Report to the Secretary

Health Resources and Services Administration
State Planning Grants Program

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Executive Summary

Introduction

Minnesota has long been a leader in state-based health care innovations focused on making affordable health coverage available to its citizens. Our MinnesotaCare subsidized health insurance program is over a decade old, and has provided a model for other states as they developed their own coverage expansions under S-CHIP. As a result of this and above average levels of employer-sponsored health insurance coverage, Minnesota has long had among the nation's lowest overall rates of uninsurance.

Under the HRSA State Planning Grant (SPG) program, Minnesota has conducted a series of research activities that have added significantly to the state's knowledge of its uninsured population. We used a variety of methods and approaches to gain an understanding of how factors such as an increasingly diverse population, sluggish economic growth, cost increases in the private insurance market, and the changing and evolving views of the population regarding health reform and coverage options impact on the level and make-up of our uninsured population.

Research under the State Planning Grant

The research conducted under Minnesota's SPG grants has been widely-scoped and varied, with various aspects meant to address or examine factors that influence the likelihood of having health insurance coverage. This report describes work that was completed subsequent to the March 2002 Interim Report to the Secretary. Reports on activities completed prior to the March 2002 Report were reported in either the October 2001 or March 2002 Reports to the Secretary. The results from those projects were critical to the consensus building and policy option development that has occurred over the course of the past several years in Minnesota . The following research projects were completed over the time period addressed in this report:

- In-person household survey of 2,085 Minnesotans;
- Young Adult Focus Groups;
- A plan to communicate the results of the 2001 Minnesota Health Access Survey to a wide range of stakeholders and community groups;
- 2002 Minnesota Employer Health Insurance Survey;
- Small Employer Focus Groups;
- Study of the Adequacy of Health Insurance Coverage and Benefits;
- Study of Provider and Health Plan Network Arrangements;
- Research into the values and beliefs of Minnesotans regarding health care reform and coverage options.

Briefly summarized below are the primary findings from these various study components. Overall, the finding suggest the following:

- Minnesota's overall low rate of uninsurance masks wide disparities in coverage that exist between racial and ethnic groups in Minnesota, whether measured via a household telephone survey or using in-person sampling.
- There are a variety of contributing factors to the higher uninsurance rates for populations of color and American Indians in Minnesota, and these reasons vary by population group.
- Approximately half of Minnesota's private employers offer health coverage and over 82% of private sector employees worked for an employer that offered coverage. These rates of coverage are stable compared to employer surveys conducted in Minnesota in 1993 and 1997. There was, however, a decline in the percentage of eligible employees who enroll for coverage.
- Small employers, who employ approximately 60% of the uninsured in Minnesota, are struggling to continue to offer or to begin to offer health insurance coverage. Overall, our focus group results found that small employers would find it easier to offer coverage if it were less costly, if rate increases were fixed or predictable, and if there were simpler plans that required little paperwork or explanation.
- Small employers were varied in their opinions about three policy options presented as ways to potentially lower health insurance costs: premium sharing or employer/employee subsidies, tax credits, and stop-loss protection. Some of the small employers expressed an interest in the premium-sharing concept. Others were concerned that all of the options would lead to higher taxes and potentially to second-class health care for their employees. Most of the small employers stated that none of the proposed options would address the underlying problem of rapidly rising health care costs.

Policy Options

Despite the actions taken by the 2003 legislature to address the budget imbalance, the State's most recent budget forecast for the 2006 – 2007 biennium is that there will be a deficit of nearly $1 billion. As a result, it is likely that additional changes to public programs will be considered in the coming legislative session.

Because of the critical importance of a strong private market in keeping the rate of uninsurance low and because of concerns that rising costs could erode private coverage (ultimately resulting in higher enrollment and costs for public insurance programs), there is interest in exploring a variety of ways in which the state could support private insurance coverage in a cost-effective manner, through subsidies (either direct or indirect) or tax credits.

