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Minnesota Department of **Human Services**

Memo

DATE: April 8, 1998

TO: Edward A. Burdick, Chief Clerk Minnesota House of Representatives;
Patrick E. Flahaven, Secretary of the Minnesota Senate

FROM: Mary B. Kennedy, Medicaid Director
Assistant Commissioner Health Care

SUBJECT: Transition Plan for MinnesotaCare Enrollees

Please see attached a revised report to the Minnesota Legislature on the Transition Plan for MinnesotaCare Enrollees.

The report comprises two sections of Laws of Minnesota 1997 statutes directing the Department to develop an implementation plan to transition higher income MinnesotaCare enrollees to the private sector, and to report on the impact of outreach efforts for the MinnesotaCare program, and reasons why enrollees are leaving the program.

Our original report left out the cite for the report on the impact of outreach efforts and it is included in the appendix of the corrected version attached. Please discard the earlier version.

Thank you.

1997 Minn. Laws Chap. 225 Art. 1 Sec. 20(a)

1997 Minn. Laws Chap. 225 Art. 1 Sec. 20(b)

Minnesota Department of **Human Services** **Health Care**

Mission Statement

The Department of Human Services, in partnership with the federal government, county and other public, private, and community agencies throughout Minnesota, is a state agency directed by law to assist those citizens whose personal or family resources are not adequate to meet their basic human needs. It is committed to helping them attain the maximum degree of self-sufficiency consistent with their individual capabilities. To these ends, the Department will promote the dignity, safety, and rights of the individual, and will assure public accountability and trust through responsible use of available resources.

A Report to the 1998 Minnesota Legislature as required by Laws of Minnesota 1997, Chapter 225, Article 1, Section 20(A) and Section 20(B)

The MinnesotaCare Program:

Demographics, Premium Affordability, Outreach, & Interaction with the Private Sector Insurance Market

and

Transition Plan for MinnesotaCare Enrollees

March 1998

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Minnesota Department of **Human Services**

Minnesota Department of **Health**

INTRODUCTION

The 1997 Legislature required the Minnesota Department of Human Services, in consultation with the Minnesota Departments of Health, Employee Relations, and Commerce and the Legislative Commission on Health Care Access, to develop "an implementation plan to transition higher-income MinnesotaCare enrollees to private sector or other non-subsidized coverage."[1] In developing the plan, the department was to consider "the feasibility of using the health insurance program for state employees administered by the commissioner of employee relations as a source of coverage."[2] In addition, the 1997 Legislature required the Minnesota Department of Human Services to report to the legislature on the impact of the outreach efforts for the MinnesotaCare program, and on the reasons why enrollees are leaving the MinnesotaCare program, and make recommendations on: (1) the affordability of the MinnesotaCare premium schedule; (2) the eligibility income level for the MinnesotaCare program that will result in the greatest number of individuals having health coverage; (3) what will encourage greater availability of health coverage in the private market; (4) steps to increase the availability of health coverage in the small employer market; (5) the need, if any, and the feasibility of increasing the MinnesotaCare program income eligibility level for individuals and households without children; and the possibility of alternative premium payments and of waiving the premiums for the MinnesotaCare program for certain low-income enrollees.[3] This report fulfills both of these legislative mandate.

I. BACKGROUND ON MINNESOTACARE ENROLLEES

A. Current MinnesotaCare Eligibility Criteria

Under current MinnesotaCare eligibility standards, families with children are eligible to enroll in the program with incomes up to 275 percent of the federal poverty guidelines (FPG). Eligibility for single adults was expanded during the 1997 legislative session from 135 percent of FPG to 175 percent of FPG, a change that became effective July 1, 1997. Children are eligible to be enrolled in MinnesotaCare through age 20. All enrollees in MinnesotaCare pay some premium. However, the premium level varies depending on the income of the enrollee. At the lowest income levels, enrollees in the program pay $4 per month. In addition, during the 1997 legislative session, the Minnesota legislature added an asset test. Under this new law, applicants for MinnesotaCare would not be eligible for the program if their assets exceeded $30,000 for households with two or more people, or $15,000 for one person households.[4]

The MinnesotaCare program currently imposes two additional eligibility criteria related to the private sector insurance market. First, applicants for MinnesotaCare must not have been eligible for employer-subsidized health insurance coverage for 18 months prior to applying.[5] Employer-subsidized coverage is defined as coverage where the employer pays 50 percent or more of the cost. In addition, families and individuals applying for MinnesotaCare must have

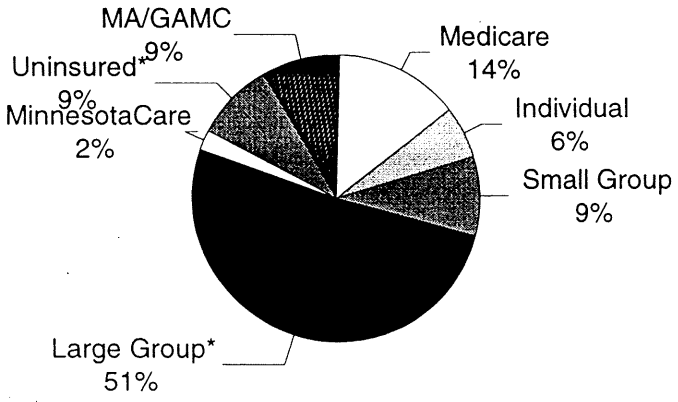
been uninsured for a period of 4 months prior to enrollment. Both the four month uninsured and eighteen month access to employer-sponsored coverage barriers are waived for children in families with incomes below 150 percent of the federal poverty guidelines.[5]

Children and pregnant women receive the same benefits as those provided to Medical Assistance participants. Health plan choices available to MinnesotaCare enrollees depending on their geographic location include Blue Plus, Central Minnesota Group Health Plan, First Plan of Minnesota, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan and UCare Minnesota.

B. Enrollment Demographics

Although filling a crucial need in terms of access to insurance, overall enrollment in MinnesotaCare remains a relatively small part of Minnesota's overall health care market. As shown in Figure 1, MinnesotaCare provides the primary source of insurance coverage for slightly less than 2 percent of the population in Minnesota.

Figure 1: Distribution of MN Population by Primary Source of Coverage



* Estimates of uninsured range from 6% to 9%. Large Group estimates range from 51% to 54%.
Source: Minnesota Department of Health, Health Economics Program.

The MinnesotaCare program was designed to specifically target children and lower-income working families and individuals. As a result, the enrollment demographics for the program tend to reflect these target populations. Tables 1, 2, and 3 below show the demographics for the different categories of MinnesotaCare's enrolled populations: families with children and adults without children.

Table 1: MinnesotaCare Families and Children Enrollment, November 1997

Eligibility Group	Age	Enrollment
Children	0-1	2,378
	2-5	8,625
	6-14	27,858
	15-17	9,481
	18-20	6,361
	21-25	4
Parents	21-25	2,930
	26-35	11,409
	36-45	14,648
	46-55	5,493
	56-65	967
	Over 65	16
Pregnant Women	<21	129
	21-25	220
	26-35	397
	36-45	93
	46-55	2
Total Families and Children		91,101

Source: Minnesota Department of Human Services.

The concentration of enrollment in the age 6 to 14 category among children on MinnesotaCare reflects the fact that Medical Assistance coverage is richer for younger children (under 6) and less generous for those who are older (in the 15 to 18 year old category).

Table 2: MinnesotaCare Adults without Children Enrollment, November 1997

Eligibility Group	Age	Enrollment
Female	21-25	680
	26-35	764
	36-45	694
	46-55	1,418
	56-65	1,987
	Over 65	40
Male	21-25	483
	26-35	664
	36-45	605
	46-55	761
	56-65	936
	Over 65	22
Total Adults without children		9,054

Source: Minnesota Department of Human Services.

It is interesting to note that enrollment among single females on MinnesotaCare is clustered in the 46 to 65 year old age group. MinnesotaCare appears to be filling a need in terms of affordability and access to insurance for this population.

Table 3: MinnesotaCare Enrollees by Demographic Group and Income, November 1997

Income as % of FPG	Children	Pregnant Women	Adults without Children	Parents	Total
<100%	15,494	351	5,026	10,455	31,326
100%-150%	23,131	326	3,352	14,090	40,899
151%-200%	11,089	115	499	7,387	19,090
201%-250%	3,677	39	109	2,547	6,372
251%-275%	602	4	17	454	1,077
>275%	714	6	51	530	1,301
Total	54,707	841	9,054	35,463	100,065

Source: Minnesota Department of Human Services.

The targeting of MinnesotaCare to certain populations is reflected in the overall enrollment figures for the program presented in the tables above . We found:

- **The overwhelming majority of MinnesotaCare enrollment is in families with children, with children making up more than half of the program's total enrollment.**

- **Nearly three-quarters of MinnesotaCare enrollment is among families and individuals with incomes of 150 percent or below of the federal poverty guidelines. Nearly all (91%) of MinnesotaCare enrollment is with individuals and families at incomes of 200% or below of federal poverty.**

In the first comprehensive examination of the MinnesotaCare program, a recent study by researchers at the University of Minnesota found that the program had been **"effective in maintaining a low rate of uninsurance and reducing this rate among children."**[6] The enrollment patterns in the program tend to support this finding.

