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Minnesota Health Care Commission

Report

February 1997

Progress Toward Universal Coverage: Annual Report 1997

The mission of the Minnesota Health Care Commission is to help Minnesota communities, providers, group purchasers, employers, employees, and consumers improve the affordability, quality, and accessibility of health care.

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Minnesota Health Care Commission February, 1997

Progress Toward Universal Coverage: Annual Report 1997

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Executive Summary

Legislative Study Charge

The Minnesota Health Care Commission is charged with providing a report each year to the Legislature regarding the state's progress toward achieving universal health care coverage. The report is to include estimates of the number of uninsured in the state, and any recommendations by the Commission on strategies to continue progress toward universal coverage (Minnesota Statues 62Q.165, Subd. 3).

Primary sources of information on the uninsured

There are two main sources of information about the number and characteristics of the uninsured in Minnesota. One source is from a special survey conducted recently by the University of Minnesota's Institute for Health Services Research for the Blue Cross and Blue Shield of Minnesota Foundation. The survey was completed in late 1995 and analyzed in 1996. The other source is provided through ongoing annual surveys conducted as part of the US Census Bureau's "Current Population Survey (CPS)" and the Minnesota Behavioral Risk Factor Surveillance System (BRFSS).

Not surprisingly, two different surveys mean two different results. Moreover, because the surveys use different methodologies to estimate the number of uninsured, the estimates are not statistically comparable. However, even with this incompatibility, the surveys independently suggest some common findings regarding certain key aspects of the uninsured in Minnesota. Most notably, *the surveys indicate that the uninsured rate seems to have remained stable since 1990.* As discussed in greater detail below, the surveys suggest two different, *but stable,* uninsured rates: one set of data indicates that roughly 6% of Minnesotans lack health insurance at any point in time; other data suggest a rate closer to 9%. There is also relative agreement on the *characteristics of the uninsured: they are more likely to be male, single, younger, less educated, and have lower incomes.*

Minnesota Health Care Commission Recommendations

The Commission recently adopted a number of recommendations for consideration by the 1997 Legislature to help bring about a more equitable, more stable, and more efficient health care financing system, which is essential to achieving universal coverage. The recommendations include increasing access to the MinnesotaCare program for the uninsured by

- *expanding the MinnesotaCare Subsidized Health Insurance Program eligibility level to include adults without children with incomes to 175% of the federal poverty level (up from the current level of 135% FPL), and*

- *developing outreach, promotion and education to enroll more of the estimated 86,000 persons who are currently eligible for the MinnesotaCare Subsidized Health Insurance Program, but who have not yet enrolled.*

The Commission also recommends strengthening the current financing system, while beginning a transition to a more desirable system with greater general fund financing of health care.

- ▶ Because the 2% provider tax which funds the MinnesotaCare program for the uninsured is not as broad based or stable as general revenues, the *Commission recommends phasing out the 2% tax over 2 years and replacing it with general revenues. This recommendation is conditional: the phase-out of the 2% tax should not occur unless and until adequate general fund financing of MinnesotaCare is secured.*

- ▶ During the transition above, *better enforcement of the pass-through provisions of the 2% tax are needed to ensure that the tax, which falls directly on providers, is passed on to consumers and third party payers as the Legislature intended.*

- ▶ The Commission recommends *changes in funding of the state's high risk pool, the Minnesota Comprehensive Health Association (MCHA), and in the financing of charity care, medical education and research, and public health.* The cross-subsidies that now finance these activities are increasingly seen as an unfair and unsustainable source of financing. These measures will address cost-shifting and unfair burdens which especially jeopardize coverage for small groups and individuals.

The remainder of this report briefly describes the research strategies used in estimating the number and characteristics of Minnesota's uninsured and summarizes their findings. The report also discusses recommendations of the Health Care Commission to reduce the number of the uninsured.