There are a number of proposals to support the private health insurance market that have been advanced for consideration by key policymakers and legislators. None of these proposals has been adopted, due in part to a lack of information on the likely impact of each proposal in terms of cost (for employers, individuals, and government), potential crowdout, and reduction in the number of uninsured Minnesotans. To fill this information gap and to promote discussion and comparison of private market options, Minnesota plans to use its recently awarded FY 2004 SPG funds to examine and consider the implementation of options to support the private health insurance market. We will contract with Dr. Jonathan Gruber of MIT and Mercer Government Human Services Consulting to perform economic modeling activities that will help to quantify

the impacts of the various proposals. The results of this project will be used to promote discussion and consensus building around which policy options would be most effective.

Recommendations to States and Federal Government

Lessons Learned and Recommendations to States

In Minnesota, state-specific data and analysis have been a crucial part of health policy decision-making for over a decade. Minnesota has a long tradition of using state-collected and state-analyzed data to better understand it own health care market, and policymakers and stakeholders have come to rely on the availability of state data to make coverage expansion and other health policy decisions. Support from the State Planning Grants program since FY 2000 has been critical to Minnesota's ability to collect and update state-specific information on health coverage and health care markets; without this support, we would not have the high quality, up-to-date information that we need to support policy decisions.

Minnesota has a long history of commitment to creating and maintaining the technical capacity within state government to apply quantitative research to the development of health policy. Having in-house staff with the expertise to use the state-specific data collected with SPG funding is a critically important aspect of health policy development. The ability for in-house staff to use the data to respond to real-time, ad hoc requests as the policy development process unfolds is a key part of making sure that the research and data collection efforts supported by the SPG are successfully translated into policy. In addition, it is important that this type of research be viewed as credible and objective in order for it to be most effective.

Recommendations to the Federal Government

Funding that Minnesota has received through the SPG program has been critically important in enabling the state to expand and update its knowledge of health care access and health care markets in Minnesota and to apply this research to the development of policy. The State of Minnesota continues to strongly support federal funding for state-specific data collection around the uninsured. While our initial State Planning Grant award and supplemental awards have provided an invaluable source of data and information, equally important is the support for states to conduct ongoing monitoring of their uninsured populations. Since most states experienced economic downturns and budget deficits, the ability to analyze and understand the impact that these downturns had on coverage and access is critical, and we expect that the results of the 2004 household survey which is currently nearing completion will prove to be invaluable. We therefore recommend that the federal government continue to provide funding so that those states that have received past funding to establish baseline information on their uninsured can update their analyses in order to monitor the effect of changing economic conditions and any policy changes implemented.

A. Update on Projects Funded or Unfinished Since March 2002 Interim Report to the Secretary

Under Minnesota's original (FY 2000) HRSA grant and supplemental grants (FY 2001 and FY 2003), a number of different projects have been funded. The following projects were completed prior to the March 2002 Interim Report to the Secretary and the results were reported in either the October 2001 or March 2002 Reports to the Secretary, so they will not be described in this report:

- 2001 Minnesota Health Access Survey
- Focus Groups with Populations of Color
- Farmer Focus Groups
- Key Informant Interviews
- MinnesotaCare Disenrollee Survey
- Evaluation of Employer Buy-In Options
- Study of Policy Options for Individual Health Insurance Market

The results from these projects, as well as findings from the projects described below, have been critical in consensus building activities and the development of policy options to reduce the number of uninsured Minnesotans as described in Part B of this report.

Section 1: Projects Related to Uninsured Individuals and Families

In-Person Household Survey

The in-person household survey started in late 2001 and was completed in early 2003. Roughly 2,000 in-person surveys were conducted over this two-year period with a sample size of approximately 400 each for White, Black, American Indian, Asian, and Hispanic populations in the state. The purpose of the in-person survey was to supplement information from the telephone household survey (2001 Minnesota Health Access Survey) and to address concerns about undercoverage and trust in telephone surveys from stakeholder groups representing populations of color and American Indians. The primary goals of the in-person survey were to collect and compare information on insurance status to the 2001 Minnesota Health Access Survey and to examine potential reasons why populations of color and American Indians have significantly higher rates of uninsurance than the White population in the state.