C. Outreach Grants

While enrollment patterns indicate that MinnesotaCare is hitting its target population, data also indicates that a number of currently uninsured Minnesotans may be eligible for MinnesotaCare. The University of Minnesota estimates that approximately 86,000 currently and continously uninsured Minnesotans are likely eligible for the MinnesotaCare program but not currently enrolled.[7] Based on this and other information, policymakers have expressed some

concern that MinnesotaCare enrollment is not reaching its fullest potential. Among continously uninsured Minnesotans, the most commonly cited reason for not enrolling in the program was that they "didn't know where to apply" or "think they are not eligible."[8]

In order to facilitate outreach to populations of uninsured Minnesotans to make them aware of the existence of the MinnesotaCare program, the 1997 Legislature provided an annual appropriation of $750,000 to the Minnesota Department of Human Services for the purposes of awarding grants to "public or private organizations to provide information on the importance of maintaining insurance coverage and on how to obtain coverage through the MinnesotaCare program in areas of the state with high uninsured populations."[9]

In October, The Department of Human Services issued a Request for Proposals (RFP) for MinnesotaCare outreach. DHS received 28 proposals in response to the RFP. There was little duplication in the proposals, with the exception of the seven-county metro area, which received nine proposals. Three proposals targeted the entire state and three proposals targeted communities of color. The majority of proposals came from public agencies; five came from health care providers and three came from advertising/media firms. Twenty-six proposals were recommended for funding. For fiscal year 1998, $724,071 will be awarded in grants for MinnesotaCare outreach. More information on the specific outreach proposals and grants can be found in Appendix 1.

II. MINNESOTACARE APPLICATION, DISENROLLMENT AND APPLICATION PROCESSING

A. Application Volume

The MinnesotaCare program receives approximately 2,000 new applications and 3,500 renewal applications each month. While total enrollment for the program as of November, 1997 was slightly over 100,000 individuals, many more Minnesotans have been enrolled in the program since its inception in 1992. As the program has matured, enrollment increases have stabilized, and approximately 100 additional enrollees are added each month. The large number of new and renewal applications received each month, combined with the relatively slow rate of growth in the program over the recent past, indicates that there is significant turnover of the population in the MinnesotaCare program.

In order to better understand some of the dynamics as to why individuals leave the MinnesotaCare program, we conducted a survey based on a sample of individuals whose MinnesotaCare coverage ended June 30, 1997. As part of this survey, individuals were interviewed four to five months following MinnesotaCare disenrollment and were asked about their current health insurance status. We found:

- **Over half of individuals leaving MinnesotaCare had coverage at the time of the survey, with three-quarters of these insured individuals having private sector coverage.**

At the time of the survey, private insurers were providing health care benefits to 39.5 percent of people who left MinnesotaCare at the end of June — over 95 percent through employers. Other public programs — MA, GAMC and Medicare — picked up 12.7 percent of former MinnesotaCare enrollees. Table 4 shows the distribution of this population by reason for disenrollment.

Table 4. Percent of MinnesotaCare Disenrollees by Reason

Reason for Leaving	Percent
Have other insurance	39.5%
Didn't comply with enrollment procedures	16.2%
Can't afford premiums	14.6%
Enrolled in other public program	12.7%
Moved from state or household	10.2%
Expected other coverage	2.3%
Other reasons	4.5%
Total (N=481)	100.0%

Source: Minnesota Department of Human Services, MinnesotaCare Disenrollment Survey, 1997.

B. Caseload Size and Application Processing Time

As the MinnesotaCare program has grown, both in terms of enrollment and complexity, the processing time for MinnesotaCare applications has also grown. Requirements for additional information from those applying for the program, and a need to verify this information, along with continued growth in the number of enrollees in MinnesotaCare have resulted in an application processing time of approximately 30 days. MinnesotaCare currently has 50 enrollment representatives who manage ongoing eligibility, each with a caseload of approximately 750. Eighteen representatives currently work determining the eligibility of applicants.

As a comparison, county Medical Assistance representatives generally have a caseload of approximately 150 to 225 cases. While there are a number of differences between MinnesotaCare cases and county Medical Assistance cases, there is a need for MinnesotaCare to reduce the current caseload to provide better service to those currently in the program, as well as increased turnaround time in processing applications for new enrollees. The Department estimates that a caseload size of 600 cases per worker would allow for processing of applications and maintenance of current enrollees at a level that meets legislative and consumer satisfaction. Reaching this caseload size per worker would require an additional 15 to 17 enrollment representatives. If the expected effect of the MinnesotaCare outreach activities is factored in, the

necessary number of enrollment representatives to maintain the 600 cases per worker caseload grows to approximately 29 additional enrollment representatives. Minnesota counties may begin processing MinnesotaCare applications as of January 1, 2000, which may lessen the current caseload size for MinnesotaCare at DHS. In addition, in March, DHS is releasing a Request for Proposals (RFP) for advice on ways to automate and streamline the application and administrative process for MinnesotaCare.

III. MinnesotaCare Premium Affordability

The MinnesotaCare program was established to enable working individuals who did not qualify for Minnesota's Medical Assistance program to have access to affordable health insurance coverage. The sliding-scale used to determine the premiums for MinnesotaCare coverage is defined in *Minn. Stat.* §256L.08, Subd. 3. Individuals with lower incomes pay the minimum premium of $4 per month. Premiums rise according to a sliding scale that increases in steps of 1.5%, 1.8%, 2.3%, 3.1%, 3.8%, 4.8%, 5.9%, 7.4%, and 8.8% of gross family income. Table 5 shows the percentage of income paid for MinnesotaCare premiums for various family sizes.

Table 5: MinnesotaCare Premiums by Household Size and Income Measured as a Percent of Federal Poverty Guidelines (FPG).

	100%	150%	175%	200%	275%	>275%
Premiums as Percent of Income	2.3%	3.8%	4.8%	5.9%	8.8%	=\< 12.5%
1 Person	$15	$37	$55	$78	$128	$128
2 Persons	21	51	74	105	213	255
3 Persons	25	63	94	131	268	383
4 Persons	31	77	112	157	322	383

Source: Minnesota Department of Human Services.

As part of a survey of recently disenrolled MinnesotaCare enrollees, individuals were interviewed four to five months following MinnesotaCare disenrollment and were asked to comment on whether they believed the MinnesotaCare premiums to be affordable. We found:

- **Nearly three-quarters of those interviewed responded that MinnesotaCare premiums were affordable. As expected, individuals who were enrolled in another public program at the time of interview and those who were still without health care benefits were less likely to indicate that the premiums were affordable.**

Table 6 shows more detail of the results of the survey question related to affordability by current insurance status.

Table 6: Reported MinnesotaCare Premium Affordability by Category of Coverage Following MinnesotaCare Disenrollment

	Private health insurance N = 190		Public Health Programs N = 61		No Health Benefits N = 180	
Premiums Affordable	151	79%	38	62%	125	69%
Premiums Not Affordable	38	20%	23	38%	55	31%
Didn't know	1	< 1%				

Source: Minnesota Department of Human Services, MinnesotaCare Disenrollment Survey, 1997.

Individuals surveyed who said their MinnesotaCare premiums were affordable paid an average monthly premium that was approximately 2.6 percent of their monthly gross income. In contrast, those who said the premium was not affordable paid an average monthly premium that was about 4.4 percent of monthly gross income. People who said the premium was not affordable were also asked how much they felt would be affordable. On average, responses were equal to approximately 2.3% of income, or approximately half of their previous MinnesotaCare premium.

One additional way to compare the affordability of current MinnesotaCare premiums is to examine its premium structure relative to the recently-passed federal State Children's Health Insurance Program (S-CHIP, or KidCare) which was authorized under the Balanced Budget Act of 1997. Under S-CHIP, participating states may include cost-sharing (including premiums and copayments) up to a level of 5 percent of gross family income. As a comparison, the figures in Appendix 2 show a comparison of current MinnesotaCare premiums as a percentage of income relative to premiums at 5 percent of gross family income. MinnesotaCare premiums are 4.8% of income at 175% of the federal poverty guidelines, and increase to 5.9% of income at 200% of FPG. It is interesting to note that the vast majority of MinnesotaCare enrollment is below 200% of FPG, where premium payments are below 5% of gross family income.

This finding is not surprising in light of a variety of studies showing that the level of premium relative to family income is predictive of program participation. Table 7 shows results from a recent study by researchers at the Urban Institute of subsidized insurance programs that use sliding premium scales.[10] The table shows a large drop-off in willingness to participate in programs as the percent of income paid for health insurance premiums increases towards 5 percent.

Table 7: Willingness to Participate in Subsidized Insurance Programs by Premium as Percent of Income

Premium as Percent of Income	Percent of Eligibles Participating
1% or less	57%
3%	35%
5%	18%

Source: Ku and Coughlin, 1997.

IV. PRIVATE MARKET "CROWD OUT"

Some analysts and policymakers have expressed concern that if eligibility for MinnesotaCare continues to expand, MinnesotaCare may enroll some individuals who might otherwise be served by the private insurance market. This phenomenon of a government program supplanting the private market is often referred to as *"erosion of the market"* or *"crowd out."*

A. What Might Contribute to "Crowd-Out?"

Analysts have, in recent years, debated the issue of "crowd out." On the national level, during debates over the State Children's Health Insurance Program (S-CHIP) initiative enacted during the 105th Congress, concern was raised that expanding governmentally-sponsored health insurance coverage for children might tend to replace private sector health insurance. As a result, provisions were added to the final law requiring states, when designing programs to expand access to insurance for children, to include some features designed to prevent erosion from the private market.

