program.

Executive Summary

- B. Recommendation: Continue development and implementation by the Minnesota Department of Human Services of a consolidated sliding scale subsidy program, combining Medical Assistance, General Assistance Medical Care, and MinnesotaCare to provide low income uninsured persons with subsidized health coverage as described below.
- Eligibility, benefits, and reimbursement or purchasing strategies for the subsidy program should be designed to make best use of limited resources, and to target those most in need.
 - Design of the consolidated subsidy program should follow the principles outlined in Department of Human Services (DHS) *Minnesota Response, Third Draft*.
 - The commission should continue to be involved in assisting DHS in designing and implementing the consolidated program.
 - Design and implementation of the consolidated program should also take into account the findings and recommendations of the commission's long term/acute care coordination project.
- C. Recommendation: In the implementation of the above two recommendations, the commission strongly recommends that the funding for the MinnesotaCare subsidy program be continued to be used exclusively for the original purposes for which it was intended and for which it is mandated in the MinnesotaCare Act.

2. Insurance reforms

- A. Recommendation: Broaden the Minnesota Comprehensive Health Association (MCHA) funding base on a revenue neutral basis to achieve broader, more stable, more equitable financing of MCHA.
- B. Recommendation: Maintain current rating and underwriting reforms. Do not institute further reductions in rate bands or guaranteed issuance in the individual market.
- C. Recommendation: Explore making additional health insurance options available to consumers on a pretax basis when these options are consistent with, and complementary to, MinnesotaCare reforms, and when the options:
- do not lead to risk segmentation in the market;

Executive Summary

- are tied to savings or insurance strategies which also effectively help individuals meet long term care needs; and
- are designed to also encourage use of appropriate, cost-effective primary and preventive care.

3. Purchasing Pools

- A. Recommendation: Continue authorization of voluntary purchasing pools. Monitor the number and characteristics of the uninsured. Delay decisions on opening a state-sponsored purchasing pool to individuals until more information becomes available on the effectiveness of private and state-sponsored purchasing pools, including the experience of states which have recently opened pools to individuals.

4. Personal Responsibility

- A. Recommendation: Provide education and information to inform individuals of the need for health insurance, and the costs to the individual, families, and the state of being uninsured. Provide consumers information and assistance on health insurance options, and sources of information or assistance in purchasing coverage.
- B. Recommendation: Support and facilitate efforts already being undertaken to enforce child support laws for medical support. Facilitate information exchange between employers and child support enforcement entities to aid in identifying children with court ordered medical support and employees responsible for making the support payments. Facilitate employer roles in withholding child medical support payments from employees with court ordered medical support obligations, or enrollment of the affected children on the employer's group health plan, as appropriate and as already required by law.
- C. Recommendation: Explore mechanisms with employer and employee representatives that would require all employees with access to employer-funded coverage to purchase such coverage.

Progress Toward Universal Health Coverage in Minnesota: Annual Report

January, 1996

Introduction

The 1995 MinnesotaCare Act directed the Minnesota Health Care Commission to report annually to the Legislature on "the extent to which the State is making progress toward the goal of universal coverage." The report is to include findings of monitoring the uninsured, and recommendations regarding possible additional steps toward universal coverage which should be undertaken. The Legislature also requires the commission to make recommendations to improve health coverage for persons with disabilities. This latter reporting requirement was incorporated as part of the commission's annual report on universal coverage, below, and as part of a separate commission planning study to improve coordination of acute and long term care.

The commission formed a work group to address the study issues. The work group met five times in the autumn and early winter of 1995, and drew upon the large body of information commissioned for our two previous reports on universal coverage, as well as more recent contributions by state agencies and consultants. The work group's findings and recommendations were then reviewed by the full commission in December 1995 and January 1996.

The commission's recommendations are described in greater detail in the discussion section below. We have not proposed health-related tax increases or mandates, but our recommendations do reflect the need to address rapidly growing publicly financed health care expenditures, and to prepare for likely reductions in the federal share of health care funding. Our recommendations build on reforms which have been demonstrated to be successful, and which make use of voluntary, market-based efforts to improve health coverage.

The following section of the report updates our previous estimates of Minnesota's uninsured, and concludes with a brief examination of some of the key challenges and issues to be addressed in the future to continue making progress toward universal health coverage in Minnesota.

Discussion

Estimates of the Uninsured in Minnesota

The commission estimates that approximately 9% of the state's population -- approximately 400,000 persons -- lack health insurance at any given point in time. This estimate is based largely on Minnesota-specific data from a national survey (the Current Population Survey, or CPS), and preliminary data for the first half of 1995 from the Behavioral Risk Factor Surveillance System. For additional information on these two data sources, please see appendix A.

Minnesota's estimate of the uninsured appears to be holding steady while the national trend in uninsurance is upward. Over the period 1990-1994, the national rate of uninsurance rate rose from 13.9% to 15.2%, while Minnesota's rate of uninsurance has remained at about 9%. These data suggest that the range of health care reforms known as MinnesotaCare have had a positive impact on keeping the state's rate of uninsurance one of the lowest in the country. However, continued economic restructuring, including downsizing of large organizations, expansion of service sector jobs, and use of contingent workers, is leading to fewer employer-based health insurance opportunities, and continues to place upward pressure on the ranks of the uninsured.

The estimates above may be substantially modified when new data is available from a survey of the uninsured now being completed by the University of Minnesota's Institute for Health Services Research. The survey was sponsored by the Blue Cross/Blue Shield Foundation of Minnesota. It is anticipated that the number of the uninsured from this study may differ from the commission's estimate for two reasons. First the research methodologies employed are different. The University's survey used additional questions and probes of the uninsured to better discern whether they in fact were covered by public programs, and therefore were not truly uninsured. The University's study also utilized a significantly larger sample size, which will reduce the variance in the estimate of the uninsured. Second, the University's survey will provide more recent data which may indicate that MinnesotaCare reforms are having a greater impact than measured to date. The commission's estimates of the uninsured this year relied upon data from 1994 and the first half of 1995, and this data may not have recorded the full impact of insurance reforms which were initiated starting in 1993, and the growth of the MinnesotaCare subsidy program during 1995.

The commission's previous universal coverage studies have reported in depth on the characteristics of the uninsured. Key findings on the uninsured appear below.

- The most striking difference between the insured and uninsured populations is their income distribution. The uninsured have lower incomes than the insured, as shown in the table below.

Discussion

Income Distribution of Insured and Uninsured Persons in Minnesota¹

	Percent with incomes less than 100% of poverty	Percent with incomes 100% to 200% of poverty	Percent with incomes 200% to 300% of poverty	Percent with incomes greater than 300% of poverty
Insured	10.8%	13.3%	19.5%	56.3%
<i>Uninsured</i>	<i>18.5%</i>	<i>29.1%</i>	<i>25.6%</i>	<i>26.8%</i>

- More than 72% of uninsured adults are employed. The uninsured were more likely to work in service and labor occupations, and less likely to work in managerial, professional, or technical occupations.
- The uninsured are disproportionately young and single. The single largest group of uninsured is young, unmarried adult males, ages 18-34, who account for nearly one-third of the uninsured.

Discussion of the Commission's Recommendations

1. Assist low income uninsured persons and persons with disabilities

- A. **Recommendation:** *Expand the MinnesotaCare subsidized health insurance program consistent with the availability of funds and maintenance of the integrity of the MinnesotaCare program.*

Discussion

Health coverage for low income persons, especially those without access to employer-sponsored

¹ U.S. Bureau of Census, 1994 Current Population Survey

Discussion

group coverage, may be unaffordable without a subsidy. The commission estimates that approximately 18.5% of the uninsured have incomes at or below the federal poverty level, and that an additional 29% have incomes less than twice the poverty level.

The table below shows the 1995 federal poverty levels (FPL) and multiples of FPL by family size for reference. A four-person family with both parents making minimum wages would have a combined earned income of approximately \$17,680 per year, which is approximately 117% of the federal poverty level for a family of four. Depending on the type of health insurance purchased, family health coverage often may cost in the range of \$200 to \$400 per month, or more, or \$2400 to \$4800 annually. For the hypothetical family above with a combined yearly income of \$17,680 per year, annual health insurance costs of \$3600-\$4800 per year would amount to 13.5% to 27% of the family's annual income, a level of expense which may be unaffordable without a subsidy.

1995 Federal Poverty Levels (FPL) by Family Size²

Family size	100% of FPL	125% of FPL	135% of FPL	150% of FPL	200% of FPL	250% of FPL	275% of FPL
One	\$7,470	\$9,338	\$10,085	\$11,205	\$14,940	\$18,675	\$20,543
Two	\$10,030	\$12,538	\$13,541	\$15,045	\$20,060	\$25,075	\$27,583
Three	\$12,590	\$15,738	\$16,997	\$18,885	\$25,180	\$31,475	\$34,623
Four	\$15,150	\$18,938	\$20,453	\$22,725	\$30,300	\$37,875	\$41,663
Five	\$17,710	\$22,138	\$23,909	\$26,565	\$35,420	\$44,275	\$48,703

The MinnesotaCare subsidized health insurance program was established in 1992 and is now helping meet the needs of more than 90,000 low income uninsured persons who do not qualify for other forms of public assistance. MinnesotaCare is not an entitlement program, and is not funded through the state's general fund. Eligibility to purchase subsidized health coverage through the program is based on income, family status, and requirements that enrollees must have

² Minnesota Department of Human Services, January 1996

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been uninsured at least four months prior to enrolling in MinnesotaCare, and must not have had access to employer provided coverage within eighteen months of enrolling.

Families with children are currently eligible to purchase coverage through the program with incomes to 275% of the federal poverty level. Individuals without children are eligible to purchase coverage with incomes to 125% of the federal poverty level. Everyone in the program pays a premium based on income; those at the highest income levels pay nearly the full actuarially determined cost of coverage. The hypothetical family of four above with an annual gross earned income of \$17,680 (117% of FPL) would pay \$31 per month for family coverage under the MinnesotaCare subsidy program. Another family of four covered under the MinnesotaCare program, but with an annual income approaching 275% FPL, would pay nearly the full cost of family coverage of \$312 per month.

According to a recent study by the University of Minnesota's Institute for Health Services Research, MinnesotaCare is a program that is "hitting its target," providing low income persons a source of health coverage that otherwise would not be affordable for them, with important positive health benefits. Over eighty percent of those who responded to the University's survey of MinnesotaCare enrollees reported that they received health care through the program which they otherwise would not have received. Two-thirds of those who were surveyed said their health would suffer if MinnesotaCare were discontinued.³

Further evidence that MinnesotaCare is succeeding is provided by recent reports from the Department of Human Services (DHS) that attribute a decline in the number of persons obtaining welfare assistance through Aid to Families with Dependent Children (AFDC) to the availability of MinnesotaCare. According to DHS analyses, approximately 4100 fewer families have enrolled in AFDC because the availability of subsidized health coverage allows the working poor to remain off welfare. This translates to a combined net savings to the state and federal governments of approximately \$2 million per month, or approximately \$24 million annually.⁴

MinnesotaCare is funded through a dedicated revenue source, the Health Care Access Fund. This fund is maintained through premium payments from enrollees, a 2% provider tax, and recently implemented gross premium taxes on HMOs and nonprofit health plans such as Blue Cross and Blue Shield of Minnesota.

³ N. Lurie, A. Pheley, and M. Finch, *Is MinnesotaCare Hitting Its Target?* (Institute for Health Services Research, University of Minnesota School of Public Health, and Hennepin County Medical Center, October 24, 1995)

⁴ M.R. Gomez, *MinnesotaCare: Providing quality services, saving money* (Minnesota Department of Human Services, December 1995).