Progress Toward Universal Coverage: Annual Report

Estimates of the Uninsured in Minnesota

Perhaps the single most important common thread running through the different surveys used to estimate the uninsured in Minnesota is that they show the level of overall uninsurance in Minnesota remaining about the same since 1990. This is in contrast to the national rate of uninsurance which has steadily climbed from 13.9% in 1990 to 15.3% in 1995. The surveys also agree in their characterization of the uninsured: the uninsured are more likely to be male, single, younger, less educated, and have lower incomes.

However, because different surveys use different methologies to estimate the number of uninsured, they produce essentially two different estimates of the percent of uninsured in the state.

- The *1995 Minnesota Health Care Insurance and Access Survey* (MHCIAS) recently conducted by the University of Minnesota reports an uninsured rate of 6%, or approximately 276,500 uninsured Minnesotans at any point in time during 1995. This rate is nearly identical to that of a 1990 estimate derived from a similar survey conducted by the University.

- The *US Census Bureau's Current Population Survey (CPS)* data, in contrast, showed an uninsured rate of about 9% during the same time period, or approximately 414,800 uninsured in 1995. This data also fluctuates slightly from year to year but remains relatively constant at about 9%. The state's BRFSS data shows a slightly higher rate, but is skewed because it does not include persons under 18 years old — including these children is expected to reduce the overall uninsurance rate.

The Minnesota Department of Health's Health Economics Program (HEP) has also recently completed an issue brief, *Measuring Trends in the Number of the Uninsured in Minnesota,* which describes the two different survey techniques and reports key findings. The issue brief is attached as an appendix.

Key Findings

The 1995 Minnesota Health Care Insurance and Access Survey (MHCIAS): In comparison to the CPS data cited above, the 1995 survey found an uninsured rate of approximately 6.0%, essentially unchanged from a similar study conducted in 1990.

The Current Population Survey (CPS): The rate of uninsured in Minnesota is reported by the CPS as 8.0 percent in 1995. However, the Census Bureau recommends that the data be averaged over a number of years to reduce the potential error in the estimates generated by both their lack of precision and yearly fluctuations in sampling.

The two and three year averaged uninsured rates for 1995 are reported as 8.8 and 9.2 percent respectively. These figures are approximately the same for both categories as they were in 1990 (8.8 and 8.7 percent respectively). However, the national averages have changed from 13.8 and 13.6 percent for the two and three year averages for 1990 to 15.3 percent for both in 1995. These results suggests that the *uninsurance rate for Minnesota has remained relatively unchanged.*

The Behavioral Risk Factor Surveillance System (BRFSS): The 1995 Minnesota BRFSS reports the rate of uninsurance among the adult population as approximately 9%. The results of this survey between 1990 and 1995 suggest a fairly stable uninsurance rate at around 9%, though the 1992 and 1993 estimates were a bit higher at approximately 10.5% and 11% respectively. Again, the BRFSS results will likely be skewed toward higher estimates of the uninsured because the sample does not include children.

A Closer Examination of MHCIAS Data

Key findings of the 1995 MHCIAS data and its comparison with a similar 1990 survey are briefly summarized below.

► **Changes in those with and without insurance:**

- The number of continuously uninsured children in Minnesota *dropped* from approximately 51,000 in 1990, to roughly 31,000 in 1995. During the same period, the rate of uninsurance among children has been rising at the national level.

- Minnesotans who purchased *individual* health insurance policies dropped from 9.4% in 1990 to 5% in 1995.

    - Over the same period, the proportion of Minnesotans covered by public policies *increased* from 19.7% in 1990 to 22.7%

- Minnesotans insured by employers or unions remained relatively steady (64.9% in 1990 and 66.2% in 1995)

▶ **Characteristics of the uninsured**

- Minority representation among the uninsured has increased: from 5.6% of the continuously uninsured in 1990, to 12.5% in 1995; and from 5.4% of the on/off uninsured in 1990, to 10.3% in 1995.

- Most uninsured adults were employed: at least 25% of the continuously uninsured were self-employed, and less than 16% of the intermittently uninsured were self-employed.

- When the uninsured were asked why they had not bought insurance on their own, cost of health insurance was the primary reason given. Very few report that they did not need or want health insurance. Most of the uninsured did not have access to health insurance through family members and their employers.