Table 1 provides information on uninsurance rates by race/ethnicity from the in-person survey and the telephone household survey (2001 Minnesota Health Access Survey). The in-person and telephone household surveys produced different estimates of uninsurance; however, these differences are not statistically significant. Both surveys find that the White and Asian populations in the state have lower uninsurance rates and that the Black, American Indian, and Hispanic populations in Minnesota have much higher uninsurance rates.

Table 1
Comparison of Uninsurance Rates Between In-Person and Telephone Surveys

Population Group	In-Person Household Survey	Telephone Household Survey (2001 Minnesota Health Access Survey)
White	4.3%	4.5%
Black	11.3%	15.6%
American Indian	20.7%	16.1%
Asian	2.1%	6.6%
Hispanic	25.2%	17.3%

Note: differences in uninsurance rates between the two surveys are not statistically significant.

In addition to information on insurance status, the in-person household survey also collected information from respondents on the value of health insurance, views of public health insurance programs, and cultural competency. The responses to these questions provide some insight as to why populations of color and American Indians in Minnesota have higher uninsurance rates. Results of interest from the in-person household survey pertaining to these topics are listed below:

Value of Health Insurance

- Over 70% of Hispanics do not think that healthy people need health insurance compared to 5% or less of White, Black, American Indian, and Asian populations.
- Over 45% of American Indians and 32% of Asians and Hispanics say that they rely on the type of health care that health insurance does not usually pay for.

Views of Public Insurance Programs

- 46% of American Indians worry that they will lose their property if they enroll in public health insurance programs.
- American Indians (32%) and Hispanics (29%) are more likely than other population groups to agree that people on public programs feel bad about themselves.
- Hispanics (15%) are more likely than other population groups to agree that public health insurance programs are for people who are lazy.
- Compared to the White population (18%), Black (46%), American Indian (51%), Asian (32%), and Hispanic (32%) populations are more likely to report that doctors treat people with public coverage worse than people with private coverage.
- American Indian (45%) and Black (37%) populations are more likely than other population groups to disagree that public program eligibility workers treat people well.

Cultural Competence

- Compared to the White population (5%), Black (24%), American Indian (35%), and Hispanic (22%) populations are more likely to feel that doctors and nurses do not respect people of their cultural or ethnic group.
- Compared to the White population (8%), Black (40%), American Indian (27%), and Hispanic (23%) populations are more likely to say that doctors and nurses are not trusted by their cultural or ethnic group.
- Black (39%), American Indian (38%), Asian (58%) and Hispanic (43%) populations are more likely than the White population (78%) in Minnesota to report that doctors and nurses are supportive of the things that people of their cultural or ethnic group do to feel better.
- Compared to the White population (8%), Black (17%), American Indian (15%), Asian (12%), and Hispanic (17%) populations are more likely to report that doctors and nurses recommend treatments that go against their cultural or ethnic beliefs.

The in-person survey results listed above suggest that there are a variety of contributing factors to the higher uninsurance rates for populations of color and American Indians in Minnesota, and that these reasons vary by population group. The results show that some people may be uninsured because they do not see a need for health insurance, because there is a stigma associated with public health insurance programs, or because they do not feel that they are treated well by the doctors and nurses that are associated with the health care system and health insurance in general.

Young Adult Focus Groups

Results from the 2001 Minnesota Health Access Survey indicate that young adults age 18 through 24 in Minnesota have a significantly higher uninsurance rate than any other age group in the state. Almost 14% of young adults age 18 through 24 were uninsured in Minnesota in 2001, compared to 5.4% for the state population as a whole. Through a supplemental HRSA grant, SPG funds were used to conduct focus groups with uninsured young adults to determine the reasons why they are uninsured and uncover potential strategies to increase insurance coverage among this age group. Krueger & Associates conducted six focus groups with young adults throughout the state during the spring of 2002.