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Numerous safeguards are in place to ensure the solvency of the Health Care Access Fund, including requirements for:

- maintenance of reserves equal to 5 % of the expected cost of state premium subsidies;
- quarterly assessments of expected expenditures for the remainder of the current biennium and for the following biennium;
- consultations by the Commissioner of the Department of Human Services (DHS) with the Legislature's House Ways and Means Committee, Senate Finance Committee, and the Legislative Oversight Commission on Health Care Access, regarding the status of the fund;
- and any adjustments necessary to eligibility for MinnesotaCare to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

The 1995 MinnesotaCare Act gives the Commissioner of DHS authority to raise eligibility for the MinnesotaCare program for adults without children to include those with incomes to 135% of FPL after October 1, 1995, if the conditions above for ensuring the solvency of the Health Care Access Fund are met. In addition, the Commissioners of DHS and the Department of Health are to consult with the Legislative Oversight Commission on Health Care Access and make recommendations about expanding MinnesotaCare eligibility for adults without children to 150% of FPL by February 1, 1996.

At current MinnesotaCare eligibility levels, a surplus of more than \$357 million in the Health Care Access Fund is projected for the end of the next biennium in 1999⁵. Increasing MinnesotaCare eligibility for adults without children, consistent with the availability of funds and maintenance of the integrity of the Health Care Access Fund, will:

- help insure additional low income persons;
- help provide access to the preventive and primary care benefits of MinnesotaCare, to prevent more costly treatment of serious or unattended conditions later;
- reduce the level of uncompensated care that results when uninsured persons receive care they cannot pay for, and reduce the level of cost shifting that may arise if providers

⁵ Minnesota Department of Finance, *November Forecast, MinnesotaCare Health Care Access Fund*, December 1, 1995.

Discussion

attempt to make up for their uncompensated care by charging other payers more;

- continue the movement from dependency on welfare programs such as AFDC to employment and self-sufficiency; and
- not jeopardize the solvency of the Health Care Access Fund.

B. *Recommendation:* Continue development and implementation by the Minnesota Department of Human Services of a consolidated sliding scale subsidy program, combining Medical Assistance, General Assistance Medical Care, and MinnesotaCare to provide low income uninsured persons with subsidized health coverage as described below.

- *Eligibility, benefits, and reimbursement or purchasing strategies for the subsidy program should be designed to make best use of limited resources, and to target those most in need.*
- *Design of the consolidated subsidy program should follow the principles outlined in Department of Human Services (DHS) Minnesota Response, Third Draft.*
- *The commission should continue to be involved in assisting DHS in designing and implementing the consolidated program.*
- *Design and implementation of the consolidated program should also take into account the findings and recommendations of the commission's long term/acute care coordination project.*

Discussion

Minnesota's publicly funded health care programs are growing at a rate that exceeds available state funding. At the same time, the federal government is considering a number of spending reductions to balance the budget. While the federal budget debate has not been resolved, significant reductions in the growth of federal outlays budgeted for Medicaid and Medicare are likely, and Medicaid may be restructured as block grants or capped entitlements to states. These limits on the state's ability to fund current projected levels of health care spending for low

⁶ *State of Minnesota Fiscal Outlook: Presentation to the Health Care Commission, November 15, 1995*

Discussion

income persons and persons with disabilities, coupled with anticipated federal reductions in federal Medicaid and Medicare spending, require a comprehensive, systematic approach to adequately address the health care needs of all low income persons and persons with disabilities within finances that will be available.

Consolidation of the state's Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare programs will result in streamlined eligibility determination, simpler, more efficient administration, and more effective purchasing. The commission supported a federal waiver request by the Department of Human Services in 1994 to begin integration of these programs.

The Department of Human Services (DHS), which administers the state's Medical Assistance (Medicaid) program, has outlined its emerging framework for responding to federal reductions in Medicaid spending in a series of recent briefing papers. The commission has discussed the framework with DHS, and supports its "building block" guiding principles and key components. The commission, which was named a primary stakeholder forum for purposes of addressing issues related to the DHS waiver, is ready to assist the design and implementation of the planned consolidated subsidy program with broad-based input and public discussion.

The DHS framework suggests that a supplemental benefit set to address long term care needs to be designed which "wraps around" other standard benefits sets, and which is provided in coordination with other services. The commission is undertaking a separate legislatively mandated planning study this year to improve the coordination of acute and long term care. The findings and recommendations of this study will be relevant to the DHS framework for responding to federal Medicaid funding reductions, and should be considered in subsequent iterations of the DHS response.

- C. ***Recommendation:*** *In the implementation of the above two recommendations, the commission strongly recommends that the funding for MinnesotaCare subsidy program be continued to be used exclusively for the original purposes for which it was intended, and for which it is mandated, in the MinnesotaCare Act.*

Discussion

The MinnesotaCare subsidy program was originally conceived of as a means of helping provide low income persons who did not qualify for other public assistance with affordable health

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coverage that encouraged timely access to basic preventive and primary acute care. The original legislative compromises resulting in passage of the 2% provider tax to fund MinnesotaCare were largely predicated on the fact that providers would ultimately also benefit from increased coverage of the uninsured, and that much of the tax would ultimately be returned to providers in the form of payment for health care services delivered as part of MinnesotaCare.

At this time however, concerns have been raised about the possible impact of anticipated federal reductions to the Medicaid program. Approximately 45% of the Medicaid budget is used to pay for long term care services. As MA, GAMC, and MinnesotaCare are consolidated, it would be inappropriate to consider MinnesotaCare funding as a source of replacement revenue for long term care services no longer paid for by shrinking federal Medicaid dollars. Because demands for long term care as currently delivered and paid for will far outstrip the state's ability to pay for these services, structural change in the long term care delivery and financing system is needed.

Simply transferring dollars from the Health Care Access Fund to long term care will not alleviate the need for comprehensive, structural change in the delivery and financing of long term care. Such a transfer may also have the unintended effect of increasing the demand for expensive long term care if primary and preventive acute care is not available to prevent or limit more serious health conditions. It is also likely that funding for acute care and other services for low income persons may be more limited because of federal Medicaid reductions. If this leads to more stringent eligibility thresholds for Medicaid, those no longer eligible for Medicaid may seek coverage through the MinnesotaCare subsidy program, and place additional pressures on MinnesotaCare resources. The commission strongly recommends that, as MA, GAMC, and MinnesotaCare are consolidated, funding for the MinnesotaCare subsidy program continue to be used for the original purposes for which it was intended in helping provide coverage for basic preventive and primary acute care for low income uninsured persons.

2. Insurance reforms

- A. ***Recommendation:*** *Broaden the Minnesota Comprehensive Health Association (MCHA) funding base on a revenue neutral basis to achieve broader, more stable, more equitable financing of MCHA.*

Discussion

The Minnesota Comprehensive Health Association (MCHA) was formed in 1976 and is one of the oldest high risk health insurance pools in the nation. With 28,000 enrollees, it is also the

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largest high risk health insurance pool in the country. MCHA provides a source of guaranteed issue health coverage for persons who have been denied coverage in the private market due to their health status or health risk. Without MCHA, "medically uninsurable" individuals might not be able to obtain coverage.

MCHA premium rates are required by law to be no more than 125% of the market average for similar coverage. The high risk enrollees in MCHA incur costs greater than the revenue generated by premiums, and MCHA experienced a \$44 million deficit in 1994⁷. The annual MCHA deficit is financed through an assessment on all state regulated health insurers. The assessment does not extend to self-insured organizations due to federal ERISA preemption. Self-insured firms and organizations are the sources of more than half the private coverage in Minnesota. Because self-insured companies tend to be larger firms, the current MCHA financing burden falls disproportionately on the small group and individual health insurance markets, raising the cost to persons covered in these markets. Increased health insurance costs may lead to employers dropping coverage for employees and to insured persons dropping their coverage and becoming uninsured. The current MCHA financing arrangement also encourages businesses to self-insure, leading to continued erosion of the MCHA funding base.

Costs of the MCHA deficit should be spread more broadly without net increases in overall taxes to bring about more equitable, stable MCHA financing. This would help prevent further erosion of the MCHA funding base, distribute the burden of MCHA more equitably, and ensure that MCHA is adequately financed to continue to serve as a source of guaranteed issue health coverage for persons considered medically high risk who may otherwise be unable to obtain coverage.

- B. Recommendation: Maintain current rating and underwriting reforms. Do not institute further reductions in rate bands or guaranteed issuance in the individual market.**

Discussion

The commission's 1995 report, An Affordable Step Toward Universal Coverage, described the integral role of insurance reforms to the broader issues of health care reform as follows:

Since the state's health reform strategy is built upon a private sector health care delivery and financing system, health plan companies must operate within a legal framework that

⁷ Lynn Gruber, letter to Bernard Reisberg, Chair, MHCC Universal Coverage Work Group, October 25, 1996.

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ensures that every Minnesotan who can afford a reasonable premium is able to enroll and maintain private coverage. Our goal is to maximize the number of persons who maintain health coverage without government involvement and minimize the number who enroll in the state's programs.

Since 1992, a number of MinnesotaCare insurance reforms have been directed toward achieving this goal. Small group reforms have included guaranteed issuance to all applicants, guaranteed renewability of coverage, limitations on rate variation due to health status and risk, and portability of coverage for persons who maintain continuous coverage. According to a recent Minnesota Department of Commerce report, the small group market grew by more than 21,000 additional covered lives between 1993, when these insurance reforms were initiated, and June 30, 1994.⁸

Similar reforms have been undertaken in the individual market over the same period. Guaranteed issuance in the individual market has not been implemented however because of concerns regarding the potential for adverse selection. Adverse selection results in the current voluntary market when individuals with greater health care needs obtain coverage but healthier risks, who may assume that they do not need coverage, or do not value it, opt out. As more high cost individuals enter the market, and premiums increase, more healthy risks will leave the market, setting in motion an unsustainable cost spiral.

The commission was required as part of this year's study charge to address issues of whether further insurance reforms should be undertaken at this time. In developing its report last year, the commission undertook substantial research and analysis on questions of implementing guaranteed issuance in the individual market, and community rating in the small group and individual markets. These analyses continue to be relevant to current discussions of possible further health insurance reforms.

Our previous research showed that community rating for the small group and individual markets, and guaranteed issuance in the individual market, was not feasible because of the voluntary nature of current health coverage. Community rating will cause an increase in premium costs to younger, healthier individuals but will lower costs for older, higher utilizers of health care. Guaranteed issuance in a voluntary market would lead to adverse selection as described above. Actuarial analyses conducted for the commission last year indicated that implementing guaranteed issuance and community rating without addressing the problem of younger, healthier risks potentially **opting** out of coverage would actually result in a net increase in the number of uninsured. As the commission has previously reported, "if healthy people do not maintain coverage in sufficient numbers, premiums will become unaffordable for those who need coverage

⁸ *Department of Commerce Study of Small Employer Market* (Presentation to the Minnesota Health Care Commission by the Minnesota Department of Commerce, January 18, 1995).

Discussion

the most." As a result, guaranteed issuance in the individual market and community rating in the small group and individual markets will only be successful when "both healthy and sick people are paying premiums."⁹

The problems of younger, healthier risks foregoing coverage in a guaranteed issue, community rated environment which were examined by the commission last year have not yet been addressed, and continue to pose significant obstacles to further major health insurance reforms. In the absence of successful efforts to address these problems, further major health insurance reforms were not felt by the commission to be feasible at this time.

The commission's universal coverage work group also conducted additional preliminary discussions of a proposal for a possible limited form of guaranteed issuance in the individual market. Under the proposed modification, a standard definition of eligibility for the Minnesota Comprehensive Health Association (MCHA) would be established. Only those who met the standard eligibility criteria for MCHA could be rejected for coverage in the private market and could enroll in MCHA. All other persons would be guaranteed issue to the private individual market. This limited form of guaranteed issuance was suggested to bring about more uniform underwriting in the market, and to provide consumers who were rejected for coverage with a clear explanation for why they were rejected. The proposal was also intended to potentially reduce the number of persons covered through MCHA, at a time when MCHA's funding base continues to erode as more employers self-insure and are no longer required to pay the MCHA assessment.