The most obvious source of crowd out is **price differences between private sector coverage and governmentally-sponsored coverage**. If individuals currently purchasing in the private market are given the option to purchase governmentally-sponsored insurance coverage at a lower price, some may drop private sector coverage to purchase the publicly-sponsored program's coverage. In addition, **governmental programs are generally not underwritten for health conditions.** Therefore, there may be some individuals on the margin of insurability who, while eventually able to find private coverage, may find it easier and less cumbersome to simply apply to a governmental program where they are guaranteed access to coverage. Similarly, the **advertising campaigns and referrals** that generally accompany the establishment of a new governmental program may tend to draw people who otherwise might have purchased coverage

in the private sector.

B. What Might Discourage "Crowd-Out"?

While some have expressed concern that ready access to governmental programs might lead to people exiting the private market to enroll in publicly-subsidized coverage, there are a number of factors that might discourage people from doing so.

First, most **governmental programs have some administrative delay**. That is, individuals applying for the program must wait for their application to be processed and their eligibility for the program to be established before actually receiving coverage. In general, the larger and more complex a program becomes, the more likely it is to have a longer administrative delay. Some people are also concerned about **stigma attached to public programs**. For many people, enrolling in a public sector health care program may be seen as akin to being on "welfare" and they may therefore be reluctant to enroll. There is also an inherent delay and lack of privacy that exists in the income determination necessarily to determine eligibility for governmental programs. In addition, **the private sector has an unlimited opportunity to market insurance products to individuals**, which does not exist in governmentally-run health care programs.

In Minnesota, certain specific barriers were erected with the MinnesotaCare program to discourage crowd-out. First, in order to be eligible for the program, **individuals must be uninsured for four or more months prior to enrollment**. Second, individuals **must not have had access to employer-subsidized health insurance coverage for the previous 18 months**.[11] In both these cases, the Legislature specifically established barriers to prevent private market erosion.[12] Third, **inpatient hospital benefits are limited to $10,000 annually** for all single adult enrollees and for the parents of children with incomes in excess of 175 percent of federal poverty. Given the less-than-full coverage for hospitalization for certain enrollees, some believe this may discourage individuals from dropping policies with more complete catastrophic coverage.

C. Does Crowd-Out Exist?

Nationally

There is disagreement nationally over whether public-sector health care programs have "crowded out" private coverage. Analysts generally agree that health insurance coverage patterns for women and children over the past decade have seen two clear trends. First, private sector health insurance coverage has declined.[13] Second, Medicaid (or public program) coverage has increased.[14] Some have wondered whether these two trends are linked in some manner, and have argued that there was a substitution of public sector coverage for private health insurance. This "substitution hypothesis" has been the subject of disagreement.

Some analysts, such as Cutler and Gruber, argue that public-sector coverage crowded-out private sector coverage.[15] They estimate that up to one-sixth of the decline in overall private

sector health insurance coverage resulted from expansions of Medicaid. By contrast, other analysts, such as Dubay and Kenney, studying the same issue, conclude that there is little evidence of crowd-out.[16] There is generally no consensus as to the extent or existence of crowd-out and this issue will undoubtedly continue to be studied in detail.

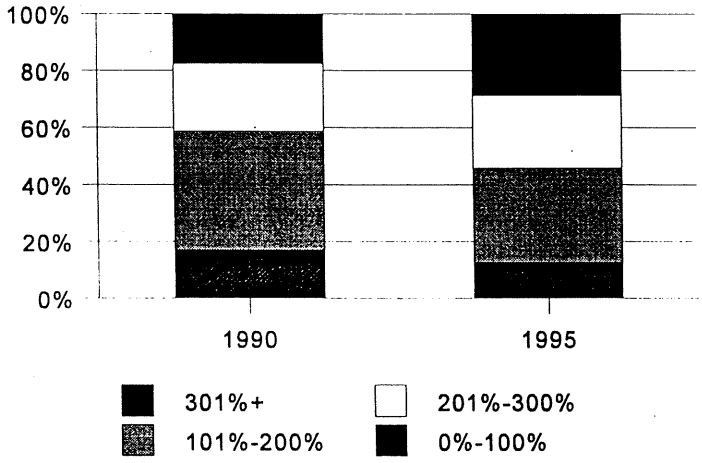
Minnesota

Analysts have noted that Minnesota's health care markets have seen phenomenon similar to those observed in national markets. That is, between 1990 and 1995, enrollment in individually-purchased private sector health policies declined, while enrollment in public programs increased.[17] While employer-sponsored health insurance coverage remained stable over this time period, some have expressed concern that enrollment in public programs, in particular MinnesotaCare, directly led to the decline in individually-purchased health insurance enrollment. This concern has more specifically centered on higher-income MinnesotaCare enrollees, who some feel should be purchasing coverage in the private sector.

A closer examination of several trends in the demographic make-up of the uninsured population may help to identify the degree of crowd-out that exists in Minnesota's health insurance market. First, as Figure 2 indicates, in 1990 nearly two-thirds of Minnesota's uninsured population had incomes below 200% of the federal poverty guidelines (FPG). MinnesotaCare was specifically focused to address the lack of access and affordability that existed with these lower-income Minnesotans, and as shown above in table 3, enrollment in the program is overwhelmingly centered on this group, with over 90% of enrollment among individuals with incomes 200% of FPG or below.

An analysis of data from two surveys of uninsurance conducted in Minnesota show that

Fig. 2: Uninsured Minnesotans by Income as % of FPG



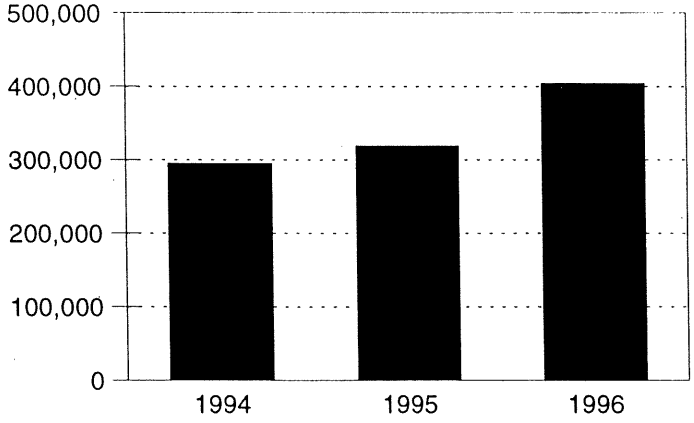
Source: University of Minnesota Health Insurance and Access Surveys, 1990 and 1996.

uninsurance among lower-income Minnesotans has fallen considerably, and that those below 200% of FPG now make up a much smaller percentage of the uninsured than in 1990.[18] As a result, the majority of the uninsured in Minnesota in 1995 have incomes in excess of 200% of FPG, in contrast to 1990. Hence, it is likely that those Minnesotans who were most likely to be uninsured in 1990 (those with incomes below 200% of FPG) were also those most likely to enroll in MinnesotaCare (as evidenced by the fact that over 90% of the program's enrollment is among individuals with incomes below 200% of FPG). Based on this information, it seems unlikely that the dramatic decline in individual enrollment in Minnesota was primarily due to MinnesotaCare.

Second, an examination of the age distribution of the uninsured in Minnesota shows a shift between 1990 and 1995. Specifically, children made up a smaller percentage of the uninsured in 1995 than in 1990. According to the 1990 and 1995 University of Minnesota Health Insurance and Access Surveys, in 1990, 26% of the uninsured in Minnesota had were below age 18. By 1995, this figure had declined to 17%. Over the same time period, the percentage of uninsured Minnesotans who were between the ages of 25 and 44 increased from 35% to 45%. ***Again, information seems to indicate that MinnesotaCare hit its target population: low income children who were previously uninsured. Evidence does not suggest crowd out of private market coverage.***

A likely answer to why Minnesota's individual market saw declining enrollment relates to another development in Minnesota in the 1990s: the implementation of small group insurance reform. Starting in 1992, the Minnesota legislature passed a series of reforms intended to make health insurance more accessible and affordable for small employers. Early evaluations showed

Figure 3: Enrollment in Small Group Products, size 2-49, Minnesota



that the reforms had their intended effect, as enrollment in small group products increased 8% in the first year after implementation.[19] More recent data shows that enrollment in small group products in Minnesota continues to increase, as demonstrated in Figure 3. The data presented in Figure 3 is drawn from a survey conducted by the Minnesota Department of Health in 1997. The data show that enrollment in small group products for employers with 2 to 49 employees has

increased considerably in the past several years. It seems plausible that many employees who previously purchased private, individual coverage because the small company they worked for didn't offer health insurance coverage switched to group insurance when small group reform and a healthy economy prompted many small businesses to begin to offer coverage.

The combination of these two trends--lower uninsurance rates among the low-income population in Minnesota and increased small group enrollment--seems to indicate that individual coverage was likely not "crowded-out" by MinnesotaCare, but rather substituted for by small group enrollment and dropped by higher-income individuals who chose to no longer pay the higher premiums for that coverage.