Young adult focus group participants said that the main reason they do not have health insurance is that it is too expensive. Many of the uninsured young adults were working in part-time or low-wage jobs; these jobs either did not provide health insurance or the young adults could not afford the coverage that was offered. They stated that they did not make enough money to buy health insurance and that they would rather spend money on things more valuable to them. Some of the participants stated that they would only purchase health insurance if it cost less than what they are currently spending for health care, which is very little since they are generally healthy. On average, the young adult focus group participants stated that they would be willing to pay $40 a month for health insurance as long as the coverage had little or no deductible or co-payments.

Most of the focus group participants had some knowledge of public health insurance programs such as MinnesotaCare and Medicaid and some had inquired about or applied for one of the programs. Some of the participants said that they did not apply because the process was too difficult. Most of the participants that had applied said that they were denied because they either made too much money, had too many assets, or because they lived with their relatives and that made them ineligible.

In addition to affordability and ineligibility for public programs, many uninsured young adults stated that they did not have health insurance because they did not think that they really needed it. Most stated that when they get sick now that it is not serious and that they rely on over-the-counter remedies or go to a clinic when they really need to and make payments later. Some also stated that they go to low cost or sliding-fee scale clinics when they need care. They stated that there was little or no risk to being uninsured because they did not believe that they would get seriously sick or injured. Many stated that if they were to get sick or injured that it would most likely be in a car accident and that their car insurance would pay for their care. They also stated that if they were to get sick that they would either set up a payment plan, ask their parents to help pay for their care, or file bankruptcy. Most did not believe that they could be denied health care coverage in the future if they were to get sick now and almost all of the participants expected to get health insurance in a few years when they made more money and got a job with health insurance or when they got married.

When asked what strategies could be used to increase health insurance coverage among young adults, the focus group participants stated that health insurance needs to be more affordable and less complicated. They also stated that they did not really understand how health insurance works and that they would prefer that an employer or someone else provide coverage for them so that they do not have to deal with all of the confusing terms and forms. Lastly, some participants stated that young adults would get health insurance coverage if it was required like car insurance.

Communications Plan

Minnesota received supplemental SPG funding to develop a communications plan that disseminates the results of the first round of research projects conducted under the SPG back to the communities that participated in the research, particularly to communities of color. We contracted with Policy Studies Inc. to create materials for the general public to understand the research and its results, to translate the materials into the appropriate languages, to identify ways of disseminating the information (e.g., key community organizations that are in a position to distribute it), and to distribute the information to the public. These activities were completed in November 2002.

Development and dissemination of this information to the general public was an important part of acknowledging the important role of communities that participated in the research project. It helped to build relationships with these communities, and provided them with real data that they are also able to use in their own efforts to reduce disparities in coverage.

2004 Minnesota Health Access Survey

The 2004 Minnesota Health Access Survey, partially funded by Minnesota's FY 2003 State Planning Grant, is currently in the field and should be completed by December of 2004. Results from this survey of 14,000 Minnesota households will be available in early 2005. This survey will enable us to evaluate how health insurance coverage has changed in Minnesota since 2001 given a slow economy, job losses, changes in public program eligibility, and rapidly rising health care costs. In addition to updating previous work conducted under the HRSA funded 2001 Minnesota Health Access Survey, this survey will also allow us to analyze the degree to which public program enrollees have access to employer coverage and how variation in employee contributions to premiums affects the takeup of employer coverage. The updated and new information that will be gained from this survey will be important to policymakers as they consider potential public-private health insurance initiatives and ways to maintain or increase coverage in the private market.