As discussed above, the commission has identified significant obstacles to proceeding with guaranteed issuance in the individual market until the issues of younger, healthier persons who voluntarily refuse coverage can be addressed. In the absence of true guaranteed issuance in the individual market, the universal coverage work group has acknowledged the importance of MCHA as the de facto source of guaranteed issuance for individuals, and the need to maintain and broaden MCHA funding.

The work group found that developing a single standard of "medically uninsurable" in a dynamic, competitive health care market is problematic. If the standard definition is too broad, or is not appropriately administered, more people might find themselves rejected for private coverage and enrolling in MCHA than are enrolling currently. Alternatively, if the standard eligibility is set too narrowly, a large number of persons currently in MCHA may find that they can transition suddenly to the private market, creating the basis for potential adverse risk selection problems in the market.

⁹ *An Affordable Step Toward Universal Coverage* (Minnesota Health Care Commission, January 1995)

Discussion

Similarly, administering and enforcing a single standard definition of MCHA eligibility would also potentially be administratively burdensome and expensive. The proposal might also create additional financial pressures on MCHA. To the extent that otherwise healthy individuals have been enrolled in MCHA, and have been contributing more in insurance premiums than they receive in MCHA insurance benefits, this has spread the risk of MCHA insurance more broadly, and has helped keep MCHA rates more affordable for higher risk MCHA enrollees. In view of these preliminary findings, the work group did not recommend the proposed modified form of guaranteed issuance at this time, but intends to continue to address the issue of guaranteed issuance in the individual market, including the role of MCHA, in the future.

C. ***Recommendation:** Explore making additional health insurance options available to consumers on a pretax basis when these options are consistent with, and complementary to, MinnesotaCare reforms, and when the options:*

- *do not lead to risk segmentation in the market;*
- *are tied to savings or insurance strategies which also effectively help individuals meet long term care needs; and*
- *are designed to also encourage use of appropriate, cost-effective primary and preventive care.*

Discussion

Persons who participate in an employer-sponsored group health benefit plan do not have to pay state or federal income taxes on these benefits. In addition, many persons can set up medical expense accounts funded with pretax dollars as part of an employer's "cafeteria benefits" package to cover the costs of deductibles, coinsurance, and health related services not otherwise covered under the health insurance policy.

Self-employed individuals may deduct the full cost of their health insurance premiums from their Minnesota state taxes only, and may not have access to the cafeteria plan option for pretax funding of other health care expenses. Other persons who work for firms which do not offer group health benefit plans, or are not eligible for group plans, or who are unemployed, and who purchase individual coverage, are generally not able to purchase coverage with pretax dollars. This group is thus at a disadvantage in terms of the tax treatment of their health coverage, especially compared with those who receive the full tax advantages of employer group coverage. These tax consequences can be substantial, and greatly increase the effective price of coverage to those purchasing it. For the majority of Minnesota's uninsured who do not have access to employer provided group coverage, and who have only low or moderate incomes, purchasing

Discussion

health insurance with more expensive after-tax dollars may make coverage unaffordable.

A number of proposals have been introduced both nationally and at the state level to allow new forms of health coverage to be available to consumers on a pretax basis. Many of the proposals include provisions for special health care expense accounts which would allow individuals to pay deductibles and other out of pocket health care costs also on a pretax basis. In some cases, the accounts are designed such that unused balances in the account may be carried over from one year to the next and accrue over time. The accrued balance can then be tapped to provide a source of funding for health insurance during periods of unemployment or income loss, or to help meet long term care needs. Proponents of these insurance options point out that offering catastrophic coverage in combination with an expense account on a pretax basis may result in more affordable coverage for many younger or low income persons who may not otherwise purchase coverage. The proponents also suggest that consumers will be more cost conscious when obtaining health care that they are paying for out of pocket under a catastrophic coverage plan.

A detailed analysis of these proposals was beyond the scope of the commission's assignment this year. However, we support insurance options which extend the favorable tax treatment of employer provided health coverage more broadly and equitably, and which may thus serve as a means of helping low income uninsured persons find more affordable coverage, when these options are consistent with and complementary to MinnesotaCare reforms.

In particular, it is important that these options are consistent with insurance reforms designed to reduce risk segmentation in the market, and to bring about competition between health plans on value rather than risk selection and "cherry picking" of the healthier risks. The debates regarding introduction of new forms of catastrophic health coverage and associated expense accounts have identified concerns that these insurance options may result in greater risk segmentation in the market. These undesirable consequences arise when individuals least in need of health care choose a catastrophic protection option, while those who may need comprehensive care the most because of poorer health status will increasingly have fewer risk sharing opportunities, and will increasingly have to pay more for their coverage. It is important that these concerns be addressed.

Similarly, the MinnesotaCare subsidized health insurance program emphasizes access to timely prevention and primary care to help maintain health, and to reduce costs associated with more severe illness at later stages. However, insurance coverage which emphasizes only catastrophic health expense protection may lead persons to forego needed preventive and primary care rather than pay for it out of pocket, or out of their health care expense account. These concerns also need to be addressed in the design and implementation of new health insurance arrangements currently being debated.

Discussion

The insurance options described above may offer an important source of synergy to aid in addressing another vital public policy issue, meeting long term care needs. Anticipated reductions in federal spending on Medicaid, a principal source of long term care financing, could mean that many individuals and their families may increasingly have to fund more of their long term care needs in advance, either through savings or long term care insurance. The health care expense account options discussed above should be designed to help individuals and families also save or insure to meet long term care needs.

3. Purchasing Pools

- A. ***Recommendation:** Continue authorization of voluntary purchasing pools. Monitor the number and characteristics of the uninsured. Delay decisions on opening a state-sponsored purchasing pool to individuals until more information becomes available on the effectiveness of private and state-sponsored purchasing pools, including the experience of states which have recently opened pools to individuals.*

Discussion

In theory, purchasing pools offer small groups and individuals the potential advantages of economies of scale and greater negotiating power in the market similar to those enjoyed by large employers. Legislation passed in 1994 allows voluntary formation of purchasing pools to provide opportunities for smaller groups and individuals to explore new ways of collaborating together to improve their purchases of health insurance.

The universal coverage work group discussed the issue of potentially opening a state administered purchasing pool to individuals. In particular, it considered the question of opening the Minnesota Employers Insurance Program (MEIP) to individuals. MEIP is a state administered purchasing pool for groups of size two or greater. More than 300 employers have enrolled in the MEIP since its inception in 1993, and approximately 10 to 20 businesses enroll in MEIP each month. More than four thousand persons are currently covered under MEIP. An early survey of firms buying coverage through MEIP indicated that 78 % of employers previously did not offer group insurance to their employees¹⁰.

The universal coverage work group found however that similar successes may be difficult to achieve at this time for individuals for the following reasons:

¹⁰ Minnesota Department of Employee Relations, Employee Insurance Division, *Report to the Legislature: Minnesota Employers Insurance Program, August 25, 1995.*

Discussion

- In the absence of guaranteed issuance in the individual market, opening MEIP on a guaranteed issuance basis would likely result in adverse selection and greater costs to those enrolling in the pool. If MEIP required underwriting, it would add to the administrative costs of the pool.
- Start up costs would have to be considered, and funds for a start up would presumably have to be repaid from premiums collected. It may be harder to publicize the availability of MEIP to individuals, and enrollment may be slower for individuals.
- Loss ratios -- the percent of insurance premium that must be paid out in claims -- are currently required by law to increase in the individual market, from 65% in 1992, to 72% in 1996. This will reduce the administrative load that can be charged as part of the individual health insurance premium, and narrow any potential difference between the administrative costs of products in the individual market and products purchased by individuals through a pool.
- Insurers which currently contract with MEIP are currently not interested in contracting for individual coverage with MEIP.
- In many cases, the private individual health insurance market is perceived as competitive, and as offering an array of products which are perceived as affordable for individuals.
- If price differentials between the pool and the current market are relatively small, relatively few uninsured individuals will be induced to obtain coverage through the pool.
- A number of other states have recently opened, or are in the process of, opening pools to individuals. It will be important to review the experience of these states to inform the discussion of opening a state-administered purchasing pool in Minnesota.

As a result, the commission recommends continued monitoring of the uninsured to better gauge the potential of purchasing pools to improve coverage for persons purchasing it on an individual basis. The commission further recommends that decisions on opening a state-sponsored purchasing pool to individuals be delayed until more information becomes available on the effectiveness of private and state-sponsored purchasing pools, including the experience of states which have recently opened pools to individuals.

Discussion

4. Personal Responsibility

- A. **Recommendation:** *Provide education and information to inform individuals of the need for health insurance, and the costs to the individual, families, and the state of being uninsured. Provide consumers information and assistance on health insurance options, and sources of information or assistance in purchasing coverage.*

Discussion

Because many of the uninsured are young and healthy, they may lack an appreciation of the costs to themselves and others of remaining uninsured. This may especially be the case if the uninsured feel that if they become ill or injured, a public program will automatically cover their health care expenses. Potential federal reductions to Medical Assistance may no longer provide the level of safety net, or "spend down" eligibility as in the past, and persons who become ill or injured in the future may not qualify for publicly funded health care as they may have previously. Discussions with insurers and state regulators also indicate that many consumers are not aware of the range of insurance opportunities in the market that may provide them an affordable "fit," and that many consumers do not shop the market sufficiently to find the type of product they may desire.

A key objective of the MinnesotaCare reforms is to provide consumers with more information to make wise health care decisions. The public-private Health Data Institute, and the Health Information Clearinghouse at the Department of Health, are examples of the state's commitment in this area. In addition, a number of private sector resources are available to help provide consumers information on the need for maintaining health coverage and options for coverage in the market. Resources such as these should be part of an ongoing strategy of public-private collaboration to help individuals make appropriate decisions about their health coverage.

- B. **Recommendation:** *Support and facilitate efforts already being undertaken to enforce child support laws for medical support. Facilitate information exchange between employers and child support enforcement entities to aid in identifying children with court ordered medical support and employees responsible for making the support payments. Facilitate employer roles in withholding child medical support payments from employees with court ordered medical support obligations, or enrollment of the affected children on the employer's group health plan, as appropriate and as already required by law.*

Discussion

Discussion

Minnesota is one of the first states to require medical support as part of court ordered child support, and is pursuing strategies to continuously improve child medical support enforcement. Employers play a pivotal role in child support enforcement. In 1993, employers collected more than \$123 million in support through income withholding. Cooperation between employers and child support agencies encourages parental responsibility, reduces the burden on Minnesota taxpayers through reduced public assistance costs, and helps many families provide for their children.¹¹

A significant number of Minnesota children have court ordered medical support. Minnesota law currently requires employers to assist with obtaining information from new hires about any child support obligations they may have, including medical support. Under current law, employers are required to ask new hires:

- if the individual has a court order requiring that he/she provide dependent health and/or dental insurance; and,
- if the individual has a court order requiring him/her to pay medical support payments by income withholding.

Employers must also have a new employee complete and sign a child support disclosure form, which is maintained by the employer in the employee's personnel file. If a new employee answers "yes" to either of the questions above, employers are required to:

- provide the employee with all the necessary information and forms to enroll the dependent(s) in the available insurance plan, and enroll the employee and the dependent;
- begin withholding premiums from the employee's income;
- begin withholding the medical support payments as per the income withholding statute.

Voluntary, **ongoing** communication and cooperation between employers and state and local child support **enforcement** agencies is essential to maximize the impact of current laws designed to ensure **personal responsibility** in meeting medical support commitments, and should be facilitated by both the private and public sectors.