Perhaps the most far-reaching evaluation of the MinnesotaCare program to date was recently conducted by researchers at the University of Minnesota. Using three separate data sources, the University researchers concluded that ***"there was no evidence that MinnesotaCare enrollees are gaming the program, or that the program has resulted in significant erosion from the private market."***[20]

V. MinnesotaCare Transition Plan

The MinnesotaCare subsidized insurance program, as of November 1997, provided health insurance coverage for over 100,000 Minnesotans. As noted above, the growth of the program, combined with the decline in individual health insurance enrollment in the state, has led to some concern that MinnesotaCare was supplanting the private health insurance market. While Section IV of this report showed that MinnesotaCare appears to be reaching its target population without supplanting private coverage, some policymakers have expressed concern that some higher-income MinnesotaCare enrollees may be able to afford private market insurance coverage and should therefore be purchasing in that market. During the 1997 legislative session, the MinnesotaCare bill directed the Department of Human Services to "develop an implementation plan to transition higher-income MinnesotaCare enrollees to private sector or other nonsubsidized coverage." (See Appendix 3 for the legislative language).[21] The law also required that the feasibility of using the state employee pool for such a transition be examined. The Minnesota Department of Employee Relations has examined this issue, and determined that such a transition is not feasible. For more information, see Appendix 4.

In order to develop recommendations on a private market transition plan, we examined the affordability of private sector health insurance premiums relative to private market premiums; looked at the relative incomes of MinnesotaCare enrollees; examined the number of higher-income MinnesotaCare recipients; and analyzed survey data on enrollees leaving the MinnesotaCare program. This analysis was then used to develop options for plans to transition some MinnesotaCare enrollees into private sector health plans.

A. Comparison of MinnesotaCare Rates to Private Insurance Premium Rates

In order to examine the affordability of health insurance premiums for individuals in the private market relative to MinnesotaCare rates, we requested and received information from Blue

Cross Blue Shield of Minnesota, Medica HMO, and HealthPartners HMO, the three largest health plans in Minnesota. Deductible levels examined were chosen to approximate the low level of cost sharing present in MinnesotaCare.[22] Rates for individuals and families of certain sizes were then compared to MinnesotaCare rates. Appendix 5 shows a detailed comparison between rates. In general, we found:

- **For some populations, primarily younger Minnesotans, private sector health insurance rates (including MCHA) for higher-income groups of single adults and families are similar to, and in many cases lower than, MinnesotaCare premiums;**

- **Some age groups, in particular older Minnesotans, would face premiums considerably higher in the private market than on MinnesotaCare.**

Direct comparability between policies is made more difficult due to certain differences between MinnesotaCare coverage and private market insurance coverage. For instance, single adults on MinnesotaCare, and parents with children in families where income exceeds 175 percent of the federal poverty line face a $10,000 hospitalization payment cap under MinnesotaCare. This cap does not generally exist in private sector insurance.

B. Transition Populations

In order to examine how many people might be transitioned off MinnesotaCare, we reviewed data on the incomes and other insurance status of MinnesotaCare enrollees. The baseline data for this analysis can be found in Table 3. We found:

- **Approximately 1,300 MinnesotaCare enrollees had incomes in excess of 275 percent of the federal poverty line. This represents about 1 percent of the MinnesotaCare population;**

- **Approximately 200 adults without children had incomes in excess of 175 percent of the poverty line. This represents less than 1 percent of the total MinnesotaCare population;**

- **Approximately 400 children and 300 parents with children who are enrolled under MinnesotaCare have access to employer-sponsored insurance, and therefore do not meet all of the current MinnesotaCare eligibility requirements. These individuals were grandparented into MinnesotaCare from the Children's Health Plan (a forerunner to MinnesotaCare);**

- **An additional 1,000 MinnesotaCare enrollees had incomes between 251 percent and 275 percent of the federal poverty line.**

C. MinnesotaCare Disenrollment Data

Finally, we examined a sample of individuals who disenrolled from the MinnesotaCare

program. Some of this information was discussed in Section II of this report. While this data is still being analyzed and results are preliminary, some initial conclusions can be drawn from the information examined to date.

- **More than half of those leaving the MinnesotaCare program had other coverage at the time of being surveyed and 90% of these individuals indicated that the presence of other insurance coverage prompted them to leave the program;**

- **Most (72%) of these disenrolled but insured individuals had private sector coverage;**

- **Among those who left MinnesotaCare and did not have other coverage, the primary reasons for leaving the program is that the enrollees did not send in renewal forms or did not pay premiums for the program;**

- **Three-quarters of those leaving MinnesotaCare indicated that the program was affordable.**

Given the above findings of relatively affordable private sector health insurance for certain age categories of higher-income MinnesotaCare enrollees, a pool of between 1,500 and 2,500 of these enrollees, and evidence that many Minnesotans leaving the program find private sector health insurance coverage, we developed the following options and plans to transition certain higher-income enrollees off the MinnesotaCare program and into private sector health insurance coverage. The elements of the plan are described below.

Recommendations on plan for private market transition

This report recommends the following to transition higher-income MinnesotaCare enrollees off of the program:

- **Three options for removing those at the income-eligibility limits should be explored.**

  Option A: **Individuals could be removed from the program immediately once their incomes went above the eligibility limits for MinnesotaCare. Since over half of the individuals leaving MinnesotaCare find other health coverage, and given that private sector rates for most age groups are comparable to MinnesotaCare rates, the hope would be that some individuals would find coverage on their own in the private market;**

  Option B: **MinnesotaCare enrollees at or above the income-eligibility limits could be pooled, and this pool opened to private bid. Bids would be held annually, or whenever the pool reaches a "critical mass." This option provides for a smooth transition from public-sector coverage through MinnesotaCare to private-sector coverage through the contracting carrier. Individuals would be billed through the**

carrier and would be considered part of the private market once they have transitioned. In considering this option, it is important to remember that the "pool" is only a device to ease the transition. Once individuals are in the private market, they become part of the carrier's larger individual market pool.

Option C: MinnesotaCare enrollees at or above the income eligibility limits would be eligible for a MinnesotaCare transition or continuity product. This product would be offered to those individuals disenrolled from MinnesotaCare for having incomes that exceed the eligibility limits. Health care plans would bid rates to their MinnesotaCare enrollees who are over the income eligibility limits based on the claims experience of their MinnesotaCare business. Coverage provided under this option would be at least equivalent to that offered under the current MinnesotaCare program. To help guard against the possibility of risk selection, eligibility for the transition product would be limited to 18 months.

After exhausting eligibility for the transition product (or at any time during enrollment in the transition product) individuals would be eligible to purchase conversion coverage from their current carrier under the requirements specified in §*Minn. Stat.* 62A.65.

The three options listed above provide a range of alternatives. Option A requires the lowest level of involvement by the State. Under this option, individuals who no longer meet income-eligibility standards for MinnesotaCare are terminated from the program. For some individuals, the premiums paid in the private market will be less than those under MinnesotaCare. Because Minnesota's individual health insurance market does not have "guaranteed issue" (that is, individuals applying for health insurance coverage outside of a group can be denied coverage due to a health condition), some individuals may be denied coverage by a private sector carrier. Individuals denied coverage in the individual market after the termination of MinnesotaCare could apply to the Minnesota Comprehensive Health Association (MCHA), the state's high risk pool. Although MCHA premiums are higher than individual market premiums, for some groups of higher-income MinnesotaCare enrollees MCHA premiums remain below top-end MinnesotaCare premiums.

Option B is designed to ease the transition of MinnesotaCare enrollees from a publicly-subsidized health insurance product into the private market. Under Option B, those enrollees who are above the income-eligibility limits for their given eligibility category, or who no longer meet the access to employer-sponsored insurance criteria (the case for several hundred grandparented Children's Health Plan enrollees), would be pooled together. In general, those who are enrolled in MinnesotaCare with incomes exceeding 275% of FPG have more than covered their health costs through premium payments. As a result, this group of individuals should be relatively attractive to the private market. The pool would then be opened for bid, with the lowest-bid group receiving the entire pool. Coverage offered would have to be comprehensive and similar to current MinnesotaCare coverage. Once the plan has been recognized as the low-bidder, enrollment in the plan of MinnesotaCare transition enrollees is automatic. Enrollees become enrolled with the plan, and receive a bill from the plan the

following month. The "pooling" of enrollees is a way to ease the transfer from the public sector to private markets. Once enrolled in the private market health plan, enrollees would become part of the entire individual market pool and would no longer be part of the "transition" pool, just as any individual purchasing coverage in the individual market is part of the pool. While analysis of premiums in Minnesota showed that, for many individuals at the eligibility limits, private market coverage was less expensive than MinnesotaCare coverage, in order to ease the transition from MinnesotaCare, premiums charged to individuals would be no higher in the private market than the MinnesotaCare rate. This aspect of the plan could be enforced through the contract with the enrollee.

Option C provides a similar smooth transition by enabling MinnesotaCare enrollees to continue with their current health plan if they choose. Under Option C, individuals with incomes above eligibility limits for MinnesotaCare would be given the option to purchase a MinnesotaCare transition or continuity private sector product. Any plans serving MinnesotaCAre or Medical Assistance enrollees would be required to offer a transition product, and pricing for the product would be based only on that plans MinnesotaCare claims experience. In order to protect against the possibility of risk selection, enrollment in this product would be limited to 18 months. After eligibility is exhausted (or at any time during their enrollment with the transition product), individuals being transitioned would be given the alternative to enroll in a conversion product, the requirements of which are spelled out *Minn. Stat.* §62A.65. Option C provides the greatest continuity of care for enrollees, as they are able to stay with their current plan if they choose to do so.