Section 2: Projects Related to Employer-based Coverage

Employer Survey

Minnesota's Employer Health Insurance Survey was conducted during 2002. The results from the survey are based on data from a telephone survey of roughly 2,300 private establishments, which were selected at random from Minnesota's unemployment insurance files. The sample was stratified by establishment size and region. The purpose of the employer survey was to collect information on and evaluate the impact of increasing costs and premiums on the availability of employer-based health insurance coverage and employee participation in employer-based coverage.

In 2002, roughly half (48%) of private employers in Minnesota offered health insurance coverage and over 82% of private sector employees worked for an employer that offered coverage. Compared to Minnesota's Employer Health Insurance Surveys in 1993 and 1997, employer offer rates and employee access to employer-based coverage have been stable. Table 2 provides information on offer rates by employer size and region. As shown in the table, small employers are much less likely to offer coverage than larger employers, and employers in rural Minnesota are less likely to offer coverage than employers in the Twin Cities and other metropolitan areas of the state.

Table 2
Variation in Health Insurance Offer Rates, 2002

Employer Type	Offer Rate
All private sector employers	47.7%
Less than 10 employees	**34.5%**
10 to 49 employees	**65.6%**
50 to 199 employees	**86.2%**
200+ employees	**92.9%**
Twin Cities employer	**54.0%**
Other Metropolitan Area employer	45.4%
Rural Minnesota employer	**37.5%**

Source: 2002 Minnesota Employer Health Insurance Survey
Numbers in bold indicate a statistically significant difference (95% level) from statewide rate.

Comparison of results from the 1993, 1997, and 2002 Minnesota Employer Health Insurance Surveys shows that the shares of premiums paid by employees for single and family coverage have also been stable over the past decade. However, the actual costs paid by employers and employees for health insurance coverage have increased greatly since 1997. As shown in Table 3, employees paid about 17% of the premium for single coverage and one-third (34%) of the premium for family coverage in 2002, unchanged from previous years. This table also illustrates the large increase in both single and family premiums from 1997 to 2002 compared to the growth from 1993 to 1997.

Table 3
Employer/Employee Contributions to Health Insurance Premiums

Premium Contribution and Cost	1993	1997	2002
Monthly premium for single coverage	$144	$152	$270
Monthly premium for family coverage	$384	$395	$646
Growth in single premium from previous year shown		6%	78%
Growth in family premium from previous year shown		3%	64%
Employee share of premium: single coverage	17.0%	17.5%	17.0%
Employee share of premium: family coverage	32.2%	30.5%	34.1%

Differences in employee shares of premium over time were not statistically significant.

As noted earlier, over 82% of private sector employees worked for a firm that offered health insurance coverage in 2002. Of these employees, about 76% were eligible for coverage. Table 4 provides information on the eligibility, takeup, and coverage rates from 1993 to 2002 for employees who worked for a firm that offered coverage. This table shows that eligibility, takeup, and coverage rates have declined since 1997, with 80% of eligible employees taking up coverage and roughly 61% of employees in firms that offer coverage enrolled in 2002, down from takeup and coverage rates in 1997 of 87% and 72%, respectively.

Table 4
Employer Health Insurance Eligibility, Takeup and Coverage Rates

Employees in Firms That Offer Coverage	**1993**	**1997**	**2002**
% Eligible	81.8%	82.2%	75.9%
% of Eligible Who Enroll	79.4%	**86.7%**	**80.3%**
% Covered	65.5%	71.5%	**61.5%**

Numbers in bold indicate a statistically significant difference (95% level) from previous year shown.

More detailed results from the Minnesota Employer Health Insurance Surveys are summarized in a forthcoming report and have been used by health care experts and legislators to propose various employer coverage initiatives such as a MinnesotaCare buy-in program for small employers, reinsurance of high cost claims for small employers, tax credits, employer/employee subsidies, and allowing mandate free or limited benefit set plans. A discussion of these policy options is provided in Part B of this report. The findings have also been used to call attention to the rising cost of health care and the need to reform the health care system in some way to make health care more affordable and to preserve employer-based health insurance coverage. Some policy initiatives that have emerged as a way to reduce costs but not necessarily expand coverage include the implementation of best practices and electronic medical records.