¹¹ Minnesota Department of Human Services, Child Support Division, *Employer's Guide to Minnesota Child Support Laws for Income Withholding and Medical Support* (DHS - 3177 3 94)

Discussion

- C. ***Recommendation:*** *Explore mechanisms with employer and employee representatives that would require all employees with access to employer-funded coverage to purchase such coverage.*

Discussion

The universal coverage work group has received testimony regarding individuals working for employers who offer health coverage at very low cost to the individual, but who then choose not to accept the coverage and instead remain uninsured. A proposal was presented to the work group to require mandated acceptance by employees of their employer's group benefit plan. The work group and the commission have not had the opportunity to examine this concept in greater detail but recommend further discussion and consideration of the proposal. In particular, the commission recommends that employees and employers be consulted on this issue. Further discussion of this concept is consistent with efforts to bring about greater personal responsibility in the purchase of health insurance, and consistent with the definition of universal coverage in statute, which recognizes the importance of everyone paying their fair share for coverage.

Additional Recommendations for Further Study

In addition to the study needs described above, the universal coverage work group recommends that the questions below also be explored in greater detail as part of subsequent annual reports on universal coverage by the commission. These study questions of interest include:

- The design of the benefits sets for the planned DHS consolidated subsidy program, including examination of a model for determining covered services used by the state of Oregon, and other possible models.
- The concept of encouraging employers to offer group coverage, particularly to part-time and temporary employees who often are not eligible for employer group plans, even if the employer makes only minimal contributions for the coverage. This would potentially extend the important tax advantages available through employer-sponsored group coverage to individuals who typically are not part of the employer plan, and help make the effective cost of coverage more affordable. At present, Minnesota's small group reforms require defined levels of employer contribution and workforce participation to qualify as a group plan to avoid adverse selection. Group plans with lower levels of employer contribution or workforce participation would have to be designed to minimize any potential for adverse risk selection.

Discussion

Key Challenges to Universal Coverage

In monitoring the uninsured, it will be important to continue to monitor developments which affect the availability, costs, and quality of health coverage. Perhaps the most immediate challenge is preparing for pending federal reductions in outlays for Medicaid and Medicare, and designing a consolidated subsidy program to serve as many low income Minnesotans as possible within budget constraints. There are two other challenges which will also be important, however, regardless of the outcome of current debates on leaner federal health care budgets. One is related to a changing economy and continued erosion of employer-based coverage. The second is encouraging greater personal responsibility in maintaining health coverage. These three challenges are briefly discussed below.

Reductions in Federal Funding of Medicaid

Medicaid is a state/federal source of health coverage for low income elderly, disabled, and families with children. The state currently contributes 47% of the costs of Medicaid, while the federal government funds 53% of the costs. Minnesota currently covers more than 430,000 residents through Medicaid, at a cost to the state projected at more than \$3 billion in 1997.¹²

Both Congress and the Clinton Administration are considering reducing the rate of growth of the Medicaid budget to help achieve a balanced budget. As described above, the state's Department of Human Services is developing a framework for responding to likely reductions in federal financial participation in Medicaid. The framework emphasizes that, within taxpayer affordability, the largest number of uninsured, low income Minnesotans possible should have access to publicly funded care. It is not known at this time what impact any federal reductions in Medicaid funding will have on the state's ability to fund health care for low income persons, or on the percent of the state's population that lacks health coverage. The commission will continue discussions with DHS to review developments at the federal level, and to determine their potential impact on publicly financed health care for low income persons.

Erosion of employer-based health coverage due to changes in the economy

While Minnesota is now in a period of economic recovery and job growth, many of the new jobs

¹² *Crafting Minnesota's Response: Federal Reform Briefing, Medicaid, Third Edition, November 1995* (Minnesota Department of Human Services issue brief, November, 1995).

being created do not provide access to employer-based health coverage. Nationally, the percent of the population with employer-based health coverage fell from 62.1% in 1987, to 58.3% in 1992. Employer-based health insurance in Minnesota followed the national trend during this time period: the percentage of Minnesotans with employer-based coverage fell from 65.7% in 1987 to 60.6% in 1992.¹³ The effects of economic restructuring, including downsizing of large organizations, growth of the service sector, and employment of part-time, temporary, and contract workers, should be monitored and evaluated to help inform policy discussions of trends in employment-based health insurance in Minnesota. Maintaining progress toward universal coverage will require continued innovation and collaboration to ensure that employer-based health coverage remains as affordable and available as possible.

Bringing About Greater Personal Responsibility in Maintaining Health Coverage

A fundamental challenge in making greater progress toward universal coverage is achieving higher insurance rates among those who can afford health insurance, but who do not purchase it because they feel it is unnecessary or that it is a lower priority than other needs. Our previous reports have described the adverse impact this behavior has in making health insurance less affordable and less available to persons who are responsibly paying into the system.

This report has only modest recommendations to improve participation among persons who can and should pay their fair share for health care, largely because mandates to carry health insurance, or meaningful penalties for not carrying health insurance, are generally not considered politically acceptable at this time, and because questions of monitoring and enforcement have also generally not been resolved.

Many of those who do not carry health insurance may believe that a public program will assume any significant medical liabilities if they become ill, injured, or disabled. However, if the state's response to federal reductions in Medicaid leads to changes in "spend down" eligibility for public programs, this group may no longer be able to assume that their health care expenses will be paid by the state. If a change in spend down eligibility occurs and is sufficiently publicized, it may cause those who have voluntarily gone without health insurance to keep adequate savings on hand to meet any health care expenditures, or to purchase insurance to avoid depleting all their assets to pay for unexpected medical bills.

¹³ Unpublished Current Populations Survey data. Income Statistics Branch/HHES Division, US Bureau of the Census, US Department of Commerce, Washington, DC, June 1994.

Appendix

ESTIMATES OF THE UNINSURED IN MINNESOTA

This Appendix contains the Minnesota Health Care Commission estimate of the number of uninsured Minnesotans, a comparison of recent state and national uninsurance trends, and selected demographic characteristics of insured and uninsured Minnesotans.

The Number of Uninsured Minnesotans

In 1994, the Commission estimated that 8.9% of the Minnesota population, or approximately 400,000 persons, lacked health insurance coverage at any given point in time. This estimate of the state uninsurance rate was based on findings from three surveys that had been conducted since the last statewide survey of the uninsured in 1990. These surveys included the U.S. Census Bureau's Current Population Survey (1991-1993), the Minnesota Behavioral Risk Factor Surveillance System (1990-1994) and the Robert Wood Johnson Foundation Family Survey (1993). More detailed discussions of these data sources and the methodology for making this estimate appear at the end of this Appendix.

In October of 1995, Commission staff examined the most recent estimates of the rate of uninsurance provided by the 1994 and 1995 Current Population Surveys (CPS) and the 1995 Behavioral Risk Factor Surveillance System (BRFSS), in conjunction with the survey data available last year. Using these data, staff have concluded on a preliminary, interim basis that the rate of uninsurance currently remains at approximately 9% of the state's population.

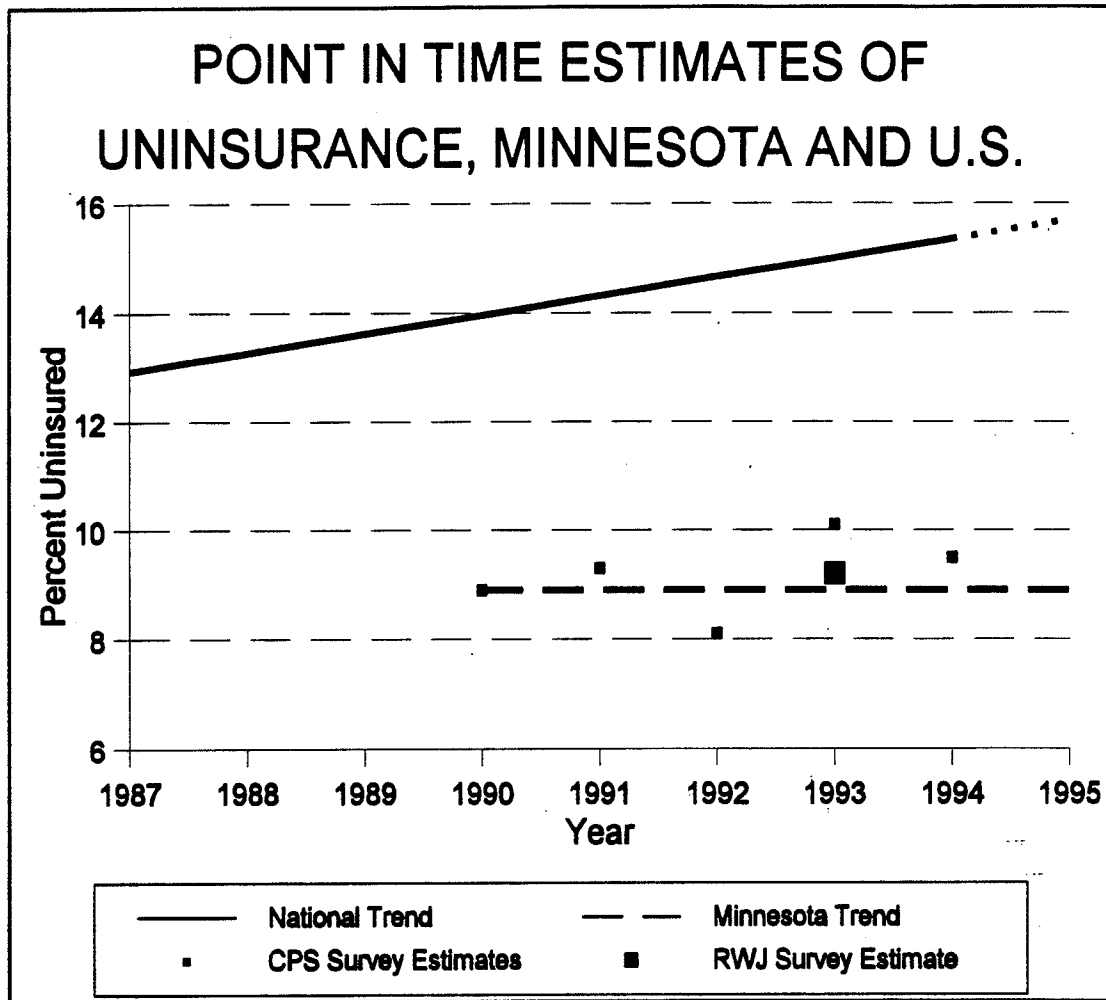
State and National Trends

Based on the available survey data, the Commission has concluded that the rate of uninsurance in Minnesota has remained essentially *unchanged* over the period 1990 to the present. The Minnesota trend contrasts sharply with the national trend in the rate of uninsurance, as reported by the U.S. Census Bureau using CPS data.¹ These data show that the rate of uninsurance in the nation as a whole increased steadily at an average rate of about 2.8% per year, beginning at 12.9% uninsured in 1987, growing to 13.9% in 1990, and reaching 15.2% in 1994. These data suggest that one impact of the MinnesotaCare health reform efforts has been to prevent the rate of uninsurance in the state from increasing, as it is elsewhere in the nation.

¹ Unpublished Current Population Survey Data, Income Statistics Branch/HHES Division, U.S. Bureau of the Census, U.S. Department of Commerce, Washington, D.C., June 1994.

Chart 1 shows the trends since 1990 in both the Minnesota and the national rates of uninsurance. The chart also shows the 1990-1994 point in time estimates of the uninsurance rate in Minnesota from CPS data and the 1993 Robert Wood Johnson Foundation Family Survey (RWJ).