▶ **The uninsured and MinnesotaCare**

- In 1995, 63% of the continuously uninsured, and 67% of the intermittently uninsured, had heard of MinnesotaCare. Reasons for not enrolling included: not certain if eligible, did not know where to go or how to apply, could not afford the premium, or did not want or need.

- Roughly half the continuously uninsured Minnesotans (over 86,000 currently uninsured persons) were eligible for MinnesotaCare.

  - Almost 80% of the continuously uninsured families with children were eligible for MinnesotaCare.

  - Approximately 14% of adults without children were eligible.

▶ **Health status and utilization**

- The uninsured were less likely to respond they are in "good to excellent health" than those who were insured.

  - When the uninsured did need care, they were more likely to delay getting medical care, primarily because they could not afford it.

  - The results indicate selective use of medical services among the continuously uninsured; they were as likely to seek attention for illness and injury as the insured, but were significantly less likely to make regular visits to a doctor's office or outpatient clinic.

► **Financial consequences**

- Taking both out-of-pocket costs and unpaid bills into account, a significantly greater percentage of the uninsured spent "excessive" amounts (that is, greater than 10% of their income) on health care than the group insured.

  - During 1990 and 1995, nearly twice the proportion of uninsured had unpaid medical expenses as did the insured.

  - While fewer continuously uninsured persons had out of pocket expenses than the group insured, they paid 1.5 to 4 times more on average out-of-pocket than the group insured.

Health Care Commission Recommendations

The Commission adopted a number of recommendations in December 1996 to help achieve the ultimate goal of universal coverage. The more immediate goals of the recommendations are to establish a broader based, more equitable, stable health care financing system and to reduce the number of persons lacking health coverage in the state.

Broader, more equitable, more stable financing of health care is key to achieving universal coverage. Today, the state's "patchwork" of health care programs (which provide every Minnesotan at least some level of health care) relies upon another "patchwork" of financing streams that is, to a great degree, unfair and unstable. The ability of the patchwork to finance public programs adequately and over the long term is jeopardized by growing competition in the health care market, pending reductions in federal outlays for health care, and continued erosion of the state regulated, insured market. The Commission's recommendations are intended to move the state to a more equitable, more stable financing system based on greater general revenue funding of health care.

Minnesota's current levels of health coverage are among the highest in the nation. To maintain these high rates of health coverage, the Commission's health care financing plan seeks to reduce or eliminate hidden cost shifts, and to finance care more broadly and fairly. At the same time, the Commission believes that the state should take steps described below to help bridge the gap between those with insurance and those without it, and to reduce the percent of uninsured Minnesotans to fewer than 4 percent of the state's population by the year 2000, the target set by the Legislature.

Summary of Recommendations

☆ ***Move toward broader, more equitable and stable financing of MinnesotaCare.*** An important source of coverage in Minnesota's health care market is the MinnesotaCare subsidized health insurance program. This program helps low-income, working families obtain *affordable*

coverage for primary and preventive care. For many of them, MinnesotaCare made it possible to move from welfare to work. The MinnesotaCare program has been hugely successful, and the state should ensure its long term viability by providing an equitable, adequate and stable source of financing.

The major source of funding for MinnesotaCare is revenues from the 2 percent tax on hospitals and health care providers. A premium tax on HMOs, CISNs and nonprofit health service corporations and enrollee premiums are other important sources of funding. The Commission believes that the provider taxes are neither fair nor broad based (in comparison to general fund financing), falling as they do on only those Minnesotans who seek medical care (or their providers, depending on the extent of the pass-through to patients and third party payers). In addition, difficulties in passing through the 2% tax on to third party purchasers, makes this tax fall disproportionately on to providers. As financing sources for MinnesotaCare, the provider and premium taxes are becoming problematic given increased price competition in the market, the pressure to control costs and the growth in the number of self-insured employer plans (which do not pay premium taxes).

The state should *begin general fund financing of MinnesotaCare* on January 1, 1998, replacing revenues from the provider tax over two years. Provided that adequate general revenue funding of MinnesotaCare is secured, the 2% provider tax would be reduced to 1% on January 1, 1998, and repealed completely on January 1, 2000. The other financing streams (the premium taxes and MCHA assessments) will also be phased out.