Considerations for the Future

This report provides background information on the current status of enrollment and eligibility in the MinnesotaCare program, the level of crowd-out in the private market in Minnesota due to MinnesotaCare, and offers a number of options and recommendations for transitioning certain higher-income MinnesotaCare enrollees into the private sector. In addition to these recommendations, there are a number of other factors related to the MinnesotaCare program that policymakers and others should consider as the future of MinnesotaCare is debated.

In particular, MinnesotaCare should remain a program that seeks to fill existing gaps. The goal of the program should be to continue to provide safety net coverage for those ineligible for Medical Assistance but with incomes sufficiently low that affordability in the private market is a concern. Data on enrollment in MinnesotaCare show over 90% of MinnesotaCare enrollment is with individuals below 200% of poverty. Efforts should continue to focus on finding those lower-income enrollees who are eligible for MinnesotaCare but not currently enrolled. It should also be a goal that Minnesotans with higher incomes voluntarily seek insurance coverage in the private sector. Future consideration for the program should be that eligibility standards for families with children be reduced, with an increased emphasis on enrolling lower income uninsured Minnesotans.

There also remain concerns about access to affordable health coverage for various pockets of uninsured individuals. These may include children who are eligible for public

programs but not enrolled, older Minnesotans, and those who are chronically uninsured. We recommend that the circumstances surrounding these individuals and options for dealing with these populations should be studied and plans for dealing with these populations developed.

There also remains a concern that, despite the activies of the state and the private sector to ensure that individuals have access to affordable insurance, a certain percentage of the population is likely to remain uninsured. As a result, we also recommend that mechanisms which recognize and help to compensate for the costs resulting from the chronically uninsured population, such as an uncompensated care pool, should be examined and be considered as part of any complete strategy to address issues related to the uninsured.

Endnotes

1. Laws of Minnesota 1997, Chapter 225, Article 1, Section 20(a).

2. Laws of Minnesota 1997, Chapter 225, Article 1, Section 20(a).

3. Laws of Minnesota 1997, Chapter 225, Article 1, Section 20(b).

4. These asset test provisions have been repealed in both the Senate and House Omnibus Health and Human Services bills in the 1998 legislative session. As of the writing of this report, the asset test remains in law, but is likely to be repealed by the final Omnibus bill.

5. Under current law, these criteria are waived under certain circumstances. These circumstances include: (1) if employer-subsidized coverage was lost due to the death of an employee or divorce; (b) if employer-subsidized coverage was lost because an individual became ineligible for coverage as a child or dependent; or (3) employer-subsidized coverage was lost for reasons that would not disqualify the individual for unemployment benefits and the family or individual has not had access to employer-subsidized coverage since the loss of coverage. Also, the barriers are waived for children in families with incomes less than 150 percent of the federal poverty guidelines.

6. *Minn. Stat.* §256L.07, Subd. 1.

7. Call, Kathleen Thiede, Nicole Lurie, Yvonne Jonk, Robert Feldman, and Michael Finch. "Who Is Still Uninsured in Minnesota? Lessons From State Reform Efforts," *Journal of the American Medical Association*, October 8, 1997.

8. University of Minnesota, Institute for Health Services Research, "Minnesota Health Care Insurance and Access Survey, 1995," October 1996, p. 36.

9. University of Minnesota, Institute for Health Services Research, "Minnesota Health Care Insurance and Access Survey, 1995," October 1996, p. 34.

10. *Minn. Stat.* 256L.04, Subd. 11.

11. Ku, Leighton and Theresa Coughlin. "The Use of Sliding Scale Premiums in Subsidized Insurance Programs," Washington: Urban Institute, April, 1997.

12. These barriers are waived for children in families with incomes less than 150 percent of poverty.

13. Minnesota's efforts to expand coverage while preventing crowd-out were used as national models in the SCHIP legislation. In particular, analysts noted that Minnesota's barriers to crowd-out were the most strict among current programs. See "Employer Coverage and the Children's Health Insurance Program Under the Balanced Budget Act of 1997: Options for States," Mark Merlis, Institute for Health Policy Solutions, August 21, 1997.

14. According to the U.S. Department of Commerce, U.S. Bureau of the Census, Current Population Survey, private health insurance covered 75.5% of the population in 1987 and had declined to 70.2% of the population by 1996.

15. In 1987, 8.4% of the U.S. population was covered through Medicaid. By 1996, this figure had grown to 11.8%.

16. Cutler, David M. And Jonathan Gruber. "Medicaid and Private Insurance: Evidence and Implications," *Health Affairs*, Volume 16, Number 1, pp. 194-200.

17. Dubay, Lisa and Genvieve Kenney. "Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?" *Health Affairs*, Volume 16, Number 1, pp. 185-193.

18. University of Minnesota, Institute for Health Services Research, "Minnesota Health Care Insurance and Access Survey, 1995," October 1996 and University of Minnesota, Institute for Health Services Research, "Who Are the Uninsured in Minnesota? A Report to the Minnesota Health Care Access Commission," October 1990.

19. University of Minnesota, Institute for Health Services Research, "Minnesota Health Care Insurance and Access Survey, 1995," October 1996 and University of Minnesota, Institute for Health Services Research, "Who Are the Uninsured in Minnesota? A Report to the Minnesota Health Care Access Commission," October 1990.

20. Minnesota Department of Commerce. "Study of Small Employer Health Insurance Reform," January 1995.

21. Call, Kathleen Thiede, Nicole Lurie, Yvonne Jonk, Robert Feldman, and Michael Finch. "Who Is Still Uninsured in Minnesota? Lessons From State Reform Efforts," *Journal of the American Medical Association*, October 8, 1997.

22. Laws of Minnesota 1997, Chapter 225, Article 1, Section 20(a).

23. For HealthPartners, the deductible was $250. For Blue Cross Blue Shield of Minnesota, the deductible was $150. Medica HMO had no deductible, but copayments for various services exist.

Appendix 1

MinnesotaCare Outreach Proposals

Overview

DHS received 28 proposals in response to its RFP for MinnesotaCare outreach. There was little duplication in the proposals, with the exception of the seven-county metro area, which received nine proposals. Three proposals targeted the entire state and three proposals targeted communities of color. The majority of proposals came from public agencies; five came from providers and three came from advertising/media firms. Twenty-six proposals were recommended for funding.

Status report

Nine contracts are currently in the review process and expected to be ready for signature shortly. Ten contracts are in preparation, and final budget negotiations are underway for the remaining seven contracts.

1. Brown County Public Health

Proposal: Attach MinnesotaCare information and a brief questionnaire to all WIC health assessment forms. Review with client. Individuals who might qualify given more information about MinnesotaCare and the application process.

2. Carondelet LifeCare Ministries

Proposal: Build on existing program (prescreen for MinnesotaCare eligibility) by having outreach worker meet with patients one-on-one at the time of appointment; assist with filling out application; follow up with patient.

3. Centre for Asians and Pacific Islanders

Proposal: Translate and distribute MinnesotaCare materials, assess insurance status of individuals and families enrolling in CAPI's programs, work with employers. Outreach via Southeast Asian food shelf, Asian language media, cultural and community events, canvassing Asian neighborhoods, Minneapolis public schools. Assist with application and follow through for first six months of enrollment.

4. Community Health Services of Goodhue & Wabasha Counties

Proposal: Outreach via employers; worksite presentations, paycheck stuffers, poster, toll-free number. Collaborate with service agencies and county programs such as WIC, adult health clinics, immunization clinics, and home visits, also health care providers and staff (billing and reception).

5. Crow Wing County Health Department

Proposal: County-wide needs assessment/evaluation. Outreach via chambers of commerce and health care providers to identify businesses not offering insurance to all their employees;

distribution of information via payroll inserts, clinics and pharmacies, soup kitchens, food shelves, churches, schools, bars, Job Services, Fuel Assistance, social services, other community-based services, college dorms/events.

6. Duluth Community Health Center
Proposal: Outreach to employers, including presentations to employees, one-on-one assistance in filling out application, and advocacy for clients in cases of questionable denials.

7. Family Health Services/Beltrami County Public Health
Proposal: Outreach via health care providers, social service and community agencies, including tribes, schools, day care, and Beltrami County Family Services Collaborative partners. Inservice presentations for the above. Material distributed at health fairs, church bazaars, county and other fairs, sportsmen associations, hunting and fishing events. Provide application assistance and follow-through, including home visits.. Have staff available at Saturdays and some evenings. Ongoing advertising and brochure/poster distribution.

8. Hennepin County
Proposal: Creation of central data system, outreach to non-medical community organizations, community leaders, clinic/medical providers, to people in transition (students, retirees, ex-TANF families or families losing Medical Assistance; and to special populations such as teens, homeless, shelter users, cultural/ethnic groups; training for job program staff; media campaign.

9. Himle Horner
Proposal: Statewide public relations campaign via media partnerships and grass roots outreach to communities of color and community events, promotional tie-ins with businesses, and information partnerships with chain grocery stores, day care centers, schools, and nonprofit service organizations.

10. Hmong American Partnership
Proposal: Collaborate with the Minnesota School Boards Association to design and implement campaign to encourage 141 Minnesota hospitals to form partnerships with school districts to find and enroll uninsured children and their families. Includes working with hospital staff and local insurance agents to assist uninsured. Two major efforts: spring and fall.