Chart 1



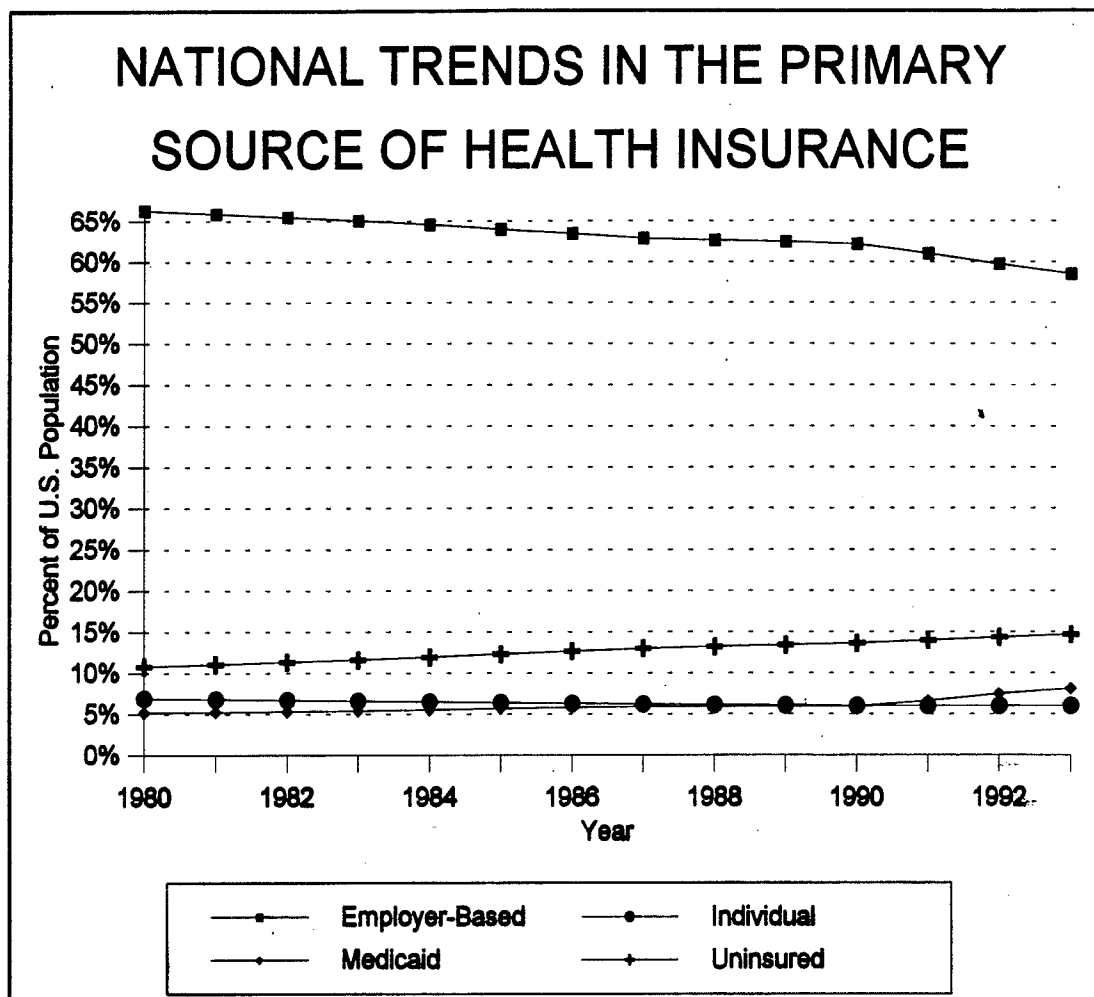
Source: Bureau of Census, Current Population Survey, 1988-95
 Robert Wood Johnson Foundation Family Survey, 1993

Along with the increase in the national rate of uninsurance over time, national data indicate a steadily *decreasing* proportion of employer-based health coverage and corresponding growth in government health care programs. These trends are shown in Chart 2. The chart shows that between 1987 and 1992, the national uninsurance rate rose from 12.9% to 14.7%, while the

percentage of the national population with employer-based coverage fell from 62.1% to 58.3%.² These national trends are likely due to a number of factors, including increasing health care costs and the disproportionate growth in service sector jobs that are not likely to offer health coverage.³

Employer-based health insurance coverage in Minnesota followed the national trend during this time period: the percentage of Minnesotans with employer-based coverage fell from 65.7% in 1987 to 60.6% in 1992.⁴

Chart 2



Source: Congressional Budget Office Estimates

² Unpublished Current Population Survey Data. June 1994. op. cit.

³ U.S. Bureau of the Census, *Statistical Abstract of the United States*, Washington, D.C., Various Issues.

⁴ Unpublished Current Population Survey Data. June 1994. op. cit.

The 1995 Minnesota Health Care Insurance and Access Survey

It is important to note that the 1995 Commission estimate of the rate of uninsurance is a preliminary, or interim estimate, based on available survey data. A new statewide survey is currently being conducted by researchers at the Institute for Health Services Research (IHSR) at the University of Minnesota. This survey, the 1995 Minnesota Health Care Insurance and Access Survey, is being sponsored by the Blue Cross and Blue Shield Foundation of Minnesota.

In this new survey, approximately 20,000 Minnesota residents are being interviewed by telephone about their insurance status, and health care needs and utilization. Because of the large sample size, these data will be able to provide a very precise estimate of the current rate of uninsurance in Minnesota. Information from this survey should become available in early 1996. It is anticipated that the estimate of the rate of uninsurance from this survey will be different than those provided by the other survey sources available to the Commission. This will most likely be due to differences in survey methodology, particularly in the use of additional questions and probes by the IHSR researchers to correctly identify persons insured through public programs.

Characteristics of the Uninsured and Insured in Minnesota

Information on the demographic characteristics of the uninsured and insured at a point in time in Minnesota is drawn from the 1993 and 1994 CPS (which provides data from samples of Minnesotans interviewed in 1992 and 1993)⁵ and from the 1993 RWJ survey.

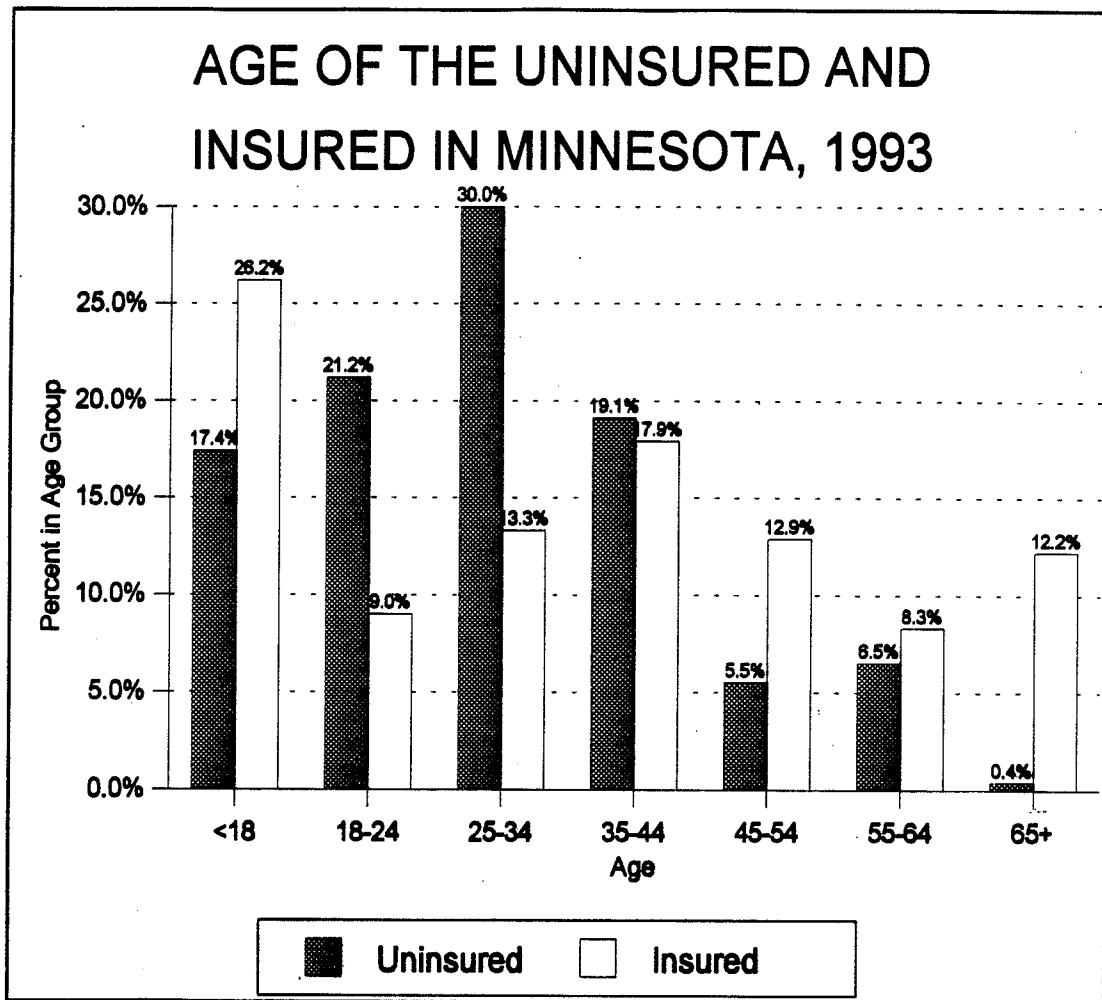
⁵ *Current Population Survey, March 1994 on CD-ROM* [machine-readable data file] / conducted by the Bureau of the Census for the Bureau of Labor Statistics. -Washington: Bureau of the Census [producer and distributor], 1994.

Current Population Survey, March 1993 on CD-ROM [machine-readable data file] / conducted by the Bureau of the Census for the Bureau of Labor Statistics. -Washington: Bureau of the Census [producer and distributor], 1993.

Age

In 1993, nearly half of the *uninsured* (51.2%) were young adults aged 18-34. An additional 17.4% of the uninsured were under age 18. In contrast, 26.2% of the *insured* in Minnesota were under age 18 in 1993, and 22.3% were aged 18-34.

Chart 3



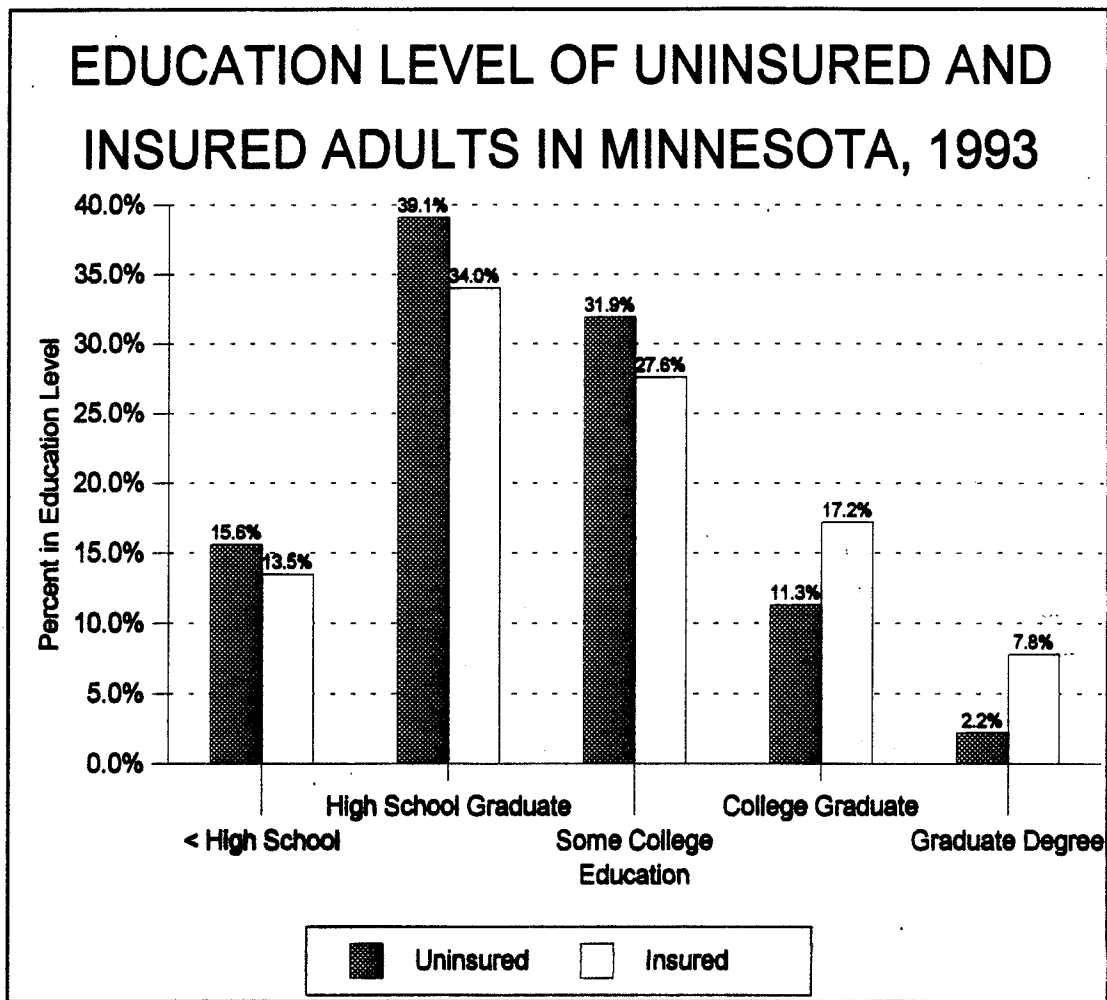
Source: Bureau of Census, 1994 Current Population Survey

Education

In 1993, most *uninsured* adults (54.7%) had a high school education or less. About 39% of uninsured adults were high school graduates, while 16% did not graduate high school. Fourteen percent of uninsured adults were college graduates or had advanced degrees.