Small Employer Focus Groups

Results from the 2001 Minnesota Health Access Survey Indicate that about 60% of uninsured Minnesotans who are employed are either self-employed or work for a small employer with fewer than fifty employees. As noted above, small employers are less likely to offer health insurance coverage to their employees compared to larger employers. Through a supplemental HRSA grant, SPG funds were used to conduct focus groups with small employers to determine the factors that influence their decision to offer health insurance coverage and what strategies could be used to entice them to offer coverage. Krueger & Associates conducted six focus groups throughout the state during the spring of 2002 with small employers who offer and do not offer health insurance coverage.

In general, the focus group participants stated that they offer health insurance coverage as a lower-cost way to insure themselves and their families and as a way to attract and keep employees. Most of the small business owners who did not offer health insurance coverage said that they did not need to offer coverage. They stated that they do not offer coverage because

most of their employees get coverage through a spouse or parent. Business owners also stated that they do not offer coverage because it costs too much and because premium increases are hard to predict and work into budgets. They also said that paperwork is another barrier to offering coverage; they do not have the time or expertise to deal with the complexity of health insurance and they cannot afford to hire someone to take care of health insurance issues. Some small business owners state that they do not offer health insurance coverage because it raises concerns about how to fairly compensate employees who do not take up health insurance. Lastly, small business owners reported that they do not offer health insurance because it is a hard benefit to take away if it becomes too expensive.

Many small employers stated that they have been struggling to offer health insurance in recent years as premium rates have been increasing significantly. Some of the small business owners have reduced coverage or shifted more of the costs to employees as premium costs have increased. Many of those who offer coverage stated that they are looking for ways to lower their health insurance costs and often shop for different insurance with lower rates.

Small business owners were asked for their reactions to three policy options that could potentially reduce premium costs and entice small employers to offer coverage. The three policy options included premium sharing or employer/employee subsidies, tax credits, and stop-loss protection. Some of the small employers were interested in the premium sharing or employer/employee subsidies. Other small employer participants were concerned that all of the options would lead to higher taxes and potentially to second-class health care for their employees. Most of the focus group participants stated that none of the proposed options would address the underlying problem of rapidly rising health care costs.

In general, small employers stated that it would be easier to offer insurance if it cost less, if rate increases were more fixed or predictable, and if there were simpler plans that required little paperwork or explanation. However, the focus group participants did not agree on how these three components should be addressed. Some small employers stated that the government should get more involved in health care and deal with cost and access issues. Other small employers want government to leave small businesses alone and some feared that more government intervention would lead to higher taxes and more regulation for small businesses.

The results from the small employer focus groups have been used to propose small employer initiatives such as a MinnesotaCare buy-in program for small employers, reinsurance of high cost claims for small employers, tax credits, employer/employee subsidies, and allowing mandate free or limited benefit set plans. A discussion of these policy options is provided in Part B of this report.

Section 3: Projects Related to the Health Care Marketplace

Study of Health Insurance Coverage Adequacy

Among the issues raised during our research, particularly with the focus groups, was a concern about the adequacy of insurance coverage, particularly for those with lower incomes. Health insurance premiums in Minnesota have been rising rapidly, and as in other states one strategy

that employers have used to control costs is to shift to less generous benefit sets – for example, higher deductibles or copayments. This potentially prevents people, especially those with low incomes, from seeking health services when needed; it could also leave them with significant medical debts when they do seek services. Our study of insurance coverage adequacy, funded through a supplemental SPG grant, had two main components: first, a study by the State Health Access Data Assistance Center (SHADAC) around synthesizing the concepts used to define what is considered "adequate" coverage; and second, collection of data from health plans doing business in Minnesota's small group and individual health insurance markets to analyze the variation in the benefit sets that are being purchased in these markets.