Finally, during the transition to general fund replacement of the 2% tax, better enforcement of the pass-through provisions of this tax is needed. Many providers complain that the provider tax, which the legislature intended to be passed on to consumers and third party purchasers, is not being passed on because of increased price competition in the market and objections from third party purchasers. Better enforcement would ensure that it does not fall unfairly on health care providers.

☆ ***Improve and expand MinnesotaCare subsidized health insurance program.*** The Commission recommends that the state expand its efforts to reach the 86,000 uninsured Minnesotans *who are currently eligible* for MinnesotaCare *but have not yet enrolled.* Those efforts should include enhanced promotion and outreach in collaboration with the private sector.

The Commission recommends that the state expand eligibility for the program to single adults and families without children with incomes up to 175% of federal poverty level, effective July 1, 1997. Based on 1996 federal poverty guidelines, 175% of the federal poverty level is an annual income of $13,545 for an individual. This annual income equals $1129 per month, or an hourly wage of $6.51 for someone working full time. Individuals with incomes approaching 175% of poverty would pay approximately $54 per month toward the full monthly premium cost of $98.

The Commission views this incremental step as an integral part of the on-going implementation of the MinnesotaCare program to serve persons with incomes up to 275 percent of the federal poverty level. Also recommended is a study of how changes in the subsidy level would increase MinnesotaCare enrollment.

☆ ***Broaden the Financing of the State's High-Risk Pool.*** The Minnesota Comprehensive Health Association (MCHA) has an annual operating deficit (currently totaling $48 million) that is directly financed by assessments on state-regulated health plans. It is indirectly financed through higher premiums charged to employers and individuals purchasing coverage in the small group and individual markets. This financing mechanism for MCHA presents two serious, interrelated problems. First, because Federal law[1] prevents the state from assessing self-insured employer plans and their number continues to grow, this assessment is falling upon an ever shrinking number of health plans. A key source of financing MCHA is drying up.

Second, the assessment is unfair and counterproductive. As more and more mid-sized and large firms self-insure, the coverage sold by the state-regulated, "MCHA-assessed" health plans is increasingly and disproportionately purchased by *smaller firms and individual buyers* of health insurance. Because of their relatively weak bargaining power, small firms and individuals pay the assessment through *higher premiums*, which has two major consequences: not only does the assessment act to price health insurance beyond the reach of some firms and people (thus contributing to the problem of the uninsured), but it also encourages more small firms to self-insure to avoid paying the assessment (and higher premiums). The result is that the market upon which the assessment ultimately falls continues to shrink, making this financing mechanism more unfair and more unsustainable.

With the objective of broadening the financing of MCHA, the Commission recommends that --

- *The general fund indirectly finances MCHA's deficit.* This would be accomplished, first, by transferring revenues from the 1% premium tax on nonprofit health service corporations, CISNs and HMOs out of the Health Care Access Fund and ***to*** the general fund; and second, by allowing health plans paying the MCHA assessment to *offset* on a dollar-for-dollar basis up to 1% of their premium tax.
- *The general fund pays the claims costs of the 600 or so Medical Assistance (MA) recipients enrolled in MCHA* -- a group with an 8-to-1 loss ratio. In addition, the current practice of enrolling MA eligibles in MCHA should be stopped.

☆ ***Broaden, stabilize funding of public health& charity care.*** Cross subsidies have traditionally financed much of public health, charity care as well as medical education and research. However, changes in the health care market (especially increased competition and cost containment) are reducing these cross subsidies, jeopardizing the financing sources of important parts of the health care continuum.

The Commission recommends that the cigarette tax increase be used to fund $7 million in family health through public health (as well as $10 million in medical education and research).

For a complete discussion of the Commission's recommendations for changes in the state's health care financing system, please see Minnesota Health Care Commission Report, *Toward More Equitable, Stable, and Integrated Health Care Financing: Summary, Recommendations and First Steps* (December 1996).