Among *insured* adults, 47.5% had a high school education or less, and 25% were college graduates or had advanced degrees.

Chart 4

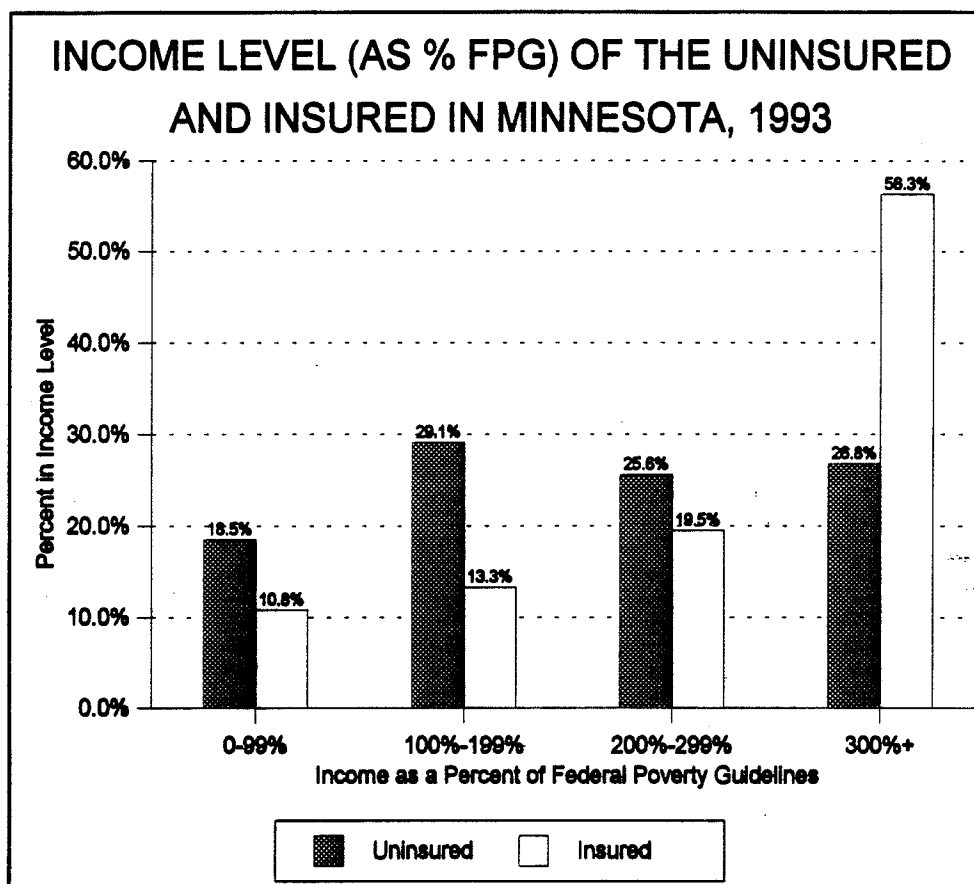


Source: Bureau of Census, 1994 Current Population Survey

Income

The most striking demographic differences between the insured and uninsured in Minnesota in 1993 were found in their income characteristics. Uninsured Minnesotans were more than twice as likely (29.1%) to have incomes between 100% and 200% of the federal poverty guideline than were insured Minnesotans (13.3%). The federal poverty guidelines vary by family size.⁶ The uninsured were also more likely to have incomes below the federal poverty guideline (18.5% of the uninsured as compared to 10.8% of the insured) and between 200% and 300% of poverty (25.6% of the uninsured as compared to 19.5% of the insured). In contrast, 56.3% of the insured had incomes equal to or greater than 300% of the federal poverty guideline in 1993, while only 26.8% of the uninsured had incomes in this range.

Chart 5



Source: Bureau of Census, 1994 Current Population Survey

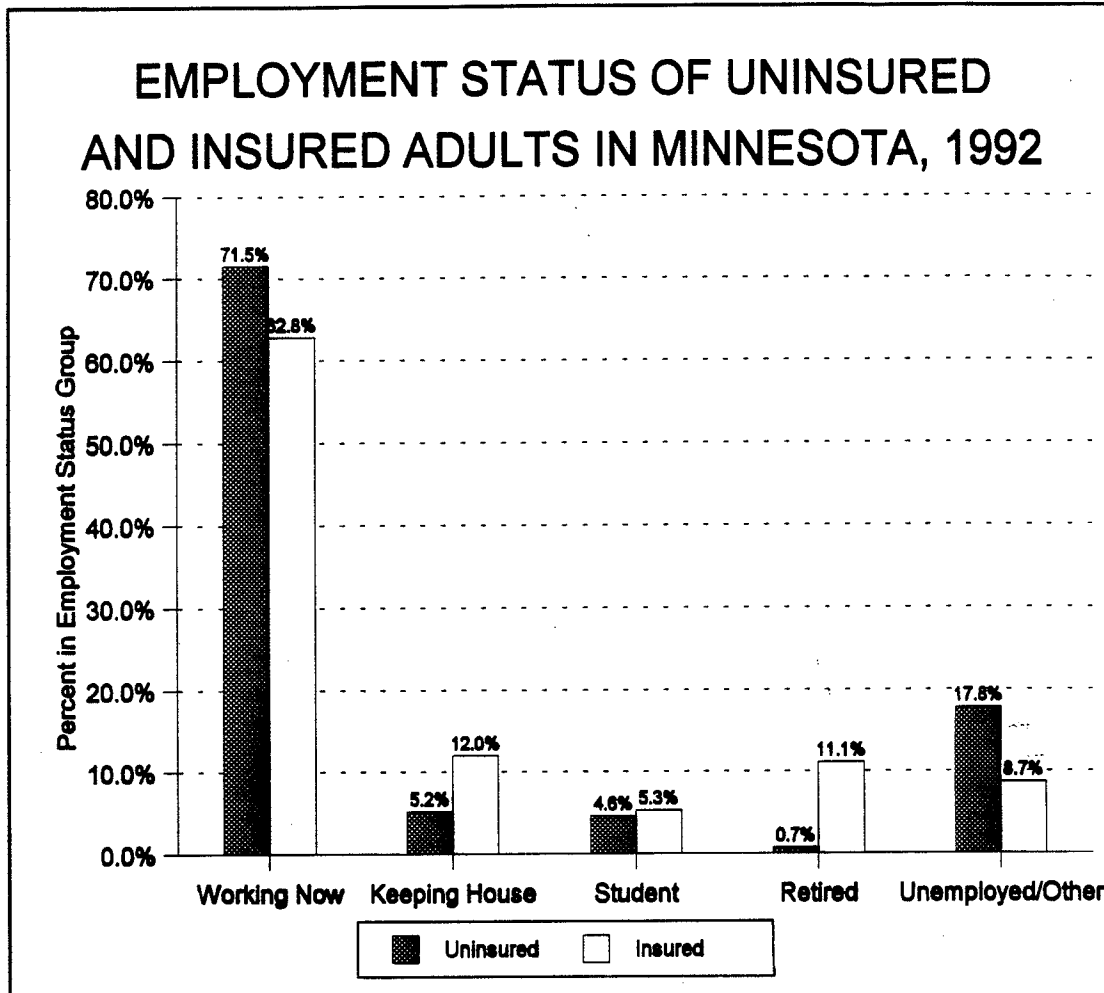
⁶ 1994 Federal Poverty Guidelines:

- \$7,360 for a single individual.
- \$9,840 for a family of two.
- \$12,320 for a family of three.

Employment Status and Occupation

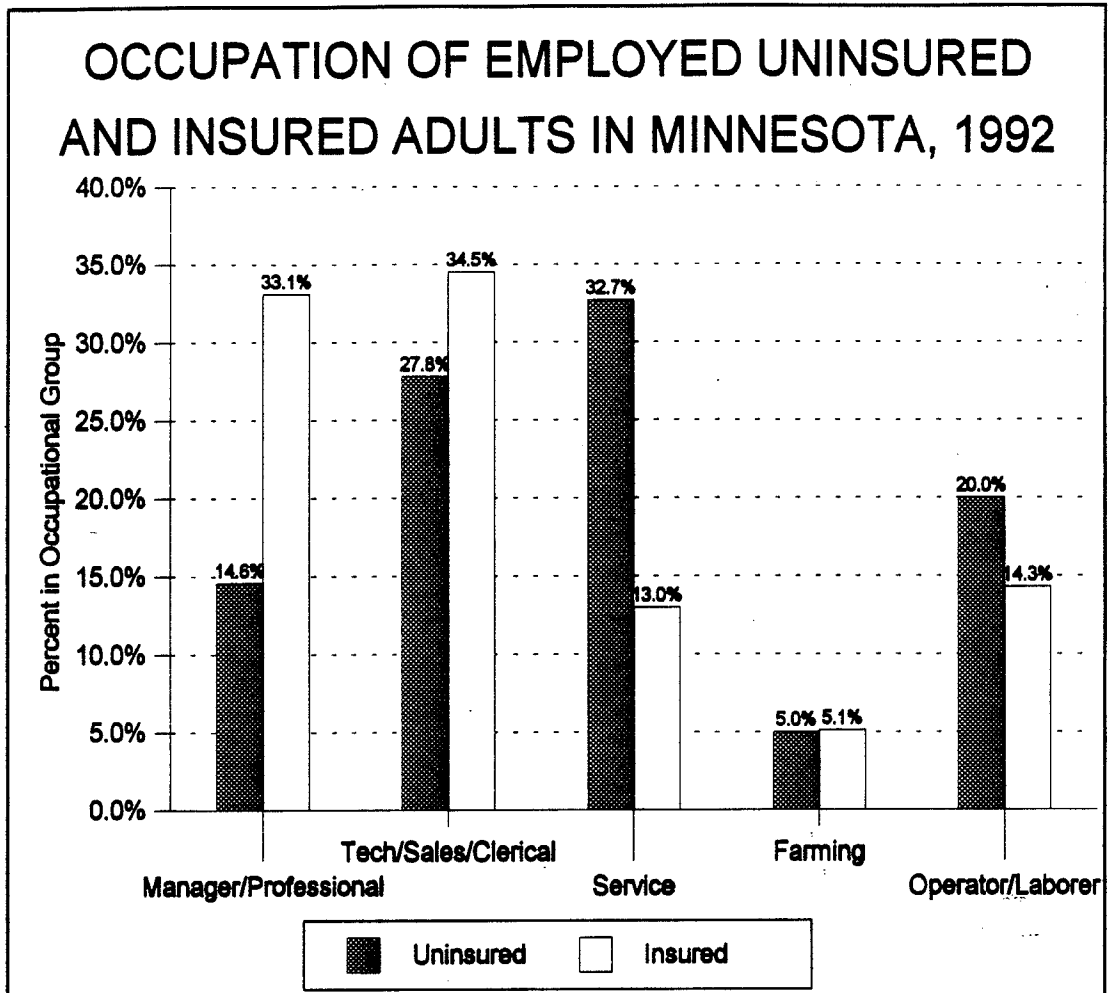
More than half of insured adults (62.8%) and most uninsured adults (71.5%) were employed in 1992. The uninsured were more likely to work in service and labor occupations than the insured, and less likely to work in managerial, professional, or technical occupations.

