A Profile of the MinnesotaCare Program

The First Six Years 1992-1998

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Minnesota Department of **Human Services**

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Introduction

The creation of the *MinnesotaCare Program* in 1992 was the result of a multi-year, grass root efforts by various organizations and a bipartisan group of legislators. The need to address the uninsured was the driving force behind the state's initiative to create a subsidized health care program. By 1988, the state had already gained significant recognition for the creation of the Children's Health Plan (CHP), the first state-subsidized health program to cover uninsured children.

Subsequent to the creation of CHP, a series of bills were introduced at the Legislature to address the broader uninsured population of Minnesota. In 1989, a MinnesotaCare-type bill passed the Senate, but not the House. The compromise created the Health Care Access Commission, charged with gathering data and recommending a plan to insure the uninsured. Legislation based on their recommendation was passed by the Legislature in 1991 but was vetoed by Governor Arne Carlson. A bipartisan group of seven legislators then drafted the HealthRight reform legislation in 1992 which was supported in both the House and Senate and proved acceptable to the Governor. HealthRight, now referred to as the *MinnesotaCare Act*, was widely recognized for its unprecedented bipartisan support to address the health care issues of Minnesotans.

One of the objectives of the MinnesotaCare Act was to expand health care access to Minnesota's uninsured population through the creation of a publicly subsidized health plan. The plan, *MinnesotaCare Program*, was designed to make health insurance affordable for the working poor, farmers, other low-income self-employed, rural residents, and small-business employees. The objective of the MinnesotaCare Program was not to replace employer-subsidized or privately held health insurance, but to provide coverage for low-income people who would not otherwise have access to or be able to afford the full cost of health care insurance.

Between October 1992 and June 1998, more than 220,000 adults and children were enrolled in the MinnesotaCare Program. At the end of June 1998, more than 100,000 Minnesotans from all 87 counties were enrolled in the program. Fifty-three percent of enrollees were children, 36 percent were adults with children, and 11 percent were singles and married couples without children. Thirty-five percent of enrollment was from the seven-county metropolitan area and 65 percent from greater Minnesota. More than 86 percent of enrollees were from families with income less than 200 percent of the federal poverty guidelines (FPG).

Most MinnesotaCare families are the working poor. In a survey conducted in 1997 by the Department of Human Services (DHS) of 422 enrolled families, only 4.6 percent of two-adult households had both adults unemployed, and 12.5 percent of single-parent households had the single parent unemployed.

In state fiscal year (FY) 1998, total MinnesotaCare program expenditures (medical and administrative) were approximately 119.9 million dollars. For every dollar spent by MinnesotaCare in fiscal year 1998, 90 cents went to medical expenditures and 10 cents to administrative cost. For every expended dollar, 19.9 cents came from enrollee premiums, 9.5 cents from federal contributions, and 70.6 cents from state revenues.

The creation and expansion of the Children's Health Plan and MinnesotaCare, both of which were originally funded entirely with state dollars, was accompanied by Medicaid expansions in order to take advantage of federal financing available to increase health care access. In some years, income ceilings were lifted, while in other years, asset tests and other barriers were eased. Recent efforts have focused primarily on outreach and program coordination. However, before welfare reform and a robust economy began to cut Medicaid rolls, these expansions, along with the enrollment of CHP and MinnesotaCare applicants who were actually eligible for Medicaid, added large numbers of very low income families to the Medicaid program.

Along with Medical Assistance (Minnesota's Medicaid program-MA), General Assistance Medical Care (GAMC), and the Minnesota Comprehensive Health Association (MCHA), the MinnesotaCare Program is a tool in furthering the state's overall objective of promoting access to appropriate health care to ensure healthy children and adults in Minnesota.

The initiatives taken by Minnesota to address the health care access issues for the state's uninsured have produced appreciable results. A study released by Families USA Foundation (*One Out of Three: Kids Without Health Insurance 1995 - 1996*) reported that Minnesota had the lowest proportion of children (22 percent) without health insurance at some point during the 24-month period in 1995-96, when states were compared nationally.

A notable impact of MinnesotaCare was also suggested by comparing the rate of the uninsured in Minnesota with the national rate between 1990 and 1995. During that period, Minnesota's uninsured rate remained stable at about 9 percent, while there was a significant increase in the national rate from about 13 percent to 15 percent.

A study conducted by DHS in 1996 identified a positive impact of the MinnesotaCare Program in reducing the AFDC caseload. Using time-series modeling techniques, the study found that approximately 4,600 fewer families were receiving AFDC in June 1996 than there would have been had MinnesotaCare not been in operation. Translated into financial terms, state and federal governments were spending $2.5 million less each month in 1996 because fewer families were receiving AFDC.

The MinnesotaCare Program is also attracting the individuals it was designed to attract—lower-income households with no affordable or available health coverage option. A 1995 study by Nicole Lurie, M.D., Hennepin County Medical Center, and colleagues who surveyed 800 individuals on MinnesotaCare, found that these individuals viewed the program as their primary option for affordable health insurance coverage. The study concluded that if MinnesotaCare were to end, those who were most likely to have difficulty affording other health insurance were in households with incomes under 200 percent of the FPG. The majority of those surveyed reported that they were in better health because of MinnesotaCare, while two-thirds reported they would most likely go without the care they need if the program were to end.

In 1995, the Minnesota Health Data Institute found that the vast majority of MinnesotaCare families were satisfied with their health coverage. Ninety-one percent were *very or extremely satisfied*, 8 percent were *somewhat satisfied,* and 1 percent were *dissatisfied.*

This profile presents background information on the MinnesotaCare program and an overview of its first six years (1992-98), including administration, impact on Minnesota's uninsured, enrollment demographics, and revenues and expenditures.

Section 1: Background

The Children's Health Plan

During the 1987 legislative session, Minnesota took a pioneering step and created the Children's Health Plan (CHP), which began July 1, 1988. The program was *"established to promote access to appropriate health care for pregnant women and to assure healthy babies and healthy children."*[1] The primary focus of CHP was to target resources on preventive and primary care services.

Minnesota became the first state to implement a state-sponsored health plan to cover uninsured children ineligible for Medicaid. After 1988, several other states followed suit and implemented a variety of initiatives to provide health care for uninsured children.

The initial CHP legislation in 1987 provided coverage to pregnant women and children under six years of age who had gross family incomes up to 185 percent of the FPG, and were ineligible for MA or GAMC, and otherwise uninsured.

Changes in 1988 legislation

Before the scheduled implementation of CHP in 1988, the federal government expanded the Medicaid program to allow coverage of pregnant women and infants under age one in families with income up to 185 percent of FPG. As a result of these changes at the federal level, the 1988 Legislature amended CHP to exclude pregnant women and infants and expanded CHP eligibility to include children ages one through eight. Children's services covered by CHP were the same as those covered under MA with some exceptions such as inpatient hospital services.

There were no copayments or deductibles for covered services. The annual enrollment fee per child was $25, and could not exceed $150 per family. Funding for the program came from enrollment fees and a penny increase in the cigarette tax. The objective of the program was revised: *"to promote access to appropriate primary health care to assure healthy children."*[2]

CHP, which was passed in 1987, began on July 1, 1988, and DHS was responsible for its administration. During the first six months, 5,000 children were enrolled in the program. Enrollment reached 13,000 by the end of 1989, and 17,000 by December 1990.

Changes in 1989 legislation

During the 1989 legislative session, CHP eligibility was expanded to include children between the ages of 1 and 18 which was to become effective in 1991. Mental health services were added and special education services excluded. As a result of the eligibility expansion, enrollment grew to more than 29,000 by the end of 1991.

Families satisfied with CHP

Families with children enrolled in CHP reported a high level of satisfaction when DHS conducted a satisfaction survey during the latter part of 1989. A sample was randomly selected from the enrolled population and a survey mailed to 1,350 families. A total of 943 questionnaires were returned, representing a 70 percent response rate.

Forty percent of the families reported that the health of their children had improved since enrolling in CHP. Many felt relieved from the stress and worry of not having health care for their children primarily because they could not afford it. Others felt the coverage was exceptionally good, the enrollment fee of $25/year very affordable, and the mail-in application process was simple.

During the three-and-one-half years after its implementation, CHP served 38,000 children (unduplicated), and gained national and statewide recognition for innovative and outstanding service to children.

CHP won national recognition

"The Children's Health Plan won national recognition when the program was awarded one of eight Successful Projects Initiative Awards presented by the American Public Welfare Association (APWA) February 28, 1991, in Washington, D.C. Minnesota was the first state in the nation to implement a low-cost health insurance program for children."

Nation's Cities Weekly
April 22, 1991

First universal access bill

In 1988, the year CHP started, Minnesota's first universal health care access bill was introduced at the Legislature. The bill, Healthspan, called for expanding the MA program to include a more comprehensive and cost-effective benefit package for all uninsured Minnesotans. However, Healthspan never made it through the policy committees, largely because of the lack of agreement about the number of uninsured people in Minnesota, the diversity of interests and issues on the table, and the cost of funding such a program.

At the time, Minnesota was also seen as one of the healthiest states, based on national statistics.[3] For many local policy makers, this gave little impetus to urgently pursue major health care reform. However, other policy makers were beginning to see fundamental problems associated with health care access for many Minnesotans.[4] Reports from the Citizen's League, Metropolitan Healthcare Council, Department of Health (MDH) and other organizations were beginning to illuminate the problems dealing with access to health care and Minnesota's uninsured population. It was also clear that the issues had not been fully studied and that a funding mechanism for undertaking universal access to health care had not been fully debated.