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[1] Employee Retirement Income Security Act of 1974.

Appendix:

Measuring Trends in the Number of Uninsured in Minnesota

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Measuring Trends in the Number of Uninsured in Minnesota

Health Economics Program Issue Paper

Minnesota's health care reform initiatives over the past several years were in part prompted by a concern that individuals in the state did not have adequate access to health insurance. As a result, studies that estimate how many Minnesotans lack insurance coverage are of importance to policy makers as they debate issues related to health care reform. This issue paper describes differences between various surveys of health insurance conducted in Minnesota, provides information about Minnesota's rate of uninsurance over time, and outlines changes in the demographic composition of the uninsured population during the 1990s.

Estimates of Minnesota's Uninsured Differ and Are Not Directly Comparable

Each year, a number of surveys measuring health insurance coverage are conducted in Minnesota. For example, the national Current Population Survey (CPS), and Minnesota's Behavior Risk Factor Surveillance System (BRFSS) annually survey Minnesotans about their health care coverage. In addition, periodic studies are conducted that examine health care coverage in the state, often funded by non-profit organizations. Examples of these studies include The 1993 Robert Wood Johnson Foundation Family Survey and the University of Minnesota's Health Care Insurance and Access Survey conducted in 1990 and again in 1995.[1] In general, these periodic studies have larger sample sizes and provide more in-depth information about health care service provision and demographics than the annual surveys.

Since each of these studies employs a somewhat different methodology, the results from the surveys vary and *are not directly comparable*. For example, the CPS measured the rate of uninsurance in Minnesota as 8.0 percent for 1995, which differs considerably from the University of Minnesota Health Care Insurance and Access Survey's estimate of 6.0 percent in 1995. A direct comparison between the two surveys could yield conclusions that are not valid. However, because the various estimates of uninsurance in Minnesota are often released without caveats about comparing the results from different surveys, misinterpretation may occur.

As a result, the Minnesota Department of Health (MDH) uses a single monitoring mechanism for examining changes in health insurance coverage for Minnesota. The goal is to monitor trends in the rate of uninsurance in the state. While the periodic studies provide a wealth of information on the uninsured population, the sporadic nature of the studies makes them unsuitable for annual tracking of trends in uninsurance. Of the annual surveys conducted in the state, the Current Population Survey best fits the needs for ongoing analysis of trends. An annual or bi-annual Minnesota-specific survey with a large sample size would greatly aid the Department of Health in its ability to monitor the precise rate of uninsurance in Minnesota.

Minnesota's Rate of Uninsurance Remains Stable while the Nation's Rate has Increased

Because of year-to-year fluctuations that occur in data collection and estimation, the Census Bureau recommends that CPS data be averaged over a several-year period to reduce the effects of these fluctuations. In particular, it recommends using a two-year average for comparisons of a single state's information over time and a three-year average when comparing the uninsurance rates of a given state to those of another state or region.[2] Presented in Table 1 are two-year and three-year averages of uninsurance for Minnesota and the U.S.

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Table 1
Two-Year and Three-Year Average Rates
Percent of Population Lacking
Health Insurance
Minnesota and U.S.

	Two-Year Average		Three-Year Average	
Average Ending	MN	US	MN	US
1990	8.8%	13.8%	8.7%	13.6%
1991	9.1	14.0	8.9	13.9
1992	8.7	14.4	8.8	14.2
1993	9.1	15.0	9.2	14.7
1994	9.8	15.3	9.2	15.1
1995	8.8	15.3	9.2	15.3

Table 1 shows that Minnesota's rate of uninsurance has remained steady at approximately 9 percent during the 1990s. In contrast, the nation's three-year average rate of uninsurance has risen from 13.6 percent to 15.3 percent between 1990 and 1995. The changes in insurance coverage are not statistically significant in Minnesota, but are for the U.S. ***In other words, Minnesota's rate of uninsurance has remained steady while the nation's rate has increased.***