11. Kandiyohi County Public Health
Proposal: Outreach based on Child & Teen Checkup model. Marketing plan to include creation of collateral and distribution to community and social services , also business, education, medical clinics, insurance agents and bankers. Data tracking system to identify who needs followup, home visits.

12. Migrant Health Services Inc
Proposal: Outreach via employers in targeted areas; also service agencies, clinics, and private homes. Register people in program, provide basic health assessment, health education, referral to

health care plan (MinnesotaCare, Medical Assistance, employer), by traveling to the above-mentioned sites. Create outreach team consisting of two full-time bilingual health outreach workers and one registered nurse or practitioner. Maintain toll-free number, create data base of participants, do follow-up.

13. MetroEast Program for Health
Proposal: One-on-one assistance with MinnesotaCare application; culturally specific outreach via culturally specific agencies and providers; access and interpreter services; train the trainer program for hospital and clinic staff; target traditional and nontraditional outlets to distribute MinnesotaCare information.

14. Minneapolis Dept of Health and Family Support
Proposal: Outreach to new students; information and referral to MinnsotaCare; on-site assistance with application; training CTC staff.

15.Minnesota Hospitals and Healthcare Partnership
Proposal: Collaborate with the Minnesota School Boards Association to design and implement campaign to encourage 141 Minnesota hospitals to form partnerships with school districts to find and enroll uninsured children and their families. Includes working with hospital staff and local insurance agents to assist uninsured. Two major efforts: spring and fall.

16. Minnesota News Network
Proposal: Produce a series of radio messages about MinnesotaCare and the importance of health care coverage. Will reach all 87 counties and 750,000 listeners a week. Will work collaboratively with Himle Horner.

17. Neighborhood Health Care Network (Ramsey County)
Proposal: Outreach in collaboration with community groups and network clinics; creation of printed materials (translated into Spanish, Hmong, and Somali), and radio PSAs; interpreter pool, referral line; focus groups and enrollment groups.

18. Quin County Community Health
Proposal: Children's Assistance and Resources Event (CARE) fair in each county once each year or twice if warranted; public awareness media campaign, outreach to all WIC sites; partnerships with social services, county extension services, and schools (such as ECFE); screening by public health staff, partner with insurance underwriters for referrals.

19. Scott County Human Services
Proposal: Identify target individuals via businesses and seven collaborating agencies; assist applicants with filling out application, including interpreter services.

20. Sherburne County Public Health
Proposal: Questionnaire for every family that seeks care to prescreen for eligibility; brochure and

poster; telephone followup, offer application assistance and home visit.

21. St. Louis County Public Health
Proposal: Develop media campaign (print and electronic), work with county public health departments. Develop survey to determine needs, make inservice presentations, distribute information to social and community services such as AEOA, Job Services, Work Force, libraries, community colleges, senior nutrition sites, WIC, church bulletins, schools and early education programs.

22. St. Joseph's Home Care (Hubbard County)
Proposal: Incorporate MinnesotaCare outreach into public health programs. Application assistance and followup for participants in Childbirth Education, Head Start, school open houses, conference nights. One-to-one outreach to WIC participants and via New Mom home visits. Distribute brochures and posters, advertise in county newspapers.

23. Wadena County Public Health
Proposal: Assessment/evaluation of current providers, outreach activities, gaps in service and providers. Distribution of information via utility bills, PSAs (radio and TV), grocery bag insert, school newsletter, posters in laundromats, grocery stores, clinics. Targeted approach via community and social services, including home visits. Provide assistance in multiple sites with filling out application, follow-through. Inservice training for participating agencies.

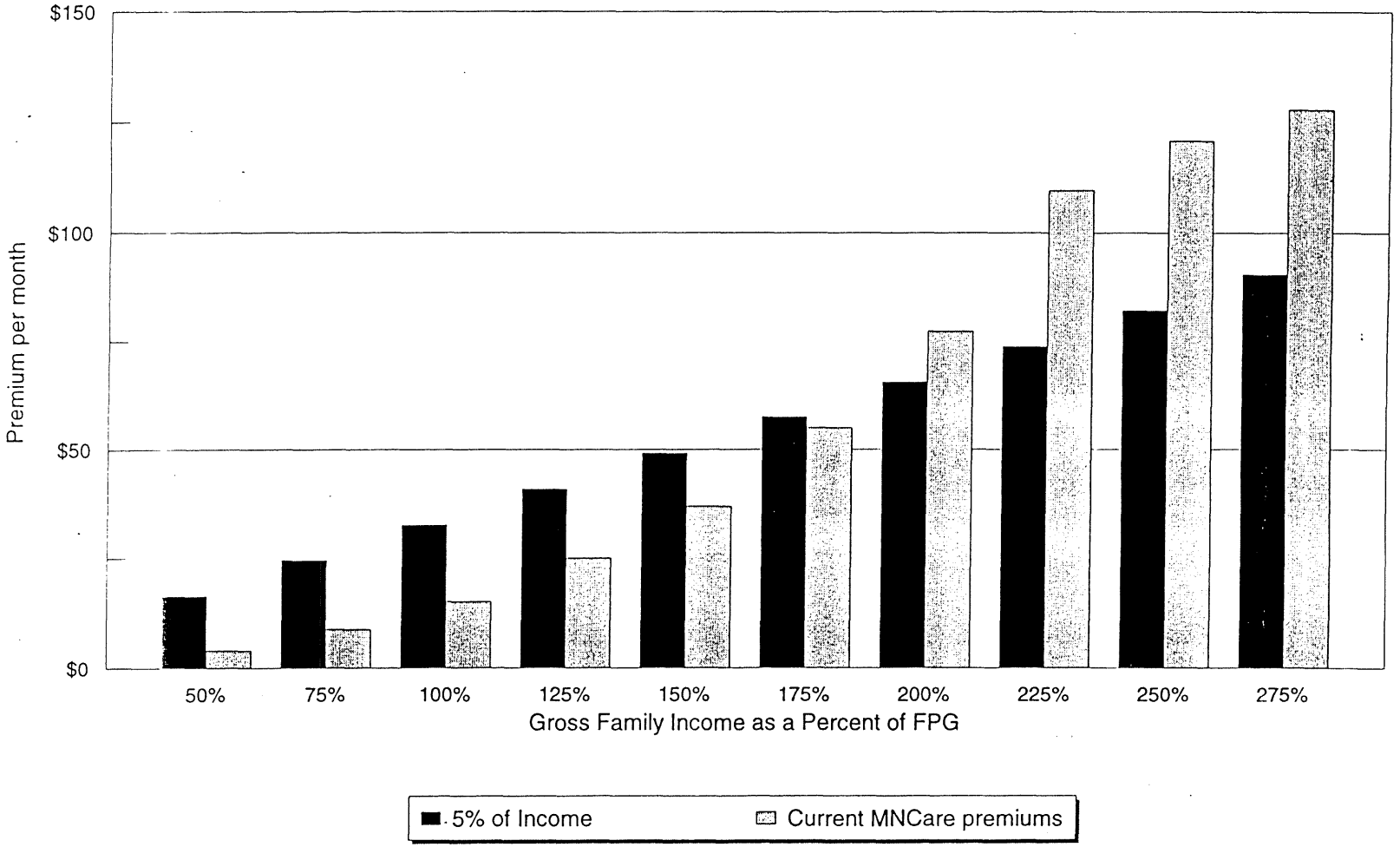
24. Washington County Community Services
Proposal: Outreach via WIC, Minnesota Workforce Center, clinics/hospital, county human services, and Parkside Resource and Referral Office (low-income housing complex), and schools. Direct outreach and inservice training to agency staff. Local phone contact; cable access TV, articles for local newspapers and distribution of magnets.

25. West Central Minnesota Community Action
Proposal: Combine with Head Start program; media campaign including newspapers, agency and school newsletters, print and electronic media; training for community agencies and schools; personal followup, home visits.