Second universal access bill creates Health Care Access Commission

During the 1989 legislative session, Healthspan was again introduced at the Legislature with the support of major health organizations. However, Healthspan was opposed by some business interests and though it passed the House, it did not survive the senate.

While the Healthspan bill did not hold up in the conference committee process, as a compromise the Health Care Access Commission (HCAC)[5] was created and funded to *"develop and recommend to the Legislature a plan to provide access to health care for all state residents."*[6] Among other duties, the Commission would give the Legislature a broader perspective on Minnesota's uninsured population.

The Commission was made up of a diverse group of individuals representing a broad spectrum of interests from both the public and private sectors. The Commission was charged to submit a final report and an implementation plan to the Legislature by January 1991.

HCAC's report to the Legislature

The Commission conducted research (household and employer surveys, legal and actuarial research) and held 19 statewide public hearings and extensive deliberations over a 15-month period.

The Commission's final report was submitted to the Legislature in January 1991. Study findings indicated that access to health care was a major problem in Minnesota; 370,000 Minnesotans were uninsured; 11,000 had been refused health care; and 50,000 delayed seeking care because they had no insurance. The findings also identified that insurance practices (such as stringent underwriting, unpredictable premium increases, and discrimination based on preexisting conditions) and high costs had contributed to the uninsured population in Minnesota.

The Commission recommended sweeping reform measures and called for the state to play a pivotal role in ensuring access to needed health care for all Minnesotans. Emphasis was placed on providing universal access to health care, helping lower-income individuals and families, ending discrimination in underwriting and other insurance practices, and providing equitable benefits.

Third health care access bill

In May 1991, the third health care access bill-House File 2-was passed by both the House and Senate, but vetoed by Governor Carlson. The bill called for a major revision of the state's health insurance system and the creation of a state-subsidized health insurance program in 1992, based, in part, on the recommendations of the HCAC. It was designed to lead Minnesota on the path to universal access to health care by 1997. However, a number of issues in the bill caused serious concerns for the Governor, which led to his veto.[7]

In a letter addressed to the people of Minnesota, Governor Carlson cited, among his concerns, that the cost of financing the provisions of state-subsidized insurance was financially unrealistic and placed the taxpayers of Minnesota at great financial risk. However, he reassured his commitment to health care reform and pledged his efforts in working with the 1992 Legislature to develop a plan that would work for the people of Minnesota.[8]

While the veto was a setback for many lawmakers and a large segment of the public, many legislators and interest groups saw Minnesota in a good position to be a pioneer in achieving universal access to health care, because of its low uninsured rates and quality health care, and were determined to continue working to make it happen.[9]

Historic reform legislation of 1992

After the Governor's veto, a bipartisan group of seven House and Senate members—four Democrats and three Republicans—began intense work to create a bill that would be acceptable to the Governor and key interest groups.[10] Largely due to its bipartisan support and comprehensive nature, the bill, HealthRight, gained unprecedented momentum as it made its way unscathed through multiple policy committees.[11]

The objectives of the HealthRight bill included a commitment to expand health care access to Minnesota's uninsured population through a state-subsidized insurance program, develop strategies on cost containment, initiate serious medical malpractice reforms, and create purchasing pools for health care services. The state-subsidized insurance plan would be designed to make health insurance affordable for the working poor, farmers, other self-employed, rural residents, and small-business employees.

The proposed financing of the state-subsidized plan was a new 5 cents per-pack tax on cigarettes that would be effective July 1, 1992, and a 2 percent tax on hospitals' medical receipts, beginning January 1, 1993, and other medical providers beginning January 1, 1994.

Even though the language of the bill raised intense debates in the medical community, many felt that the broader objective of the bill was a step in the right direction.[12]

In April 1992, through the efforts of this bipartisan legislative team, Governor Carlson, and many community organizations, Minnesota took an unprecedented step in health care reform and passed the HealthRight bill. The signing of the HealthRight law made the State of Minnesota a leader in health care reform. After the bill became law, DHS was charged with implementing the portion of the law that provided health benefits for uninsured families with premiums based on a sliding scale. The Minnesota Department of Health (MDH) was named lead agency for the overall state initiatives to expand access and contain costs by establishing annual growth limits on health care spending and monitoring health care costs overall.

From HealthRight to MinnesotaCare

The 1992 package of reform legislation was originally referred to as HealthRight (with a capital R). Soon after it became law, the State was informed that another source held the federal trademark for Healthright (small r). Through the efforts of the Department of Health and other state personnel, *MinnesotaCare* was chosen as the new name for both the landmark reform law and the state-subsidized health plan.

Because the legislation and the subsidized health care plan are both called MinnesotaCare, to distinguish the two, the comprehensive reform legislation is referred to as the *MinnesotaCare Act*, and the subsidized health care plan (which is part of the Act) is referred to as the *MinnesotaCare Program.* Thus, the MinnesotaCare Program is a subset of the MinnesotaCare Act.

In fiscal year 1993, the MinnesotaCare Program and CHP operated as two separate programs. On July 1, 1993, enrollees from CHP were transferred into MinnesotaCare. In June 1997, after five years, the number of enrollees in the MinnesotaCare Program has grown to more than 100,000.

Section notes:

1. Minnesota Statutes 1987, Chapter 403, Article 2, Section 63 [256.936], Children's Health Plan

2. Minnesota Statutes 1988, Chapter 689, Article 2, Section 137 [256.936], Children's Health Plan

3. The Health Ensurance Coalition Demonstration Project (HEC)—Ensuring Access to Health Care in Northeastern Minnesota, 1987-1994, page 16

4. Gregor W. Pinney, "Many legislators back health insurance idea, but financial backing to help uninsured will be hard to come by." *Star Tribune*, January 7, 1991, page 1B

5. Gordon Slovut, "Perpich appoints 13 to basic health care commission - Goal is to guarantee standards for all Minnesotans." *Star Tribune*, September 2, 1989, page 3B

6. Minnesota Statutes 1990, Section 62J.02

7. Dane Smith, "Carlson takes his veto vow on road, DFLers cast as big spenders." *Star Tribune*, May 24, 1991, page 1B

8. Letter to Robert Vanasek, Speaker of the House, from Governor Arne Carlson, informing him of the veto of Chapter 335, House File 2. Attached was a letter "To the People of Minnesota" from Governor Carlson, explaining the reason for his veto. June 3, 1991

9. "Redeem the health-care access bill in 1992." *Star Tribune*, June 5, 1991, page 14A

10. Howard M. Leichter, "State Model: Minnesota - The trip from acrimony to accommodation." *Health Affairs*, summer 1993, page 48-58

11. Donna Halvorsen, "Statewide health plan agreed upon; all could get access to care." *Star Tribune*, March 10, 1992, page 1A. Thomas Allen, "The politics of HealthRight." *Minnesota Medicine*, June 1992, vol. 75, page 21

12. Thomas Allen, "The politics of HealthRight." *Minnesota Medicine*, June 1992, vol. 75, page 21. Donna Halvorsen, "HealthRight lauded as a step forward; industry groups say merit outweighs flaws." *Star Tribune*, March 27, 1992, page 1B

Section 2: Administration

Summary of program development

The MinnesotaCare Program was established *to promote access to appropriate health care services to assure healthy children and adults* in Minnesota. The program was officially launched on October 1, 1992, by extending coverage to parents and dependent siblings of children already eligible for CHP. These individuals were eligible for MinnesotaCare if they were Minnesota residents, had household incomes up to 185 percent of the FPG, were underinsured, and had no access to employer-subsidized insurance within the previous 18 months.

On January 1, 1993, coverage was expanded to include all children (age 18 and younger), their parents and their dependent siblings, if residing in the same household. Individuals could enroll if they were Minnesota residents and had household income up to 275 percent of the FPG. Most individuals had to be uninsured within the previous four months, and could not have had access to employer-subsidized insurance within the previous 18 months.

On July 1, 1993, all children covered under CHP were automatically transferred to MinnesotaCare. Children in households with income less than 150 percent of the FPG were charged a premium of $4 a month or $48 a year.

By October 1, 1994, eligibility was extended to adults without children. The income limit for this group was set at 125 percent of the FPG.

In July 1995, legislation expanded the definition of a minor child to include individuals up to age 21. Also, federal funding was approved for pregnant women and children, which gave them an expanded set of benefits equivalent to MA coverage, with no copayments or limitations on inpatient hospitalization.

In October 1995, verification of income was required on all *new* MinnesotaCare applications, and on all renewals done after February 1, 1996. Also beginning October 1, 1995, verification of pregnancy was required for all pregnant women.

Beginning July 1, 1996, the income limit for adults without children was changed from 125 percent to 135 percent of the FPG. The income limit was again changed to 175 percent of the FPG effective July 1, 1997.

Eligibility requirements

To be eligible for MinnesotaCare, applicants must file an application and provide information on household composition, state residency, access to insurance, and income. Applicants are also required to provide their social security number, cooperate with child support referrals, and pay applicable premiums. At annual renewals, continued eligibility is determined by reviewing changes in residency status, and access to other health care insurance. A change in household composition or income level could result in an adjusted premium.

The 1997 legislation established an asset limit for all MinnesotaCare enrollees except pregnant women. The total maximium net asset amount for a household of two or more was set at $30,000, and for a household of one at $15,000. Assets which were exempted from the limits were homesteads, personal effects, assets owned by children, vehicles used for employment, court-ordered settlements up to $10,000, pension accounts, and up to $200,000 in net operating expenses for self-employment. In

1998, the legislation was amended to exclude children from the asset limit. The asset limits for adults will be implemented upon federal waiver approval.