At this time, it is unclear what the "true" rate of uninsurance is in Minnesota. The University of Minnesota's Health Care Access survey found a considerably lower rate of uninsurance than did the CPS, BRFSS, or The Robert Wood Johnson Family Survey, and each survey has certain strengths and weaknesses.[3] However, MDH's goal is to monitor the trend in the uninsurance rate on an ongoing basis. Taken from that perspective, all of the surveys reached the same conclusion: ***Minnesota's rate of uninsurance has remained stable from 1990 to 1995.***

Issues surrounding the trend in uninsurance are complicated, as individuals in Minnesota and nationally receive insurance coverage from one or more of a number of sources. As a result, changes in general economic conditions, public program eligibility, and employer-based offering of insurance can have impacts which simultaneously increase and reduce the percentage of Minnesotans with health care coverage. The next section of this issue paper discusses some of these issues.

Recent Trends in Employer-Based Coverage Differ for Minnesota and U.S.

Most people receive their health care coverage through an employer.[4] Traditionally, Minnesotans have received coverage through an employer at a somewhat higher rate than the national average. For example, according to the March 1995 CPS, 71 percent of non-elderly Minnesotans received coverage through an employer in 1994, compared to 65 percent nationally.[5]

Trends in the percentage of individuals who receive health insurance coverage through an employer also differ somewhat for Minnesota and the nation. While the rate of employer-based coverage declined both in Minnesota and nationally in the late 1980s and early 1990s, the rate stabilized in Minnesota around 1992 while the national rate continued to decline. Therefore, while nearly all studies indicate that the percentage of workers with health insurance coverage through an employer has declined nationally, Minnesota's rate of coverage has remained steady. The University of Minnesota's recently completed Health Care Access Survey reached similar conclusions, finding that the percentage of Minnesotans covered through a group or employer-based health insurance policy remained the same between 1990 and 1995.

Factors Influencing Employer-Based Health Care Coverage Rates

There are a number of factors which influence the rates at which employers offer insurance to their employees. For instance, employer-based coverage may decline if the cost of insurance coverage becomes so expensive relative to profits and income that firms are no longer able to offer coverage to employees as a benefit.

Alternatively, if family incomes decline or employers require employees to pay a greater share of their insurance premiums—either of which raises the

relative cost of health insurance for employees—fewer employees may choose to remain enrolled in employer-sponsored plans.[6]

Shifting employment patterns may also play a role. One often-cited reason for decreased employer-sponsored insurance coverage is the general movement among employers to part-time or contract work, where insurance coverage is less likely. In Minnesota, for instance, 62 percent of part-time employees work for companies that offer insurance to employees, compared to 82 percent of full-time employees.[7] If Minnesotans who were previously working for employers offering insurance move to part-time or contract employment where health care benefits are less likely, employer-sponsored insurance rates will fall.

Economywide shifts in employment between industries may also have an impact on the number of people enrolled in employer-sponsored plans. If employment grows in industries where fewer businesses offer insurance, the percentage of the population covered by employer-based insurance will decline. In addition, job growth in smaller firms, which are less likely to offer insurance, has outpaced job growth in larger firms. Nationally, between 1987 and 1992, firms with fewer than 100 employees created over three times as many jobs as firms with over 1,000 employees.[8] This shift may lead to a lower rate of employer-based coverage.

Several recent studies have examined the relative importance of these explanations in their impact on overall rates of uninsurance. ***The general conclusion from the studies is that, nationally, rising health care costs and falling family incomes account for the majority of the decline in enrollment in employer-sponsored plans***. While the studies note that there has been a shift in industry of employment and some movement toward part-time and contract work, the findings show that these changes do not explain much of the total change in enrollment. Rather, an overall decline in employer-sponsored coverage in all industries is a much more important factor.[9]

Minnesota Employer-Based Coverage Rates Stable

Minnesota's stable rates of employer-sponsored coverage in the 1990s, in contrast to declining U.S. rates, may in part be due to various insurance reforms enacted under the MinnesotaCare legislation. First, MinnesotaCare created the Minnesota Employees Insurance Program (MEIP). This program, designed to allow small businesses to pool their purchasing resources, has helped nearly 400 businesses purchase health coverage, 79 percent of whom had not previously offered insurance to their employees.[10]

Second, and perhaps more significantly, small employer group insurance reforms under MinnesotaCare have increased coverage and affordability in the small employer health insurance market. After the implementation of the small group insurance reforms in Minnesota, the number of small employer groups enrolled in the market increased 15 percent, meaning an additional 2,500 small businesses began offering health insurance to their employees.[11]

Finally, the cost-competitive environment for medical services that has developed in Minnesota in the 1990s has helped hold down premium rates and has made health insurance more affordable than it had been previously.