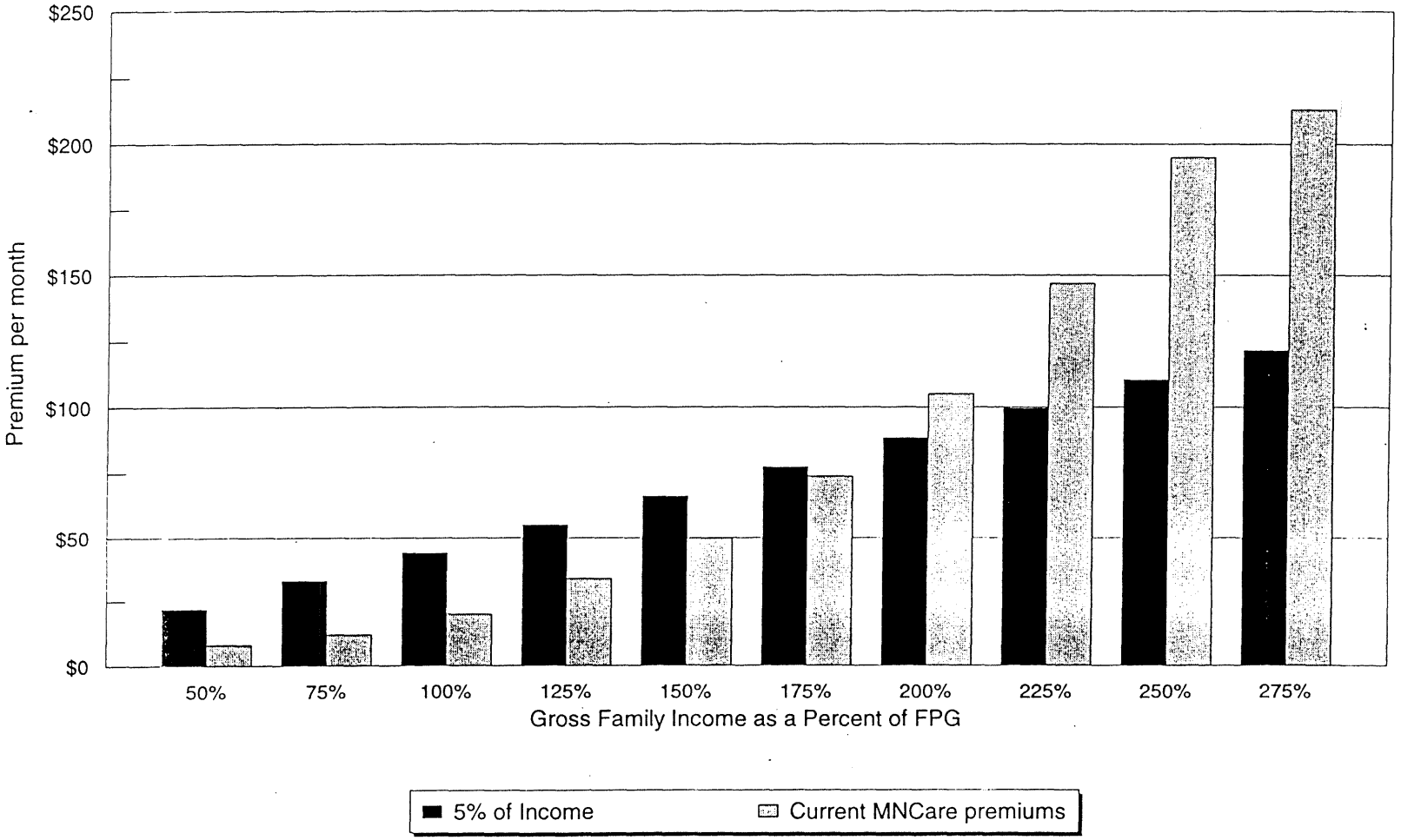
26. Winona County Community Health
Proposal: Collaborate with public health nurses. Provide one-on-one, assistance with information and application, telephone followup or home visit, access services, cultural sensitivity. Outreach via community and social service agencies. Inservice for collaborative partners and ongoing speakers bureau.

Appendix 2

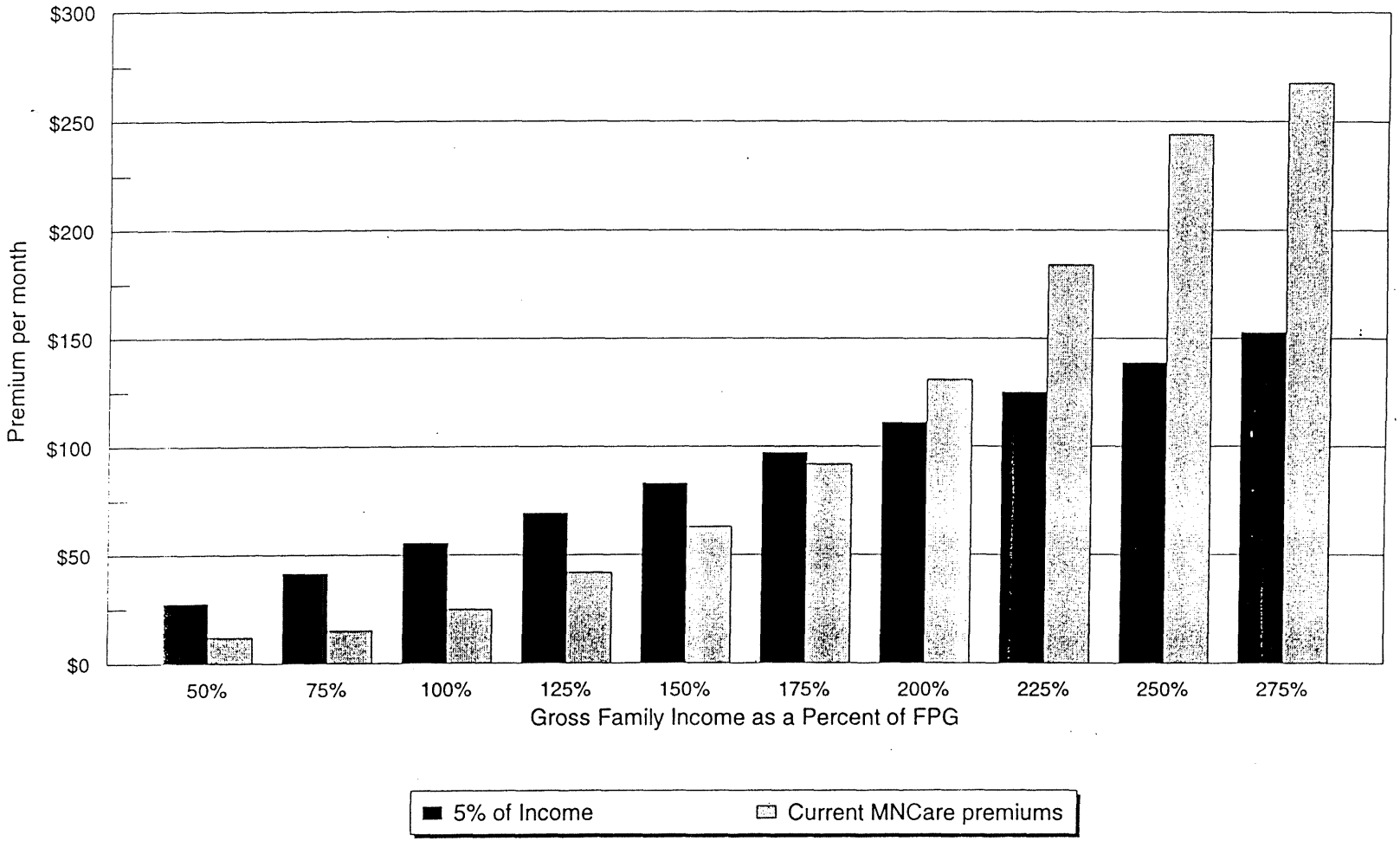
MinnesotaCare Premiums under Current Premium Structure and at 5% of Income, Single Adults



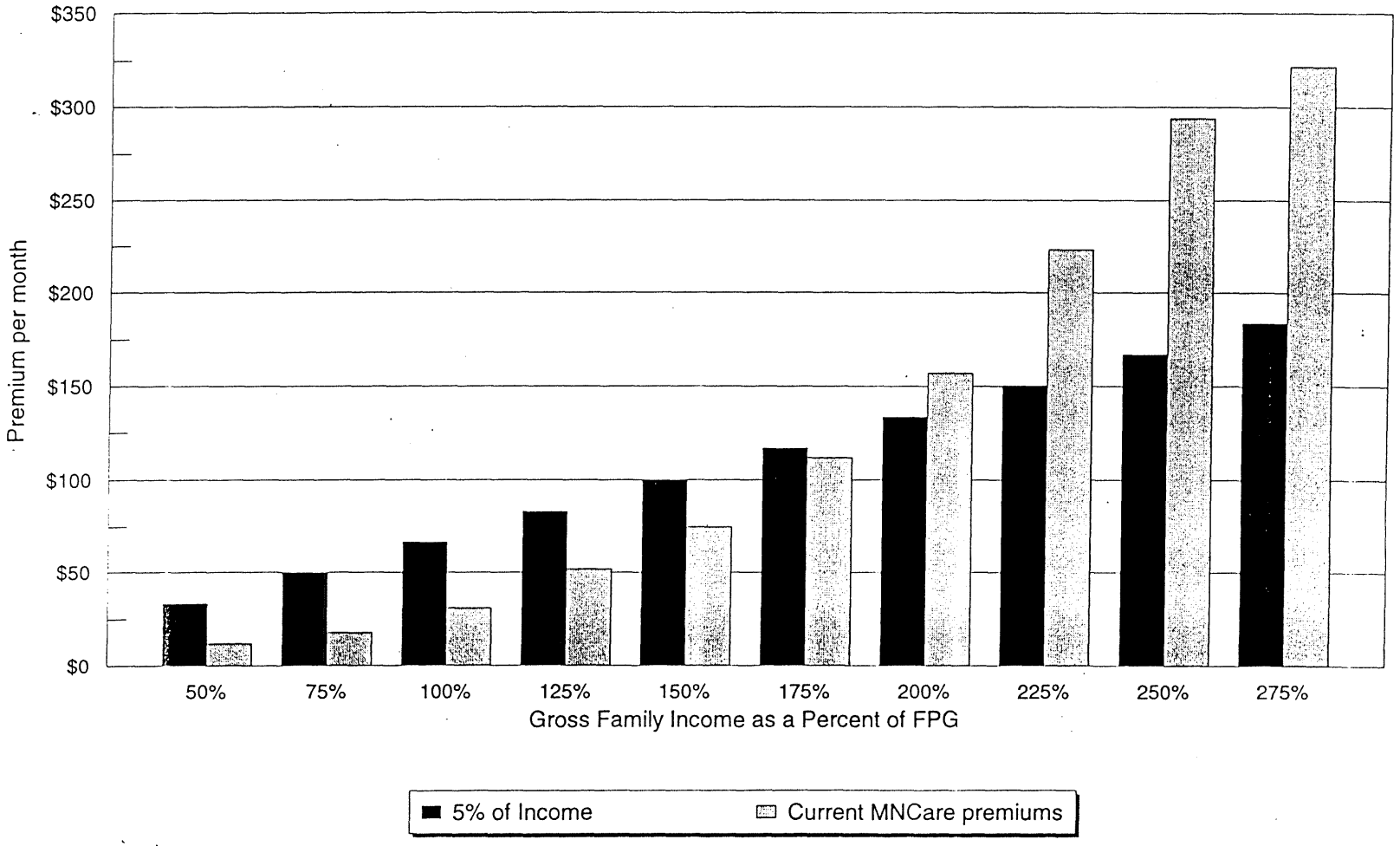
MinnesotaCare Premiums under Current Premium Structure and at 5% of Income, Family of 2