Marketing MinnesotaCare

When the MinnesotaCare program was implemented in 1992, a number of marketing initiatives were set in motion to inform potential enrollees across the state about the program. The approach relied heavily on direct mailings, press releases and presentations to community and civic groups. Marketing efforts were also focused on provider groups, counties and health fairs. A toll-free number was also established to inform callers about the program.

The marketing initiatives led to an overwhelming response of new applications and inquiries. For example, by October 1993—one year after adults in families with children became eligible—more than 22,000 adults were enrolled in MinnesotaCare.

During the 1997 legislative session, the Legislature allocated $750,000 per-year for 4 years to expand MinnesotaCare outreach initiatives. The objectives of the outreach initiatives were to create better access to the program for low-income, uninsured adults and children, and to promote the importance of maintaining health care coverage. DHS awarded the $750,000 in grants to 26 organizations and county agencies to encourage outreach at the local level.

Funding

Since 1992, the MinnesotaCare Program has been funded by a number of sources, including enrollees' premiums, cigarette taxes, health care provider taxes and federal contributions.

All enrollees in MinnesotaCare pay a premium, determined on a sliding-fee scale based on household income, household size and the number of individuals in the household who are covered. Premium payment is required before MinnesotaCare enrollment is complete. Enrollees are disenrolled from MinnesotaCare for failure to pay the required premiums within one calendar month after the due date. People disenrolled for premium nonpayment may not reenroll for four months, unless they can demonstrate good cause for nonpayment.

MinnesotaCare premiums are community rated—there is no direct connection between the enrollees' health, age or gender, and the premium amount they pay. For most enrollees, premiums only cover part of the full cost of medical treatment. The amount not covered by the premium is subsidized by state and federal contributions.

From July 1, 1992, to January 1, 1994, proceeds from a 5-cent increase in the cigarette tax covered the "startup" phase of MinnesotaCare. The cigarette tax proceeds were then transferred to the General Fund. A number of statewide taxes to fund MinnesotaCare also came into effect in subsequent years:

- On January 1, 1993, a 2 percent tax on gross patient revenues of hospitals and surgical centers
- On January 1, 1994, a 2 percent health care provider tax on gross revenues of licensed health care providers including doctors, dentists, chiropractors, wholesale drug distributors, pharmacies, etc
- On January 1, 1996, a 1 percent gross premium tax on nonprofit health service plans (HMOs, Blue Cross, Delta Dental, and other health service companies).

Beginning in FY 1996, Minnesota was approved for federal Medicaid funding for administrative and medical payments made by the state for children and pregnant women enrolled in MinnesotaCare. The financial contribution mirrors Minnesota's federal MA percentage. In July 1996, about 55 percent of MinnesotaCare's enrollment was eligible for this federal funding.

In 1997, legislation reduced the 2 percent MinnesotaCare hospitals and providers tax to 1.5 percent for the 1998-1999 biennium, but this will return to 2 percent effective January 1, 1999.

Services Covered

MinnesotaCare offers a comprehensive benefit package of services through prepaid health plans. The development of MinnesotaCare legislation embraced managed care as the preferred model of health care delivery. In July 1996, MinnesotaCare began a transition from fee-for-service to prepaid health plans. Between July and December 1996, all MinnesotaCare enrollees in households with children were converted to prepaid plans. Households without children were converted to prepaid plans in January 1997.

Enrollees in MinnesotaCare choose a health plan and get all their health care services through a physician, dentist, hospital, or pharmacy from that plan. Among the benefits of prepaid health plans is the focus on prevention and early treatment.

Enrollees who are not pregnant receive a *basic benefit package*. This package was designed specifically not to erode private-sector insurance efforts. The basic benefit package is funded by the Health Care Access Fund and requires a copayment for prescription drugs, eyeglasses, and inpatient hospital services. The current basic benefit package offers:

- Alcohol and drug dependency treatment, inpatient and outpatient (requires consultation with local human service agency staff who will assess the needs and determine appropriate treatment)
- Ambulance service (emergency use only)
- Chiropractic care (manual manipulations)
- Dental services (preventive care)
- Emergency room services
- Eye checkups
- Eyeglasses ($25 copayment; some restrictions apply)
- Family planning services
- Hearing aids
- Home care services (excluding private-duty nursing and other personal care services)
- Hospice care services
- Immunizations
- Inpatient hospital services (no limit or copayments for children and pregnant women; families with children whose income is under 175 percent of FPG have no limit but are required to pay a 10 percent copayment for inpatient services (up to $1,000 a year per adult, $3,000 a year per family); adults with income above 175 percent of FPG have a yearly inpatient limit of $10,000 with a 10 percent copayment (up to $1,000 a year per adult, $3,000 a year per family)
- Laboratory and X-ray services
- Medical equipment and supplies
- Mental health services (outpatient and inpatient; individual, family and group psychotherapy)
- Outpatient surgery
- Physician and clinic services
- Podiatry (foot care) services
- Prescription drugs ($3 copayment)
- Preventive health services
- Prosthetic (artificial limb) services
- Public health clinic visits
- Rehabilitative therapy services (physical, occupational and speech therapy)
- Routine physical examinations

As a result of the federal Medicaid waiver that went into effect in FY 1996 and subsequent state legislation, children (up to age 21) and pregnant women receive the *basic benefit package,* summarized above, plus an *expanded benefit package*. These services for children and pregnant women which mirror the MA's benefit set, are funded by both

state and federal dollars and require no copayment. The *expanded benefit package* includes:

- Access services (such as non-emergency medical transportation)
- Case-management services (coordination of services for people with serious and persistent mental illness and children with severe emotional disturbances)
- Child and teen checkups (also known as early and periodic screening, diagnosis and treatment [EPSDT])
- Comprehensive dental care, including orthodontia (prior authorization required; must be medically necessary)
- Inpatient hospital services above the $10,000 limit in the basic benefit package
- Intermediate care facility services
- Personal care attendant services
- Pregnancy-related services
- Special education services (listed on a child's Individual Education Plan from school)

Effective July 1, 1998, the program expanded covered health services to include nonpreventive dental care (except for orthodontic services) for adults with family income up to 175 percent of the FPG. Also effective was a copayment of 50 percent of the fee-for-service rate for adult dental care services other than preventive care.

Administrative activities

One of the goals of MinnesotaCare management is to keep administrative costs down while improving the quality and volume of administrative activities. Since its inception in 1992, MinnesotaCare's administrative activities have increased significantly. Despite that, MinnesotaCare continues to achieve its goal of keeping costs down while increasing the quality of services.

The administration of MinnesotaCare involves a variety of functions including:

- Developing and refining rules for program administration
- Processing new and renewal applications
- Determining eligibility of applicants and services rendered
- Processing premium payments of enrollees
- Paying providers for services rendered
- Maintaining a toll-free phone line with information regarding the program
- Performing random audits to verify reported income and eligibility
- Designing and implementing studies for program refinement
- Increasing outreach for potential new clients

To illustrate the volume of administrative activities, in a typical workday during the first half of 1997, MinnesotaCare received an average of 771 telephone calls with questions or inquiries, 231 new and renewal applications for processing, and 153 voice mail requests for application forms.

Section 3: Impact of MinnesotaCare

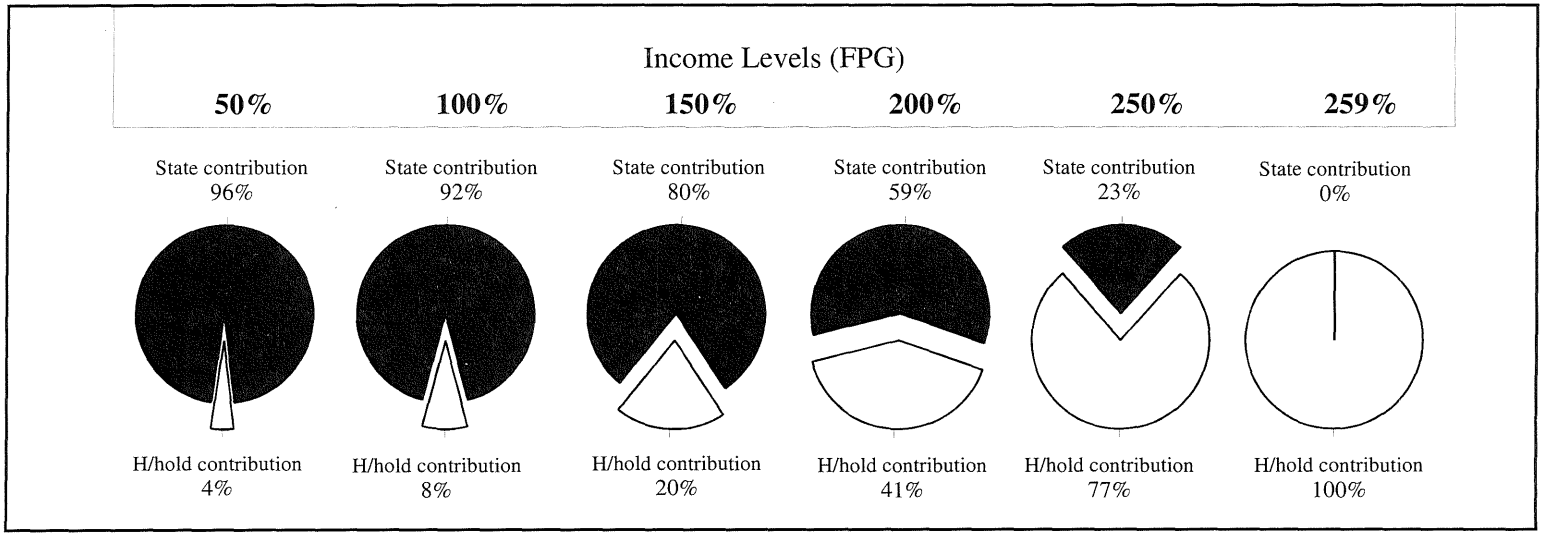
Helping families through premium subsidies

In MinnesotaCare, all individuals contribute toward the cost of their insurance coverage. Unlike the private market, MinnesotaCare takes into account a family's ability to pay, using household income, size, and the number of members to be covered. Using these elements, a sliding scale determines the premium contribution of the family.[13]

Low-income families receive the largest subsidies, while families with higher incomes pay relatively higher premiums with a corresponding decrease in subsidies. There are also families with incomes up to and above program limits that are charged the maximum premium. In FY 1998, the maximum monthly premium for one covered individual was $128, $255 for two and $383 for three or more individuals. In 1996, DHS found that *families with children* that paid the maximum premium amount not only covered their medical expenses, but the excess revenue generated from their premiums also contributed to the subsidies of poorer families.