Public Program Enrollment has Increased

In the late 1980s and 1990s, both Minnesota and the nation saw an increase in public program enrollment. Nationally, Medicaid enrollment among the non-elderly population increased from 8.5 percent to 12.4 percent of the population between 1988 and 1993.[12] In Minnesota, trends in enrollment in public programs, which include Medicare, Medical Assistance, and General Assistance Medical Care, have been similar. Enrollment in public programs in Minnesota has increased from approximately 19 percent of the population in 1990 to about 23 percent in 1995.[13]

An important difference in public program enrollment between Minnesota and the U.S. should be noted. While Medicaid enrollment increased 56 percent nationally between 1988 and 1993, it increased at a more modest 40 percent for Minnesota over that time period. More importantly, Medicaid enrollment actually declined in Minnesota between 1994 and 1995. Some of the decline in Medicaid enrollment can likely be attributed to the MinnesotaCare program. Minnesota's Department of Human Services estimates AFDC enrollment would be 7

percent higher today had MinnesotaCare not existed, saving the state and federal governments approximately $24 million annually in AFDC costs.[14]

Enrollment in Individually Purchased Insurance Declining in Minnesota but Stable Nationally

Individuals who are not enrolled in a public program or who do not have access to insurance through an employer may choose to purchase individual coverage in the open market. The use of individual insurance policies as a primary source of insurance coverage has declined in Minnesota in the 1990s, while it has remained stable nationally. Nationally, between 11 and 12 percent of the population is covered through an individual or non-group policy.[15] Minnesota, on the other hand, has seen a decline in the percentage insured through private individual policies from 9.4 percent in 1990 to 5.0 percent in 1995.[16]

A Shift in the Composition of the Uninsured

The trend in uninsurance and sources of insurance coverage have differed for the U.S. and Minnesota over the first half of the 1990s. Table 2 shows their respective experiences.

Table 2
Change in Uninsurance Rates and Sources of Insurance Coverage Minnesota and U.S. 1990-1994

	Minnesota	U.S.
Uninsurance Rate	Stable	Increase
Employer-Based Coverage	Stable	Decrease
Government Program Enrollment	Increase	Increase
Individually Purchased	Decrease	Stable

Because of the shifts in sources of coverage over the early 1990s, the composition of the non-elderly uninsured has shifted. In general, the population of uninsured have higher incomes and are somewhat older in both Minnesota and the U.S. in 1995 than in 1990. While stable employer-based coverage and increased government program enrollment have increased access for Minnesotans, the decline in individually purchased insurance offsets those increases.

Shifts in the source of insurance coverage for individuals have some predictable effects on the composition of those remaining uninsured. For instance, since government programs such as Medicaid and MinnesotaCare frequently concentrate on covering children and those with lower incomes, movement of individuals from uninsurance to public programs is likely to increase the average age and average income of the uninsured. Minnesota saw a decline in the percentage of uninsured who were children, consistent with what would be expected given coverage trends.

Similarly, people who purchase insurance through individual policies have higher average incomes and are older than people on public programs or those receiving insurance through employers.[17] Movements from individually purchased insurance to uninsurance raises the average income and age of the uninsured population.

MinnesotaCare Not Displacing Private Coverage

During the debates over the MinnesotaCare legislation, some expressed concern that passage of a subsidized insurance program would displace privately purchased insurance with a public program. However, the finding that the distribution of the uninsured has shifted toward somewhat higher income categories supports the premise that those who were previously uninsured are taking advantage of public programs, while those in higher income categories, who were previously insured through individually purchased sources, may be dropping their coverage, perhaps because of rising premiums. A study released last fall indicated that MinnesotaCare was reaching its intended audience and was not crowding out private insurance.[18] The data presented here are consistent with that finding. The decline in individual enrollment may be partially attributable to the increase in small group enrollment, as some employers who did not previously offer coverage may now provide coverage for employees who can therefore drop their individual coverage.