MinnesotaCare Premiums under Current Premium Structure and at 5% of Income, Family of 3



MinnesotaCare Premiums under Current Premium Structure and at 5% of Income, Family of 4



Appendix 3

Laws of Minnesota 1997, Chapter 225, Article 1, Section 20

[TRANSITION PLAN FOR MINNESOTACARE ENROLLEES.]

(a) The commissioner of human services, in consultation with the legislative commission on health care access and the commissioners of employee relations, health, and commerce, shall develop an implementation plan to transition higher-income MinnesotaCare enrollees to private sector or other nonsubsidized coverage. In developing the plan, the commissioner shall examine the feasibility of using the health insurance program for state employees administered by the commissioner of employee relations as a source of coverage, and shall also examine methods to increase the affordability of private sector coverage for individuals and families transitioning off MinnesotaCare. The commissioner shall submit the implementation plan to the legislature by December 15, 1997.

Appendix 4

Minnesota
Department of
Employee
Relations

Leadership and partnership in human resource management

Memo

DATE: December 18, 1997

TO: David S. Doth, Commissioner
Department of Human Services

From: Karen Carpenter, Commissioner
Department of Employee Relations

Subject: Transition Plan for MinnesotaCare
1997 Laws of Minnesota, Chapter 225

As part of the development of an implementation plan to transition higher-income MinnesotaCare enrollees to private sector or other nonsubsidized coverage, the 1997 Session directed the examination of the feasibility of using the State Employees Group Insurance Program (SEGIP) as a source of coverage. It is our position that this is not feasible.

The SEGIP currently enjoys the status of a governmental plan, exempt from regulatory provisions of federal law under the Employees Retirement Income Security Act of 1974 (ERISA). Inclusion of non-governmental employees or, for that matter, individuals who are not "employees" would deprive the plan of its "governmental" status and present far reaching consequences. The Department of Employee Relations' (DOER) independent counsel, Briggs and Morgan, prepared a legal analysis detailing the potential consequences of changing the program's status. Based upon this analysis, DOER must oppose expanding the plan to non-state employees.

Briggs and Morgan concluded that the proposed expansion of eligibility would likely require the establishment of two separate programs: a) a Multiple Employer Plan (MEP) covering union employees and b) a Multiple Employer Welfare Arrangement (MEWA) covering non-union employees. The newly eligible individuals would have to be pooled in the MEWA with the 2,250 non-union state employees (approximately 5% of the state's work force) and would not have the benefit of being pooled with the larger group of 43,000 union employees. Separating from the larger group could create a significant disadvantage for the state's non-union employees.

Both the MEP and the MEWA would be subject to additional federal regulation under the ERISA from which SEGIP is currently exempt. The MEWA would be subject to state regulation and as such, the plan sponsor would be required to:

1. register annually as an insurance company (this may result in a requirement to make the plan available on a guaranteed issue and guaranteed renewability basis to any employer who expresses interest in participating),

2. maintain the required levels of reserves and meet all other statutory requirements for insurance companies,
3. provide all mandated benefits, and
4. meet all other requirements of Minn. Stat. Chapters 62A and 62E.

(Note: With respect to item 2, the SEGIP's self-insured plans are reserved at levels recommended by its independent actuaries. The self-insured plans voluntarily comply with items 3 and 4. All insured SEGIP plans comply with applicable statutes.)

Finally, Briggs and Morgan also advised that the Health Insurance Portability and Accountability Act recently amended ERISA resulting in the requirement that a MEWA must guarantee renewability, binding the Plan to afford employers continued access in future years unless certain exceptions apply.

In conclusion, expanding SEGIP's eligibility to non-public employees or employers, let alone to those not having the status of "employee" at all, would be entirely inconsistent with the purpose of the program as well as its statutory structure. The result would have far-reaching consequences that very likely would increase the cost of delivering quality cost-effective healthcare to state and university employees.

Appendix 5

Family Size and Age of Adults	MinnesotaCare Premium (275%FPG)	Healthpartners $250.00 Deductible	Aware Care * $150.00 Deductible	Medica Choice** HMO Coverage
2 Adults Age 20 -29	255.00	*134.96*	*216.00*	290.00
+ 1 child + 2 children + 3 children	383.00	*198.03* *261.10* *324.17*	*294.50* *373.00* *451.50*	430.00 570.00 710.00
2 Adults Age 30 -39	255.00	*147.12 - 159.44*	*235.00 - 255.00*	375.92 - 388.58
+ 1 child + 2 children + 3 children	383.00	*210.19 - 222.51* *273.26 - 285.58* *336.33 - 348.65*	*313.50 - 333.50* 392.00 - 412.00 470.50 - 490.50	522.25 662.25 802.25
2 Adults Age 40 -49	255.00	*179.18 - 218.64*	287.00 - 350.00	409.68 - 464.60
+ 1 child + 2 children + 3 chidlren	383.00	*242.25 - 281.71* *305.32 - 344.78* *368.39 - 407.85*	*365.50* - 428.50 444.00 - 507.00 522.50 - 585.50	577.14 717.14 857.14
2 Adults Age 50 -59	255.00	284.14 - 369.40	455.00 - 591.00	449.92 - 515.76
+ 1 child + 2 children + 3 chidlren	383.00	*347.21* - 432.47 410.28 - 495.54 473.35 - 558.61	533.50 - 669.50 612.00 - 748.00 690.50 - 826.50	622.84 762.84 902.84
2 Adults Age 60 -64	255.00	404.78	648.00	730.70
+ 1 child + 2 children + 3 children	383.00	467.85 530.92 593.99	726.50 805.00 883.50	870.70 1010.7 1150.70

Italics represents private coverage premiums that are lower or equal to the MinnesotaCare premium.
* Standard rates with Chemical Dependency coverage. Tobacco free rates may be slightly less.
** Low end estimated average. Childrens rate set at 140.00/mo. Actual rates are age specific.

Family Size and Age of Adults	MinnesotaCare Premium & FPG					Healthpartners $250.00 Deductible	Aware Care * $150.00 Deductible	Medica Choice HMO Coverage
	175%	200 %	225%	250%	275%			
1 Adult Age 20-29	55.00	78.00	110.00	128.00	128.00	*67.48*	*108.00*	164.73 - 173.17
2 Adults Age 20 -29	74.00	105.00	147.00	195.00	255.00	*134.96*	*216.00*	329.46 - 346.34
1 Adult Age 30-34	55.00	78.00	110.00	128.00	128.00	*73.56*	*117.50*	187.96
2 Adults Age 30-34	74.00	105.00	147.00	195.00	255.00	*147.12*	*235.00*	375.92
1 Adult Age 35-39	55.00	78.00.	110.00	128.00	128.00	*79.72*	*127.50*	194.29
2 Adults Age 35-39	74.00	105.00	147.00	195.00	255.00	*159.44*	*255.00*	388.58
1 Adult Age 40-44	55.00	78.00	110.00	128.00	128.00	*89.59*	143.50	204.84
2 Adults Age 40-44	74.00	105.00	147.00	195.00	255.00	*179.18*	287.00	409.68
1 Adults Age 45-49	55.00	78.00	110.00	128.00	128.00	*109.32*	175.00	232.30
2 Adults age 45-49	74.00	105.00	147.00	195.00	255.00	*218.64*	350.00	464.60
1 Adult Age 50-59	55.00	78.00	110.00	128.00	128.00	142.07 - 184.70	227.50 - 295.50	259.76 - 297.77
2 Adults Age 50-59	74.00	105.00	147.00	195.00	255.00	284.14 - 369.40	455.00 - 591.00	519.52 - 595.54
1 Adult Age 60-64	55.00	78.00	110.00	128.00	128.00	202.39	324.00	365.35
2 Adults Age 60-64	74.00	105.00	147.00	195.00	255.00	404.78	648.00	730.70

Italics represents private coverage premiums that are less than or equal to the MinnesotaCare premium at some percent of the FPG.

Cost of completing this report:

Minnesota Statutes, section 3.197, requires the disclosure of the cost of preparing this report.

Staff time: $5,000

Submitted by the Minnesota Department of Human Services

March 1998