In fiscal year 1998, a family of four with at least three members covered, whose income was at 100 percent of the FPG[14] paid a premium that equaled about 8 percent ($31) of full cost. When the household income equaled 150 percent, the family was charged a premium that was approximately 20 percent of full cost ($77). With income at 200 percent of poverty, premium contribution was increased to 41 percent ($157), and at 250 percent to 77 percent ($295) of full cost. When income was more than 259 percent of the FPG, the family was charged the maximum premium amount of $383 which was set to equal the full cost of coverage; beyond 259 percent of the FPG, the family was not directly subsidized by state/federal funds. This example is illustrated in Figure 1.

Figure 1: Household contribution and state/federal subsidy towards full cost of coverage at various income levels for a family of four with at least three members covered.



Low-income working families

MinnesotaCare provides health care coverage for many families in low-paying jobs. Data from a recent study by DHS showed that the majority of families enrolled in MinnesotaCare were the working poor.

In the study sample of 422 MinnesotaCare families, 61 percent had income under 150 percent of FPG (38 percent were single-parent households and 62 percent were two-adult households). Ninety percent of these families had at least one adult working. Eighty-five percent of single parents were employed, and 93 percent of two-adult households had at least one adult employed (48 percent had one-adult employed; 45 percent had both adults employed).

More than half (65 percent) of the working adults in these low-income families were employed with wages, 11 percent were self-employed (non-farm) with other wages, 17 percent were self-employed (non-farm) with no other wages, 4 percent were self-employed farmers with other wages, and 3 percent were self-employed farmers with no other wages.

Helping families in transition

By subsidizing health care coverage, MinnesotaCare is providing a means of helping poor families progress from reliance on public support to self-sufficiency.[15] MinnesotaCare covers a large number of families who have had members on public assistance in the past.

The *Asset Study on MinnesotaCare Families,* conducted in 1996, revealed that for the three-year period prior to the study, 66 percent of the study sample had at least one family member who was a recipient of public assistance. Specifically, 61 percent of households had a family member who had received MA, 33 percent had received food stamps, 19 percent had received AFDC, 13 percent had received GAMC, and 1 percent had received GA. At the time the study was conducted, MinnesotaCare households with at least one member currently on MA were reduced from 61 percent to 20 percent, households with food stamps were reduced from 33 percent to 6 percent, and households with AFDC, GAMC, and GA were reduced from 19 percent, 13 percent, and 1 percent respectively, to less than one percent each.

While the MinnesotaCare Program provides coverage for families and single adults, studies show that enrollees are accepting other health coverage as it becomes available. Data from two disenrollment studies conducted by DHS showed that 39 percent of *families with children* and 51 percent of *adults without children* terminated their MinnesotaCare coverage because of the availability of other health coverage from employers, Medical Assistance (MA), General Assistance Medical Care (GAMC), Medicare, or other sources.[16]

Impact on AFDC caseload

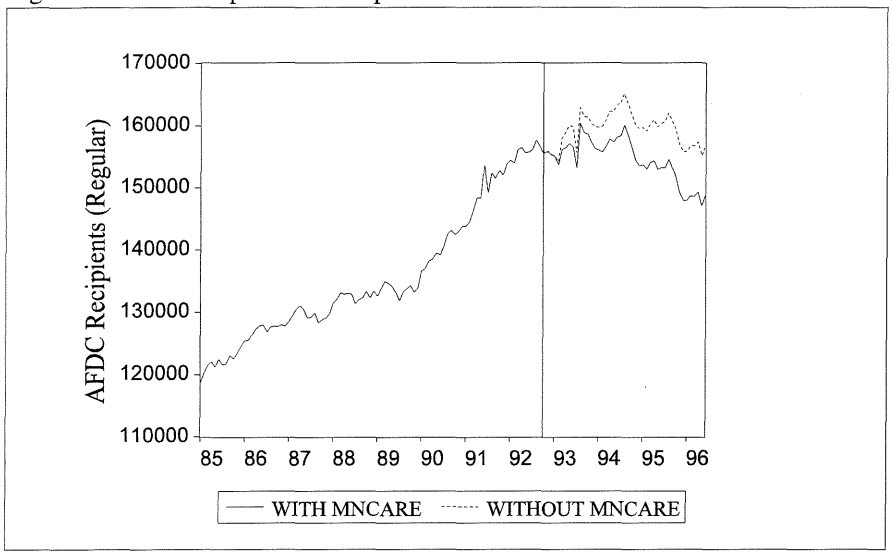
In a 1996 study, DHS identified a reduction in the AFDC caseload which can be attributed to the MinnesotaCare program.[17] Such a positive effect of MinnesotaCare in reducing the AFDC caseload is based on theoretical models of economic behavior. These models predict that by subsidizing the health insurance of low-income families, job opportunities without employer-based health insurance become a viable alternative to AFDC and Medical Assistance, allowing more potential AFDC recipients to choose employment over welfare.

Using sophisticated time-series modeling techniques, DHS statistically analyzed the probable impact of varying economic conditions and other factors on the AFDC caseload over time. From such analyses, DHS estimated that there were significantly fewer AFDC recipients than there

would have been without MinnesotaCare. For example, using FY 1997 data, there were 4,600 fewer families on AFDC per month than would have been predicted if MinnesotaCare had not been in operation.

This estimated impact of MinnesotaCare on the AFDC caseload translates into significant savings to both the state and the federal governments. It is estimated that there was a net savings of $2.5 million per month, after subtracting the $990,000 monthly MinnesotaCare subsidies for these families. Figure 2 illustrates the impact of MinnesotaCare on the AFDC-regular caseload from the end of 1992 to mid-1996.

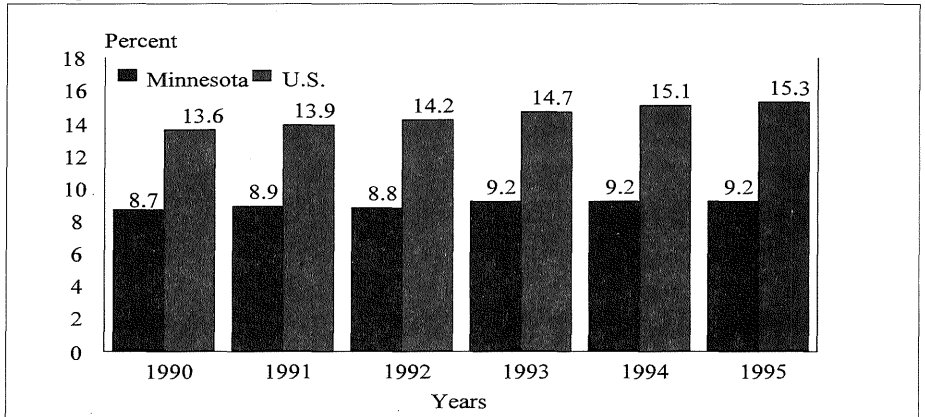
Figure 2: AFDC recipients and impact of MinnesotaCare



Uninsured rate stable in Minnesota while national rate increased (1990-95)

A plausible impact of MinnesotaCare is demonstrated by comparing the rate of the uninsured in Minnesota with the national rate between 1990-95. A study by the Institute for Health Services Research at the University of Minnesota found that while the rate of the uninsured was on the rise at the national level between 1990 and 1995, the rate of uninsured persons in Minnesota remained stable at about 6 percent.[18] While other estimates placed the uninsured rate in Minnesota somewhere between 6-9 percent, most studies confirmed that the rate in Minnesota remained stable while the national rate significantly increased between 1990-95.[19] A Minnesota Department of Health report issued in 1996 estimated Minnesota's uninsured rate around 9 percent. The report showed a comparison of the Current Population Survey (CPS) uninsured rate of Minnesota with the national rate, using a three-year average recommended by the Census Bureau (see Figure 3).[20]

Figure 3: A comparison of three-year average rates of the percent of population lacking health insurance in Minnesota and the U.S. between 1990 and 1995



Data source: Minnesota Department of Health, Measuring Trends in the Number of Uninsured in Minnesota, Dec. 1996

A report entitled, *"Minnesota Health Care Insurance and Access Survey, 1995"* by the University of Minnesota noted a drop in the proportion of continuously uninsured children from 28 percent in 1990 to about 16 percent in 1995. This drop is very significant, considering there was a concurrent increase in the rate of uninsured among children at the national level.[21] A study released by the Families USA Foundation, a Washington, D.C., based organization, reported that Minnesota had the lowest proportion of uninsured children in the country during 1995 and 1996.[22] The report provided the first state-specific estimates of the number and percentage of children without health insurance for one or more months during a 24-month period. While Minnesota had the lowest percentage of uninsured children (22 percent), the percentage in some states was as high as 46 percent.