Conclusion

The issue of the uninsured remains near the forefront of health care reform discussions. As Minnesota's health care market continues to evolve and change, the various factors influencing insurance rates will continue to change as well. The Minnesota Department of Health will continue to monitor the rate of uninsurance and the sources of insurance coverage, and will report periodically on changes or developments in the market using CPS and other data sources as they are available.

Notes

1. The 1990 Health Insurance and Access survey was funded by the State of Minnesota. The 1995 survey was funded by the Blue Cross Blue Shield Foundation.

2. See U.S. Bureau of Census, Current Population Survey, User Notes.

3. A number of these strengths and weaknesses are detailed in "Preliminary Estimates of the Number of Uninsured Minnesotans," Staff Report to the Minnesota Health Care Commission, 1994.

4. See Minnesota Department of Health, Health Economics Program, Minnesota Health Care Market Report 1995, p.34.

5. It should be noted that, starting in March 1995 (examining coverage in 1994), the Census Bureau revised the wording of the health insurance questions of the CPS. As a result, data from 1994 and 1995 is not directly comparable to previous years.

6. Several of these explanations are offered in, and examined by, Gregory Acs, "Explaining Trends in Health Insurance Coverage Between 1988 and 1991," and Steven Long and Jack Rodgers, "Do Shifts Toward Service Industries, Part-time Work, and Self-Employment Explain the Rising Uninsured Rate," both studies from Inquiry, Spring 1995.

7. See the Robert Wood Johnson Foundation Family Survey, 1993. Part-time was defined as less than 40 hours per week. Full-time is 40 hours or more per week.

8. See "The Changing World of Work and Employee Benefits," EBRI Issue Brief, Number 172, April 1996.

9. Acs, "Explaining Trends in Health Insurance Coverage between 1988 and 1991" and Long and Rodgers, "Do Shifts Toward Service Industries, Part-Time work, and Self Employment Explain the Rising Uninsured Rate."

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

11. For a more detailed analysis of the small group insurance market reforms in Minnesota, see Minnesota Department of Commerce, "Study of Small Employer Insurance Reform," January 1995.

12. Holahan, J., C. Winterbottom, and S. Rajan. "The Changing Composition of Health Insurance Coverage in the United States." Paper presented at the May 1 meeting of the Council on the Economic Impact of Health Care Reform, 1995.

13. Health Economics Program calculations based on data from the Minnesota Department of Human Services, Reports and Forecasts division and the Health Care Financing Agency.

14. "The Impact of MinnesotaCare on AFDC Caseload," Memorandum from the Minnesota Department of Human Services, Reports and Forecasts Division, December 1995.

15. See Employee Benefits Research Institute Notes, January 1996, Vol. 17, Number 1.

16. University of Minnesota, School of Public Health, Institute for Health Services Research, "Minnesota Health Care Insurance and Access Survey, 1995," p. 15.

17. Ibid, p. 20.

18. Lurie, Nicole, Alfred, Pheley, and Michael Finch. "Is MinnesotaCare Hitting its Mark?" University of Minnesota School of Public Health, Institute for Health Service Research and Hennepin County Medical Center, October, 1995.

For further information about uninsurance in Minnesota, contact Scott Leitz, Economist, (612) 282-6324 or Lynn A. Blewett, Director, Health Economics Program at (612) 282-6361.

The Health Economics Program conducts research and applied policy analysis to monitor changes in the health care marketplace; to understand factors influencing health care cost, quality and access; and to provide technical assistance in the development of state health care policy. The information is used to inform policymakers, consumers, and other stakeholders in Minnesota. For more information or for a list of recent publications, please contact the Health Economics Program at (612) 282-6367 or via e-mail at mark.meath@health.state.mn.us.

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