Chart 6



Source: Bureau of Census, 1993 Current Population Survey

Chart 7



Source: Bureau of Census, 1993 Current Population Survey

Sex

Compared to insured persons in Minnesota, the uninsured were somewhat more likely to be male: in 1993, 54.3% of all *uninsured* persons were male, while 49.1% of those with health insurance were male.

Race and Hispanic Ethnicity

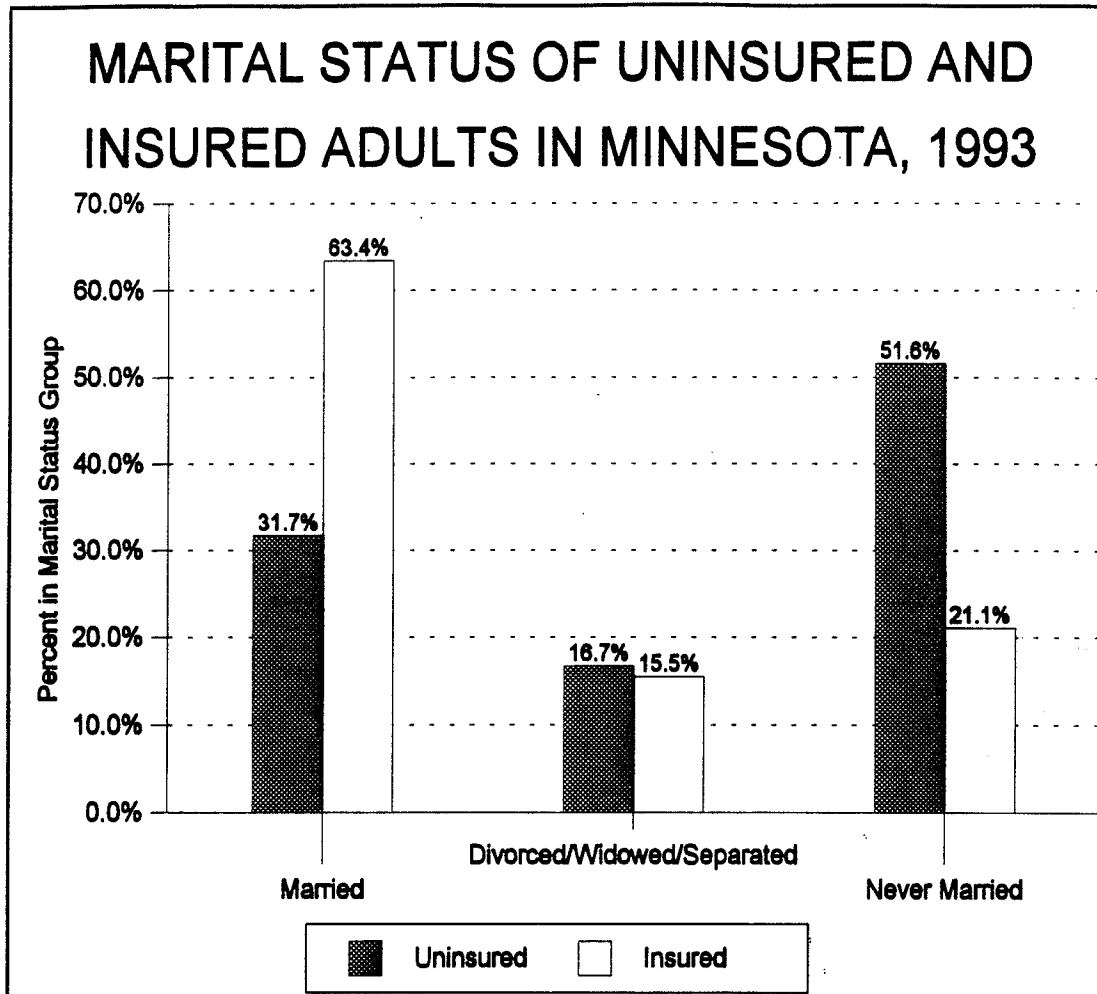
Data from the 1993 RWJ survey were used to analyze the race and Hispanic ethnicity of uninsured and insured Minnesotans, since this data set has a larger sample than the 1994 CPS data set. Even so, since over 90% of Minnesota residents are white and/or non-Hispanic, there are still relatively few non-white or Hispanic persons in the RWJ sample. While the results presented here are more precise than those available from the CPS data, the results should still be viewed with some caution.

In 1993, persons of non-white races were over-represented among the uninsured, as were persons of Hispanic ethnicity. The 1993 RWJ data showed that among the uninsured, 3.2% were African American, 3.0% were American Indian, and 1.7% were Asian, and 92.1% were white. Six percent of the uninsured were of Hispanic origin (of any race). Among the insured, 1.7% were African American, 1.1% were American Indian, and 1.1% were Asian, and 96.1% were white in 1993. Less than 2% of the insured were of Hispanic origin (of any race).

Marital Status

Compared to the insured, the uninsured were much less likely to be married in 1993. About 32% of the *uninsured* over age 18 were married, while 63.4% of the *insured* of this age were married. Just over half of uninsured adults (51.6%) had never been married, as compared to 21.1% of insured adults. Uninsured adults were about as likely as insured adults to be divorced, separated or widowed (16.7% vs. 15.5%).

Chart 8



Source: Bureau of Census, 1994 Current Population Survey

Age, Sex, and Marital Status Displayed Simultaneously

Charts 9 and 10 present more detailed demographic profiles of the uninsured and insured in Minnesota than do the previous charts in this section. These two charts show the breakdown of the uninsured and insured adult populations in Minnesota by age, sex and marital status, *simultaneously*.

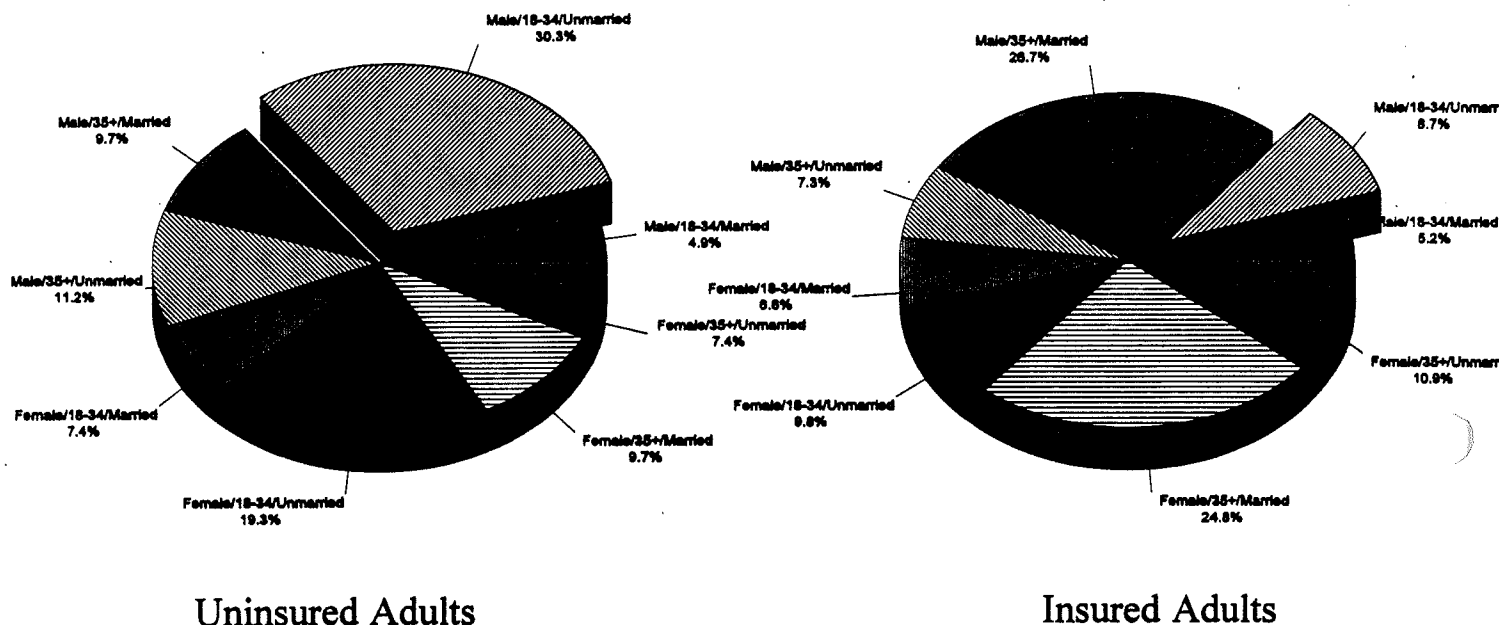
Chart 9 shows that in 1993 nearly one third (30.3%) of *uninsured* adults were young, unmarried males. While this is the most common demographic profile among uninsured adults, it is important to note that two thirds of uninsured adults fit *other* demographic profiles. For example, another relatively common profile was the young, unmarried female (19.3%).

In contrast, among *insured* adults, the most common demographic profiles in 1993 were of older married persons, either male (26.7%) or female (24.8%). Just 8.7% of insured adults were young, unmarried males. This information is shown in Chart 10.

Chart 9

Chart 10

SEX, AGE, AND MARITAL STATUS OF UNINSURED AND INSURED ADULTS IN MINNESOTA, 1993



Source: Bureau of Census, 1994 Current Population Survey

Data Sources and Methodology

The last statewide survey of the uninsured was conducted in 1990 by the Minnesota Health Care Access Commission.⁷ To estimate the number of Minnesotans who currently do not have health insurance, Health Care Commission staff used the results of three surveys conducted since the 1990 Access Commission study. These are the Current Population Survey (1991-1995), the Minnesota Behavioral Risk Factor Surveillance System (1990-1994) and the Robert Wood

⁷ Lurie, Nicole, Michael Finch and Bryan Dowd. October, 1990. *Who Are the Uninsured in Minnesota?* Report to the Minnesota Health Care Access Commission.

Johnson Foundation Family Survey (1993). Each survey has particular strengths and weaknesses. Results from one survey informed the results of the others, giving the Commission confidence in its estimates of the number of uninsured. By using several sources of data, the Minnesota Health Care Commission has obtained useful estimates without being limited by the weaknesses of any one data set.

Current Population Survey

The Current Population Survey (CPS) is conducted annually by the U.S. Bureau of the Census.⁸ It is the source of official government statistics on employment and unemployment in the United States. A secondary purpose of the survey is to collect demographic data on the national population. The yearly "March supplement" collects basic employment and demographic information pertaining to the previous year, plus detailed information on income and non-cash benefits. Data has been collected monthly for over 50 years.

This survey uses a multi-stage stratified area probability sampling frame to provide a representative sample of the noninstitutionalized population of the United States.

The CPS was not originally intended to produce regional or state level estimates. However, because of the increasing level of interest in such estimates over the years, beginning in 1984 the sample has been modified to provide more accurate sub-national estimates. CPS provides correction factors with which to adjust the standard errors for state level estimates.

Interviews are conducted in sampled households once per month for the same four months in two consecutive years. Data collection involves both face-to-face and telephone interviews; up to 60% of the interviews are by telephone. However, telephone interviews are conducted only after at least one face-to-face interview has been conducted. Information is gathered about all members of a sampled household through an interview with one adult member of that household.

Commission staff have in house CPS data from four consecutive years (1991-1994, which provides information about the population of Minnesota in 1990-1993). In 1994, 1607 Minnesota residents were included in the CPS sample.