The *stability* in the uninsured rate in Minnesota could be attributed to the advent of MinnesotaCare. While current enrollment at the end of June 1997 was more than 100,000 (a penetration rate of between 40-50 percent using 1995 estimates), the total number of unduplicated individuals who were ever enrolled at some point between October 1992 and June 1997 neared 200,000.

MinnesotaCare hitting its target

In 1995, the Minnesota Health Care Commission and MDH requested a study to determine whether MinnesotaCare was serving the population it was designed to serve. The objectives of the study were to determine whether:

- The program attracted the individuals it intended to cover
- Other options for getting health insurance were available to enrollees
- Enrollees had adequate access to health care through the program
- The program was beneficial to enrollees and to what extent
- The current premium and subsidy structure were reasonable.

The study was conducted by Nicole Lurie, M.D., MSPH; Alfred Pheley, Ph.D; and Michael Finch, Ph.D, and the findings were presented in a report entitled, *"Is MinnesotaCare Hitting its Target*?" dated October 24, 1995. As part of the study, 800 individuals were randomly surveyed. Of those surveyed, half were from the seven-county metropolitan area and the other half were from greater Minnesota. The sample did not include adults without children. Parents served as proxy respondents for children under 18. There was a 97 percent response rate to the survey. The study found that:

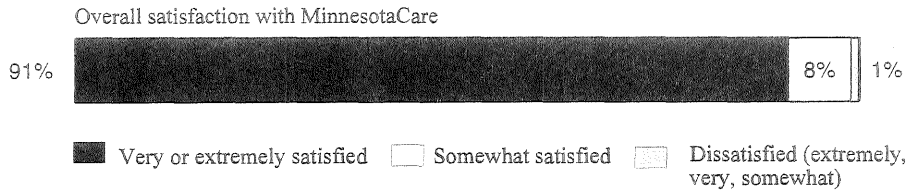
- Learning about the program was the major motivator for enrollment, and cost was the major reason people applied.
- The majority of those enrolled did not have other health insurance options at the time of enrollment in MinnesotaCare.
- Those with access to employment-based insurance or other options could not afford those premiums. The respondents viewed the program as their primary option for affordable health insurance coverage.
- Ninety-one percent of the respondents reported that access to care through MinnesotaCare was "very easy" or "somewhat" easy.
- If MinnesotaCare were to end, those most likely to have difficulty affording other insurance had incomes under 200 percent of FPG. The majority of the respondents reported that they were in better health because of MinnesotaCare and two-thirds would most likely go without the care they needed if the program were to end.

Enrollees satisfied with MinnesotaCare

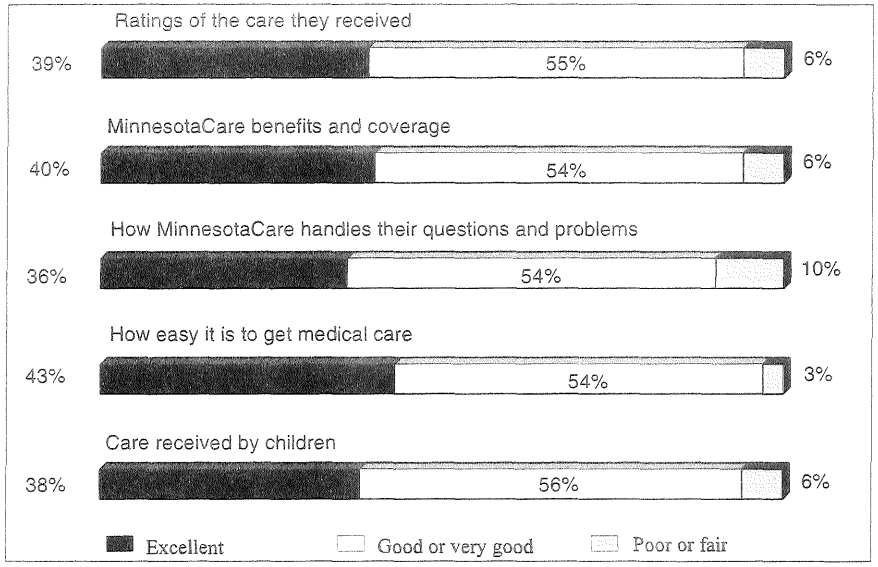
In 1995, the Minnesota Health Data Institute did a statewide survey of Minnesota consumers regarding their health plans and published the

findings in a report entitled *You and Your Health Plan*. The Institute is a nonprofit, public-private organization created by the Minnesota State Legislature in 1993 to provide comparative data on the quality of health care services to Minnesotans.

The survey was administered to a random sample of more than 400 enrollees each from 46 health plans from private insurance (network-only HMOs, point-of-service plans, and indemnity plans), Medicare, and state health programs (MA, GAMC, MinnesotaCare, MCHA). Satisfaction with MinnesotaCare was the highest of any rated plan in the survey. The majority of MinnesotaCare respondents said they were extremely satisfied with MinnesotaCare. Ninety-one percent reported they were *very or extremely satisfied*, 8 percent said they were *somewhat satisfied*, and 1 percent said they were *dissatisfied* (illustrated below).



When asked about their satisfaction with the availability of appointments when sick, 39 percent said they were *very satisfied*, 52 percent said they were *satisfied*, and 9 percent said they were *dissatisfied or very dissatisfied*. MinnesotaCare respondents were also asked to rate the care they received, benefits and services, how their questions and problems were handled, how easy it was to get medical care, and the quality of care received by children. The majority of respondents rated these categories as excellent, good or very good. Only a small percent of respondents rated the categories as poor or fair (illustrated below).



Section notes:

13. There is a fixed premium of $4 for children in families with income under 150 percent of FPG. All others are assessed premiums based on the sliding scale

14. For a family of four, the poverty guideline is $16,050 or a gross monthly income of $1,338 (In FY 1998, FPG for a family unit of one is $7,890, adding $2,720 for each additional member)

15. "MinnesotaCare: A smart way to avoid the welfare trap." *Star Tribune*, January 7, 1996, page 16A

16. Included in the 39 percent (188) of *families with children*, employers covered 87 percent, MA/GAMC 12 percent, and private 1 percent. Among the 51 percent (115) of *adults without children*, employers covered 46 percent, Medicare 33 percent, MA/GAMC 20 percent, and private 1 percent.

17. Patricia Lopez Baden, "Officials call state insurance a success—MinnesotaCare cuts welfare costs." *Star Tribune*, January 1, 1996, page 1A

18. *Minnesota Health Care Insurance and Access survey, 1995*, University of Minnesota, Institute for Health Services Research, August 1996, pages 14-21

19. The Current Population Survey (CPS), Minnesota's Behavior Risk Factor Surveillance System (BRFSS) and the Robert Wood Johnson Foundation Family Survey

20. *Measuring Trends in the Number of Uninsured in Minnesota*, Health Economics Program Issue Paper, Minnesota Department of Health, December 1996

21. Fronstin, P. Inquiry: *"Children Without Health Insurance: An Analysis of the Increase of Uninsured Children Between 1992 and 1993."* 32:353-359, 1995, cited in Minnesota Health Care Insurance and Access Survey, 1995, page 21.

22. *One out of Three: Kids Without Health Insurance 1995-1996,* Families USA Foundation, March 1997. The organization studied the nation's uninsured children (age 18 and under) and published their results in March 1997. After tracking uninsured children over a 24-month period, the study reported that some 23 million children (one in three) went without health insurance for a part or all of 1995-96.

Section 4: Demographics

Figure 4: Enrollment at the end of June 1998

Enrollment at the end of June 1998 by *children*, *adults with children*, and *adults without children* (103,545)

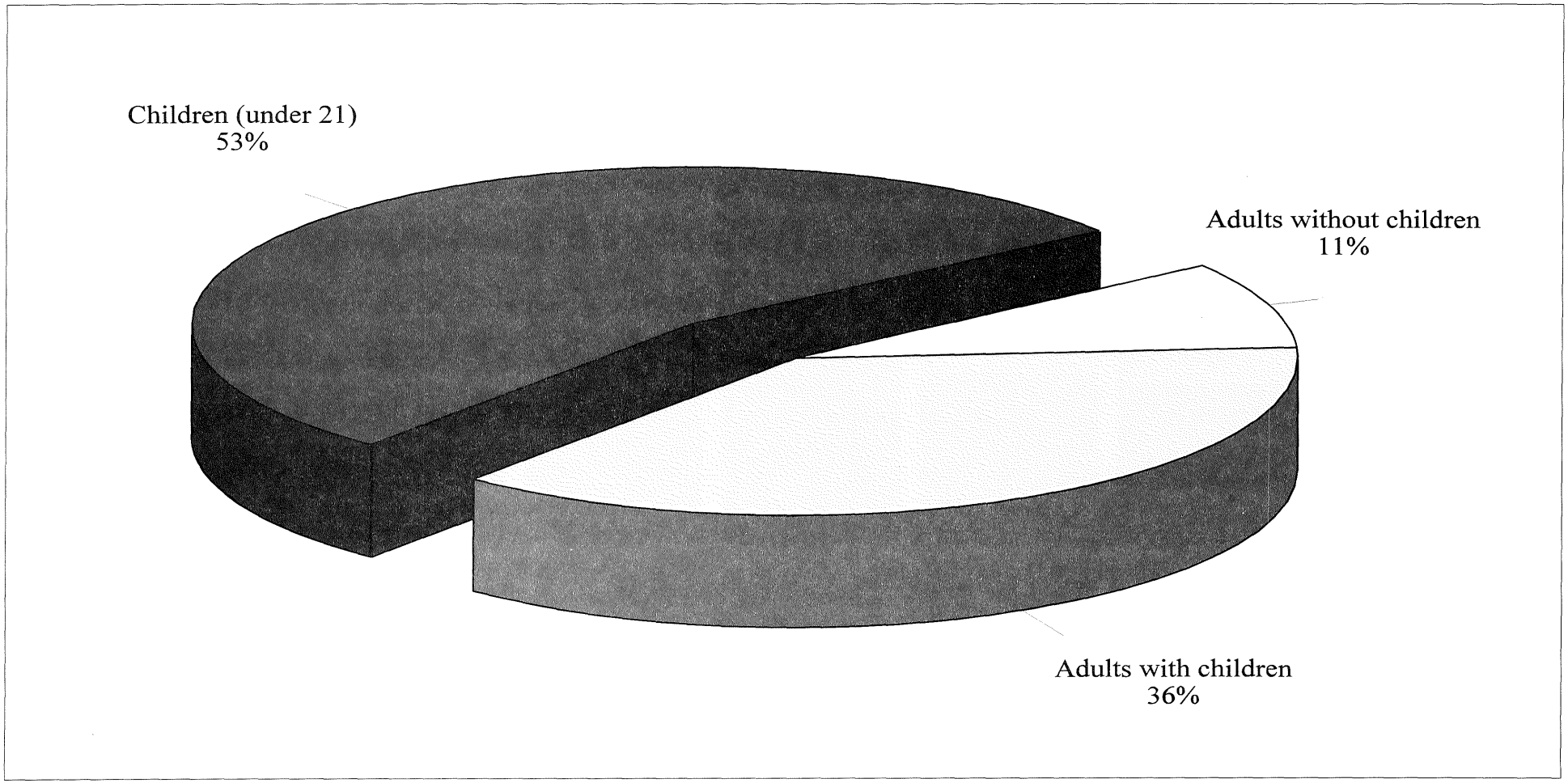
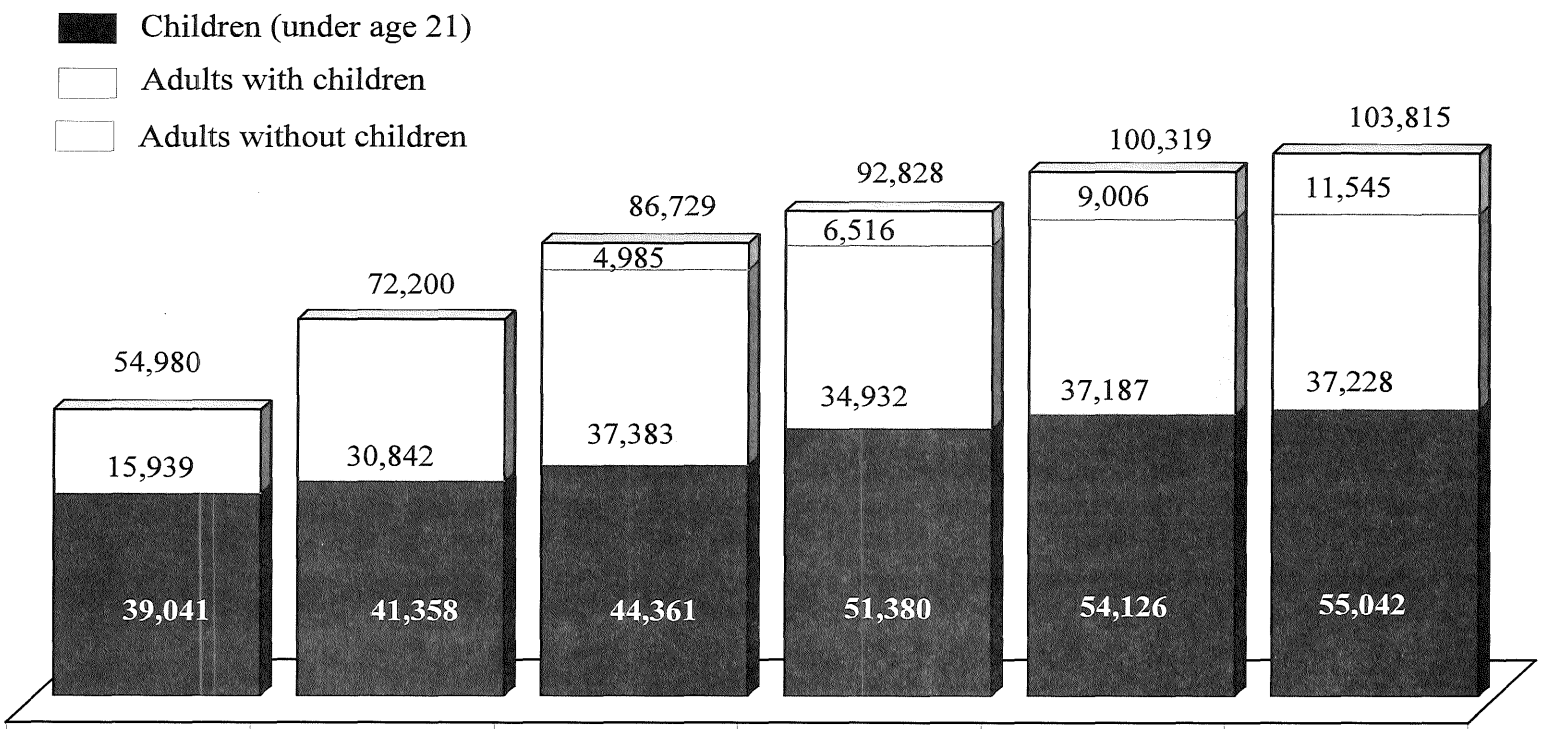


Figure 5: Enrollment at June 1993 through June 1998

Enrollment by *children*, *adults with children*, and *adults without children* at the end of June 1993-98



	June 93	June 94	June 95	June 96	June 97	June 98
■	71%	57%	51%	55%	54%	53%
□	29%	43%	43%	38%	37%	36%
□	-	-	6%	7%	9%	11%

Figure 6: Enrollment at the end of June 1998 and Total Individuals Ever Enrolled

A comparison between the current enrollment at the end of June 1998 and the number of individuals who were ever enrolled between October 1992 and June 1998 (unduplicated)

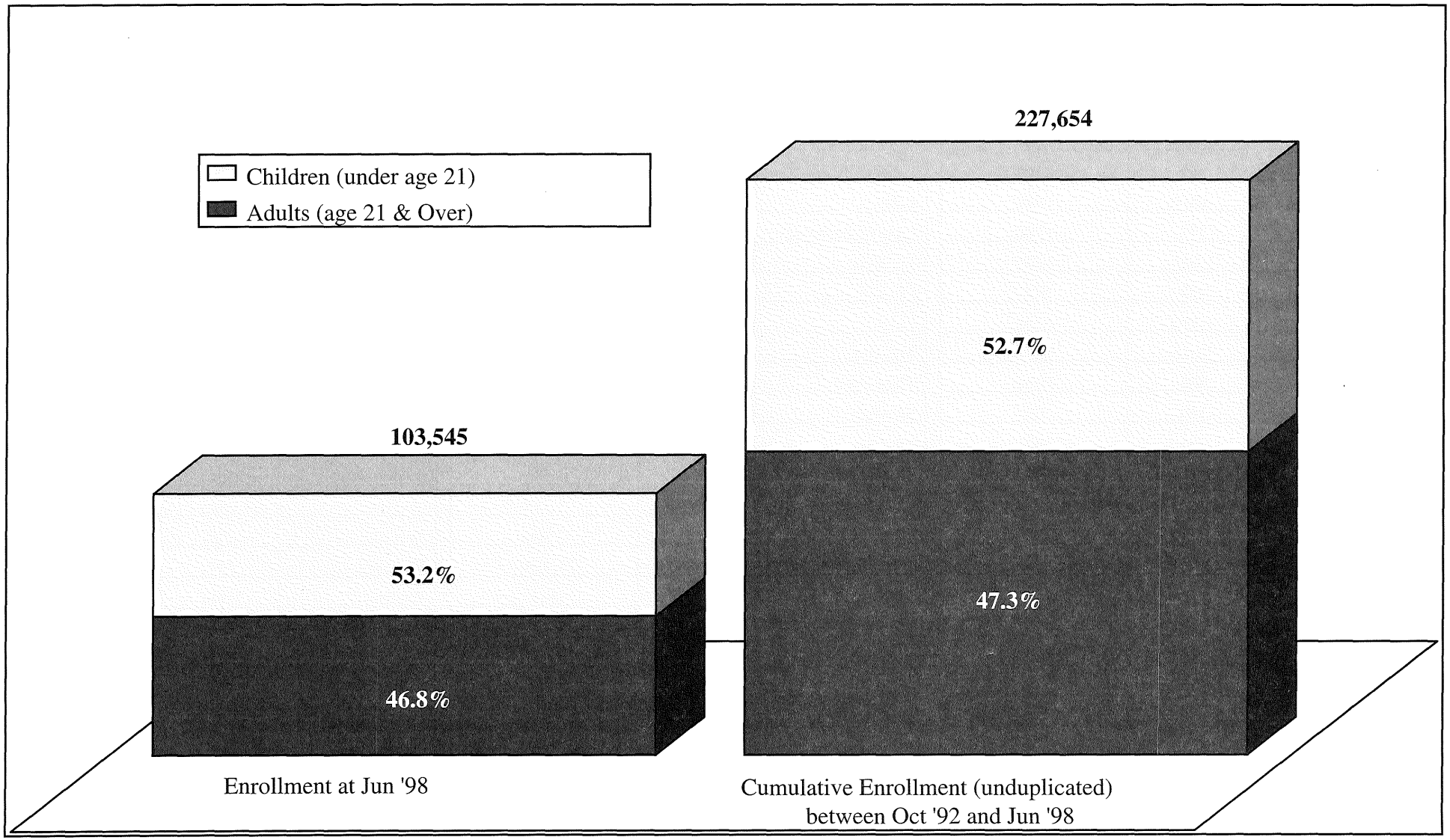


Table 1: Geographic Distribution

Enrollment at the end of June 1998 and total individuals ever enrolled (unduplicated) from October 1992 to June 1998 by county