⁸ *Current Population Survey, March 1994 on CD-ROM.* op. cit.

Current Population Survey, March 1993 on CD-ROM. op. cit.

Current Population Survey, March 1992 on CD-ROM [machine-readable data file] / conducted by the Bureau of the Census for the Bureau of Labor Statistics. -Washington: Bureau of the Census [producer and distributor], 1992.

Current Population Survey, March 1991 on CD-ROM [machine-readable data file] / conducted by the Bureau of the Census for the Bureau of Labor Statistics. -Washington: Bureau of the Census [producer and distributor], 1991.

Minnesota Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) is a seasonally-adjusted nation-wide survey study which collects data on behavioral health risks. In Minnesota, the survey is operated by the Minnesota Department of Health's Center for Health Statistics under a cooperative agreement with the Centers for Disease Control. A section of questions specific to the Minnesota segment is included at the end of a core questionnaire. This study has been conducted yearly since 1984, and the core questions have generally remained the same from year to year.

This telephone survey utilizes a multi-stage cluster probability sampling frame using the Waksberg method of random digit dialing.⁹ This sampling frame produces a random sample of households from the noninstitutionalized population of Minnesota that has telephones.

Once a household has been selected for the survey, one adult is randomly selected for the interview. Information is collected only about that sampled individual; thus, the data from this survey only refer to the *adult* population of Minnesota.

Through 1993, approximately 285 telephone interviews were conducted each month in Minnesota, for a yearly sample size of about 3420. In 1994, the sample size was increased to 4152. (The 1995 BRFSS had not been completed when the Commission made its 1995 estimate of the uninsurance rate, but provisional data from January through July, 1995 were made available to Commission staff for preliminary analyses.)

Robert Wood Johnson Foundation Family Survey

The Robert Wood Johnson Foundation Family Survey (RWJ) project was conducted in 10 states by the RAND Corporation through its subcontractor, Mathematica Policy Research, Inc. It was funded through the Robert Wood Johnson Foundation State Initiatives in Health Care Reform project. The objectives of this study were to describe problems in the current health care system, conduct prospective policy analysis, provide baseline data from which to evaluate health care reforms, and to develop standard instruments and procedures for state health insurance surveys.

In this study, the uninsured and those receiving Medical Assistance were oversampled through the use of a screening questionnaire and Medical Assistance enrollee lists. Most interviews were conducted by telephone, so a telephone sampling frame was used to draw the majority of the sample. An area probability sampling frame was used to draw a subsample of households without telephones (estimated to be 8% of the 10 state population). The Minnesota sample size was 7155. Information was gathered about all adults and some children within a sampled household through an interview with one adult member of that household.

⁹ Waksberg, Joseph. 1978. *Sampling Methods for Random Digit Dialing*. Journal of the American Statistical Association 73:40-46.

The RWJ survey was unique in that it contained several questions pertaining to coverage by specific Minnesota state health care programs, that is, Medical Assistance (MA), General Assistance Medical Care (GAMC) and the MinnesotaCare program. The other two surveys do not provide this level of detail in their questions.

Estimation Process for the Rate of Uninsurance in Minnesota

When comparing the point estimates of the rate of uninsurance from each of these surveys, some variability should be expected. The three surveys are very different in terms of their sampling methodologies, question wording and sample size, and thus should not be expected to yield identical estimates. This is not to say that the sampling design of any of these surveys is substandard or improper. Each sampling design, when carefully administered, will yield a properly representative sample of the population of Minnesota. Even two surveys which used the exact same methodology might not produce the same point estimate, due to variability in the samples drawn.

Chart 11 shows a scatter diagram of the rates of uninsurance at a point in time provided by the three surveys. These include the rates of uninsurance from the CPS for 1990 through 1994, and from the RWJ survey for 1993. These data points are the uninsurance rates for persons of *all ages*. The 1990-1995 data points from the BRFSS are for adults *aged 18-64* only. Data from the 1995 BRFSS are provisional data representing only interviews completed in the first half of 1995. (For comparison to the BRFSS estimates, Commission staff have examined estimates from the CPS and the RWJ survey for respondents aged 18-64 (not shown on the scatter diagram). The uninsurance rates for this restricted age range can be expected to be *higher* than the rates for all ages. This is because those aged 65 and over are typically covered by Medicare, and as shown above, the uninsured are concentrated in the 18-34 year old age group.)

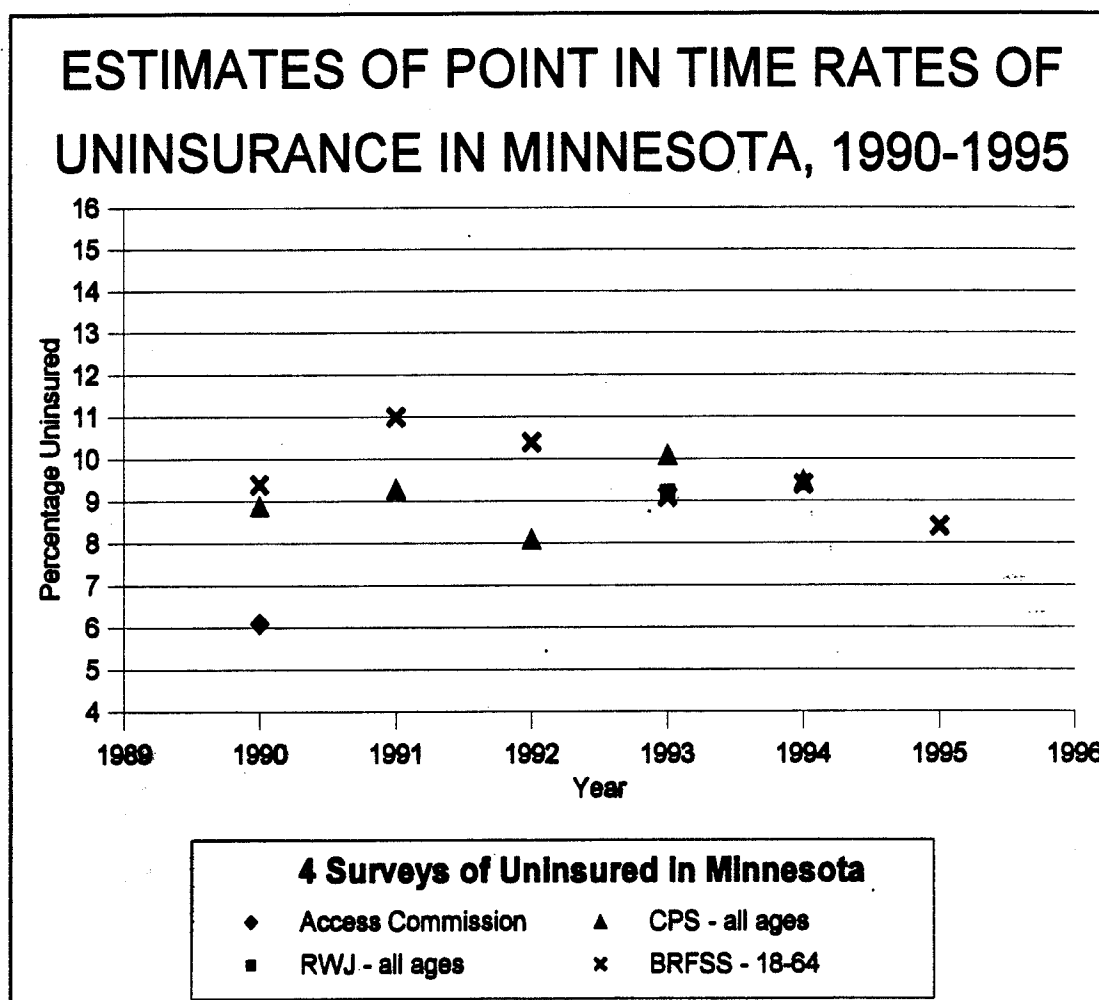
Taken together, the data points from these three surveys suggest that since 1990, the rate of uninsurance in Minnesota at a point in time has remained essentially *stable*. This is particularly evident when one follows the CPS or the BRFSS data points from year to year. More importantly, the different point estimates from the three surveys are *not* statistically different from one another at a 95% level of confidence.

The Commission's 1994 estimate of the rate of uninsurance was estimated simply by calculating the statistical *average* of the CPS data points for 1990-1992 and the 1993 RWJ survey estimates, since these *data points* referred to Minnesotans of all ages. The estimate of the uninsurance rate for 1994 ~~was an~~ extrapolation of the 1990-1993 trend. However, evidence from BRFSS data available ~~through the~~ first half of 1994 also supported the assertion that the rate of uninsurance had *not* changed in 1994.

In drawing these inferences about the rates of uninsurance from the three surveys, Commission staff consulted with experts from the Minnesota Department of Health, the Minnesota Department of Human Services, and the Institute for Health Services Research at the University of Minnesota. Note that, because of the relatively small number of data points, Commission staff were unable to perform a more sophisticated statistical analysis to estimate the rate of uninsurance in this state. A longer time series would be necessary in order to undertake such an analysis.

Chart 11 also shows the point estimate of the rate of uninsurance at a point in time obtained by the 1990 Minnesota Health Care Access Commission study.¹⁰ While the Minnesota uninsurance rates from the three additional surveys are higher than the estimate prepared for the Access Commission in 1990, the Minnesota Health Care Commission believes that this "increase" is due to differences in survey methodology and does not indicate any true growth in the number of uninsured persons since 1990. The 1995 Minnesota Health Care Insurance and Access Study, referred to above, uses a methodology very similar to the one used in the 1990 Access Commission study. The results of this survey, expected in early 1996, will be more directly comparable to this earlier survey than those of the other three surveys available to the Commission in 1994 and 1995.

Chart 11



Source: Bureau of the Census, Current Population Survey, 1991-94; RWJ Foundation Family Survey, 1993; MN Health Access Commission, 1991; Behavioral Risk Factor Surveillance, 1990-95

¹⁰ Lurie, Finch and Dowd, 1990. op. cit.

Potential for Bias

It is important to keep in mind that there are several sources of bias potentially present in any survey data set that can affect the results obtained from that survey. These sources include coverage bias (bias occurring when members of the population of interest have no chance of being selected for the sample), non-response bias (bias occurring when non-response is correlated with variables of interest), response error (bias occurring when respondents accidentally or deliberately give incorrect answers), and measurement error (questionnaire items do not actually measure what they are meant to measure, for a variety of reasons).¹¹

The problem of non-coverage often particularly applies to telephone surveys, where persons without telephones have no chance of being selected for the sample. If individuals without telephones are different from sampled individuals in terms of the survey variables of interest (such as whether or not they have health insurance), then the survey estimates of these variables could be biased.¹² However, since there are very few households without telephones, the bias introduced by the non-coverage of persons without telephones should be very small (the 1990 Census estimated that just 2.1% of Minnesota households do not have a telephone).

Probably the most important potential source of bias in the survey data is response error. It is known from previous studies that people sometimes do not know the details of their health care coverage.¹³ It is also possible that some respondents may not view certain government programs, such as Medicaid, Medical Assistance or General Assistance Medical Care as "health insurance." Survey design experts guard against the possibility of response error by careful question construction, selective probing of responses, rigorous training of interviewers, and the pretesting of questionnaires.

¹¹ Groves, Robert M. 1989. *Survey Errors and Survey Costs*. New York: John Wiley.

Lavrakas, Paul J. 1993. *Telephone Survey Methods: Sampling, Selection and Supervision*. Newbury Park, CA: Sage Publications.

¹² Thornberry, Jr., Owen T. and James T. Massey. 1988. *Trends in United States Telephone Coverage Across Time and Subgroups*. in Groves, Robert M., Paul P. Biemer, Lars E. Lyberg, James T. Massey, William L. Nicholls II and Joseph Waksberg (eds.). 1988. *Telephone Survey Methodology*. New York: John Wiley and Sons.

¹³ Lurie, Finch and Dowd. 1990. op. cit.