County	Enrollment at Jun '98	Individuals enrolled since Oct '92	County	Enrollment at Jun '98	Individuals enrolled since Oct ' 92	County	Enrollment at Jun '98	Individuals enrolled since Oct '92
Aitkin	1,001	1,878	Isanti	990	2,070	Pipestone	380	808
Anoka	4,775	11,379	Itasca	2,332	4,719	Polk	1,269	2,568
Becker	1,556	3,181	Jackson	298	661	Pope	543	1,134
Beltrami	1,630	3,385	Kanabec	578	1,262	Ramsey	8,803	21,044
Benton	703	1,621	Kandiyohi	1,432	3,183	Red Lake	338	658
Big Stone	400	758	Kittson	187	397	Redwood	559	1,225
Blue Earth	1,001	2,219	Koochiching	722	1,304	Renville	584	1,337
Brown	532	1,107	Lac Qui Parle	341	698	Rice	809	2,133
Carlton	1,019	1,959	Lake	377	803	Rock	275	662
Carver	777	1,700	Lake of the Woods	279	539	Roseau	434	954
Cass	1,621	2,885	Le Sueur	443	1,139	St. Louis	5,537	11,848
Chippewa	405	969	Lincoln	373	647	Scott	903	2,195
Chisago	1,216	2,559	Lyon	665	1,538	Sherburne	1,228	2,725
Clay	1,016	2,348	McLeod	593	1,257	Sibley	360	783
Clearwater	608	1,126	Mahnomen	177	354	Stearns	2,482	5,100
Cook	156	326	Marshall	525	1,065	Steele	544	1,188
Cottonwood	381	788	Martin	561	1,265	Stevens	263	589
Crow Wing	2,410	4,920	Meeker	698	1,586	Swift	568	1,164
Dakota	4,099	9,875	Mille Lacs	834	1,775	Todd	1,345	2,559
Dodge	348	817	Morrison	1,856	3,366	Traverse	227	441
Douglas	1,349	2,733	Mower	908	1,988	Wabasha	427	1,015
Faribault	472	1,048	Murray	329	664	Wadena	898	1,847
Fillmore	652	1,256	Nicollet	389	923	Waseca	315	756
Freeborn	816	1,903	Nobles	476	1,015	Washington	2,366	5,279
Goodhue	610	1,660	Norman	433	882	Watonwan	277	621
Grant	333	703	Olmsted	1,683	3,859	Wilkin	225	544
Hennepin	13,788	32,754	Otter Tail	2,630	5,333	Winona	989	1,906
Houston	387	838	Pennington	482	1,061	Wright	2,016	4,638
Hubbard	1,274	2,269	Pine	1,127	2,399	Yellow Medicine	447	1,020
						Total	**103,545**	**227,654**

Figure7: Age and Gender Distribution at the end of June 1998

Age and gender distribution of enrolled population at the end of June 1998 (enrollment = 103,545)

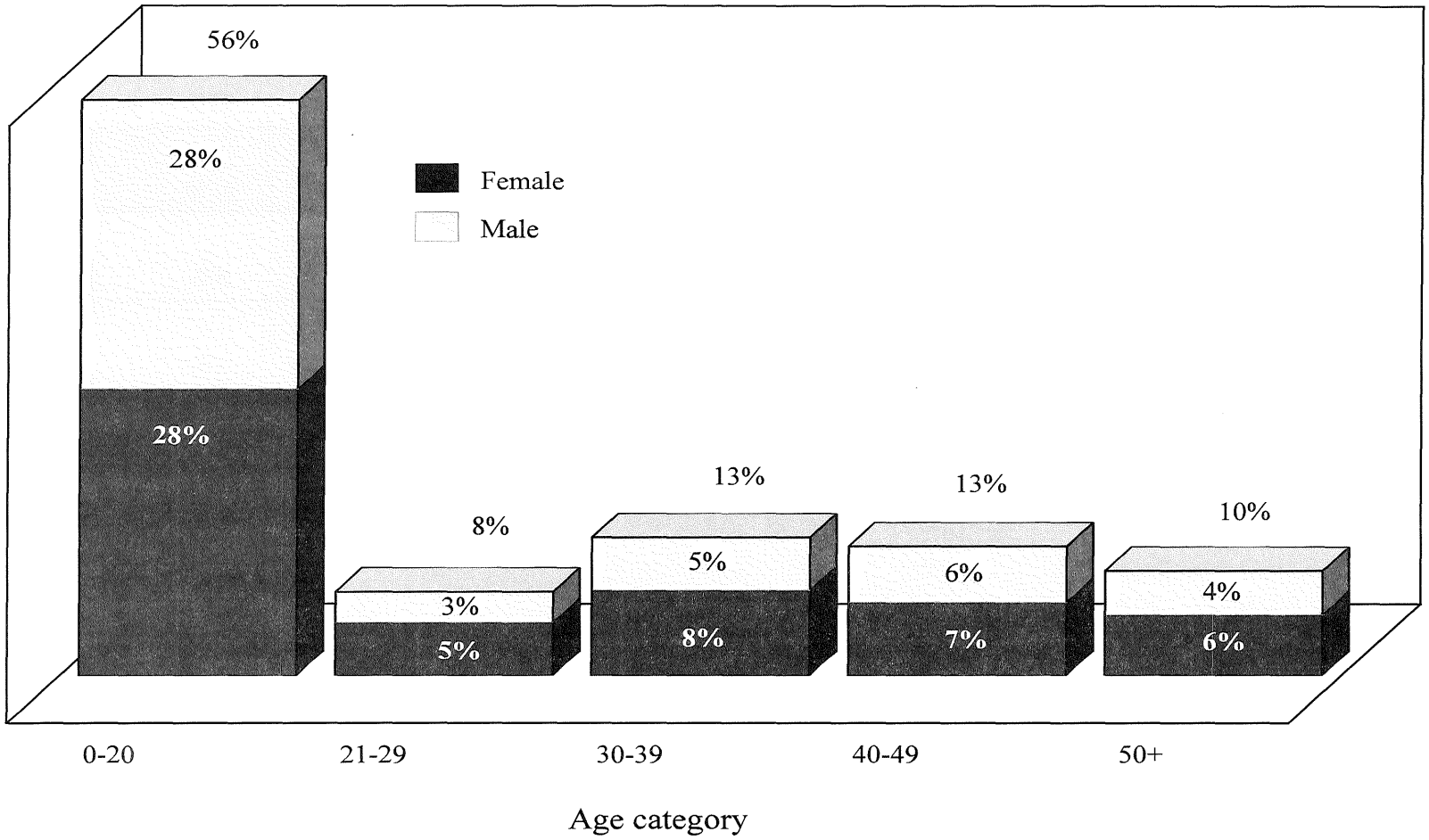


Table 2: Income Distribution of the enrolled population in June 1993 through June 1998

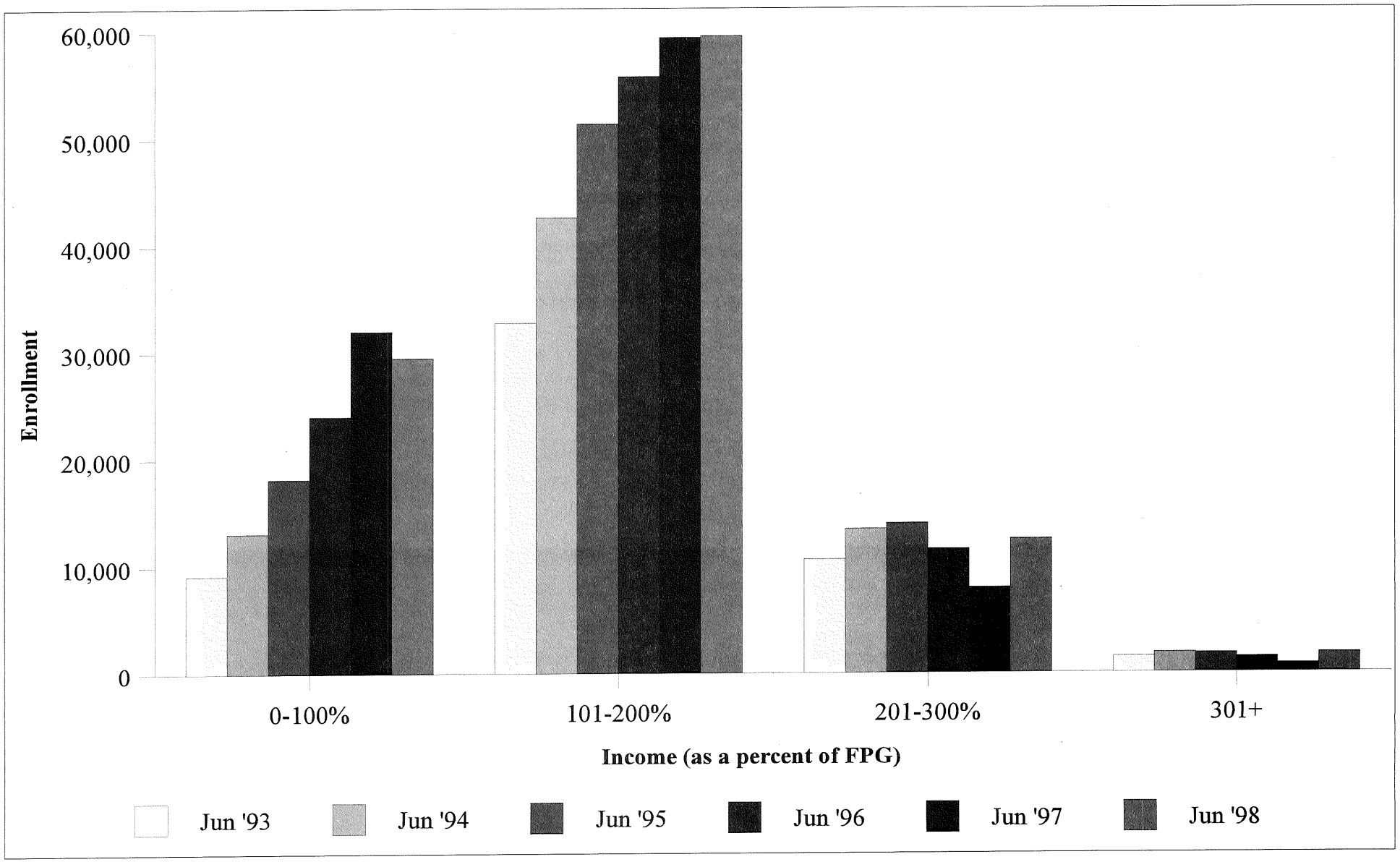
Income	1993	1994	1995	1996	1997	1998
0-100 %	17%	18%	21%	26%	32%	29%
101-200 %	61%	60%	61%	60%	51%	57%
Enrollees with income under 200% of FPG	**78%**	**78%**	**82%**	**86%**	**91%**	**86%**
201-300 %	19%	19%	16%	12%	8%	12%
301+ %	3%	3%	2%	2%	1%	2%
Enrollees with income above 200% of FPG	**22%**	**22%**	**18%**	**14%**	**9%**	**14%**

Footnote:
FPG Guidelines (1993-98)

FPG for a household of one	$6,970	$7,360	$7,470	$7,740	$7,890	$8,050
FPG for each additional household member	$2,460	$2,480	$2,560	$2,620	$2,720	$2,800

Figure 8: Enrollment at June 1993 through June 1998 by Income Category

Comparison of annual enrollment relative to income as percent of FPG at the end of FYs 1993-98



Section 5: Financial

Table 3: MinnesotaCare Expenditures & Revenue (FYs 1993-98)

		Total program expenditures			Contributions		
Fiscal year (actual)	Average monthly enrollees	Medical payments (cash basis)	Administrative costs	Total program expenditures	Federal contribution	Revenue from enrollee premiums	Net cost to state
[1] 1993	35,217	$12,809,463	$3,928,592	$16,738,055	-	$2,481,062	$14,256,993
1994	62,232	33,249,218	5,157,492	38,406,710	-	10,407,921	27,998,789
1995	77,417	56,204,081	7,299,636	63,503,717	-	14,597,741	48,905,976
1996	88,276	79,648,027	8,963,424	88,611,451	15,234,621	17,423,732	55,953,098
1997	93,136	98,127,076	11,062,597	109,189,673	12,422,998	20,306,283	76,460,392
1998	97,854	108,448,371	11,481,258	119,929,629	13,776,363	21,550,702	84,602,564

[1] In FY 1993, MinnesotaCare and the Children's Health Plan fiscally operated as two separate programs. These figures reflect the aggregate for both programs.

Table 4: Monthly Expenditures & Revenue Per Enrollee (FYs 1993-98)

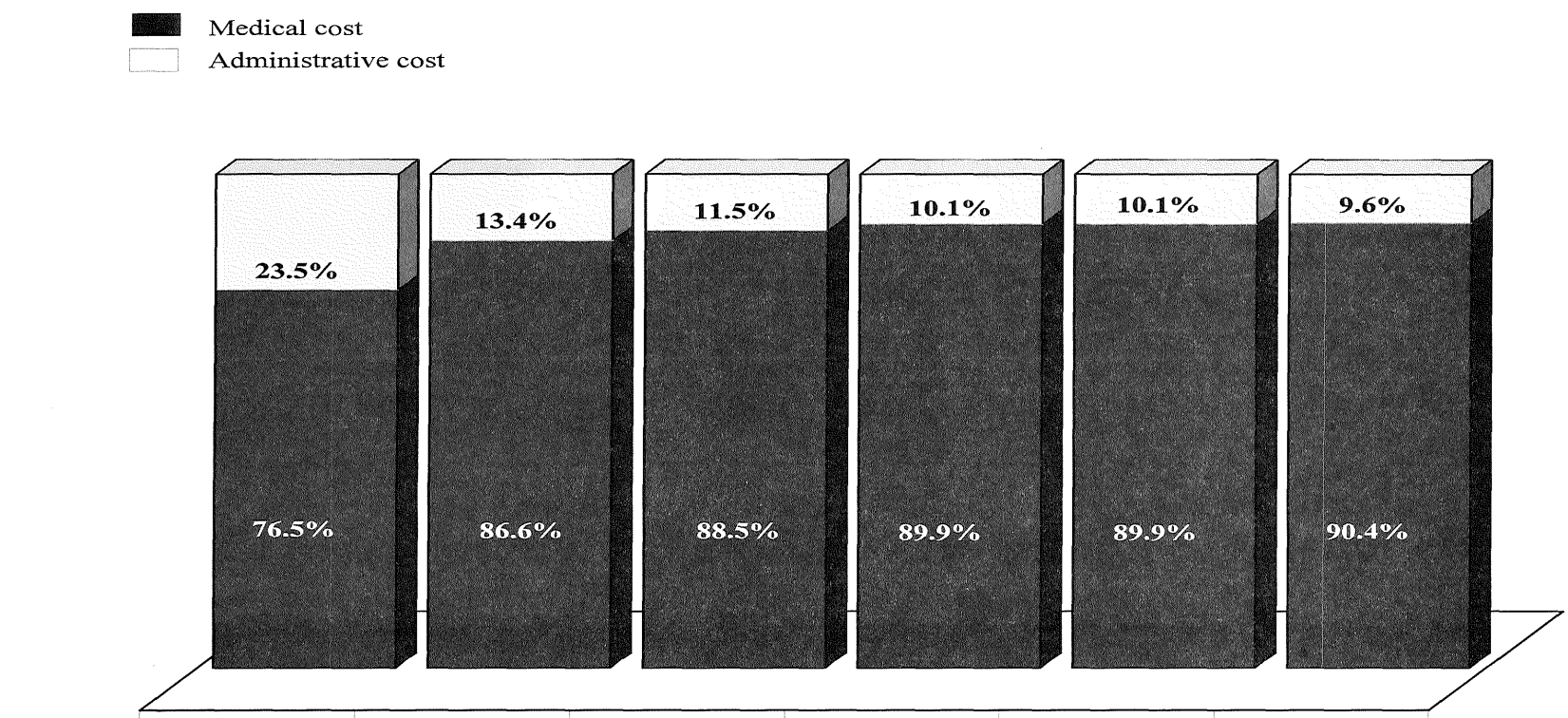
Fiscal year (actual)	Average monthly enrollees	Monthly expenditures per enrollee (dollars)			Monthly contributions per enrollee (dollars)		
		Medical payment	Administrative cost	Total monthly cost per enrollee	Premium payment	[1] Federal contribution	Cost to state
[2] 1993	35,217	$30.31	$9.30	$39.61	$5.87	-	$33.74
1994	62,232	44.52	6.91	51.43	13.94	-	37.49
1995	77,417	60.49	7.86	68.35	15.71	-	52.64
1996	88,276	75.19	8.46	83.65	16.45	14.38	52.82
1997	93,136	87.80	9.90	97.70	18.17	11.12	68.41
1998	97,854	92.36	9.78	102.14	18.35	11.73	72.06

Footnotes:

[1] Federal contribution is only made for children and pregnant women, not all enrollees. The amount of federal contribution is averaged for all enrollees to make it comparable to the other monthly averages for all enrollees.

[2] In FY 1993, MinnesotaCare and the Children's Health Plan fiscally operated as two separate programs. The figures here reflect the aggregate for both programs.

Figure 9: Medical and Administrative Costs as a Percent of Total Program Expenditures (FYs 1993-98)



	FY 1993	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998
	$3,928,592	$5,157,492	$7,299,636	$8,963,424	$11,062,597	$11,481,258
	$12,809,463	$33,249,218	$56,204,081	$79,648,027	$98,127,076	$108,448,371

Figure 10: Six-year Aggregate Expenditures Compared to the Number of Individuals Served