The SHADAC study was an important first step toward addressing the issue of coverage adequacy, because there is no consensus about what "adequate" insurance coverage is. SHADAC undertook an extensive literature review and synthesized the results of previous research on coverage adequacy.

The SPG-funded collection of data from health plans doing business in the small group and individual health insurance markets was critically important to improving the state's understanding of health insurance markets in Minnesota. Very little information is available about variation in cost sharing and levels of benefits at the state level. In 2002, we conducted a survey of health insurance companies, and asked them to provide information on each separate benefit package that they offer in the small group and individual insurance markets and the number of people enrolled in each product.

The results of this survey showed that enrollees in the individual health insurance market are exposed to greater financial risk than people with coverage through a small employer. In 2002, about two-thirds of enrollees in Minnesota's small group market were in plans without a deductible, compared to 3 percent in the individual market. Nearly 70% of enrollees in the individual market had a deductible of $1,000 or more, compared to just 6% of enrollees in the small group market. Enrollees in the individual market were also far more likely to have cost sharing in the form of coinsurance rather than a fixed copayment, which further increases the level of financial risk faced by people with individual coverage compared to the small group market.

The results of this data collection represent an important contribution to the process of developing policy options and building consensus. They provide a picture of coverage in the small group and individual markets that was previously not available, and they also provide a baseline for measuring changes in benefit sets into the future. This data and analysis will provide an important source of information in the discussion of potential policy options such as greater reliance on health savings accounts (HSAs).

Study of Provider/Health Plan Network Arrangements

During the 1990s, Minnesota's health plan market became increasingly consolidated; by 1999, the three largest health plans in Minnesota held about 82 percent of the private health insurance market. As health plans gained increasing market power, providers in the state also began to consolidate in an effort to improve their bargaining power with health plans. Under this portion

of the supplemental SPG, we contracted with Allan Baumgarten and Associates, a Minnesota consulting firm with expertise in health plan and provider market analysis.

The research conducted under the supplemental SPG provided a deeper understanding of the relationships that exist in Minnesota between health plans and providers, and how those relationships may affect health care costs and the availability of affordable health plan options. In particular, research conducted under the SPG mapped the arrangements that exist in various parts of Minnesota, showing clinic concentration in geographic areas of Minnesota and the various relationships that exist between those clinic and hospital organizations and health plans operating in those geographic regions.

This research was key in helping stakeholders and policymakers gain a better understanding of Minnesota's health care marketplace and how potential changes to insurance laws and operating rules might impact on care delivery and the cost of coverage. One key finding from the work is that regional health care markets in Minnesota tend to be dominated by relatively large multispecialty clinics operating out of the regional population hubs. The information collected under this research documented, for the first time, the degree to which concentration existed in these provider markets and achieved our key goal of providing policymakers and those advising the SPG process in Minnesota with information on provider and health plan relationships.

B. Update on Progress in Expanding Coverage

Section 4: Options and Progress in Expanding Coverage

Minnesota has a long history as a leader in expanding access to health insurance. From the creation of the nation's first high-risk pool in 1976, to the creation of the Children's Health Plan (which eventually became MinnesotaCare) in 1987 ten years in advance of the federal SCHIP legislation, to market reforms that improved the availability and affordability of coverage in the small group and individual markets, Minnesota has been a national leader in implementing health reforms that expand access to coverage. These efforts to reduce uninsurance through expansion of public programs and private market reforms have been rewarded. Minnesota has the lowest uninsurance rate in the country and consistently ranks at or near the top in overall health status. Over more than a decade, Minnesota has seen stable rates of uninsurance, even at times when the national uninsurance rate has increased.

Research conducted in Minnesota during the 1990s had suggested that most of Minnesota's uninsured population was eligible for coverage, either through an employer or a public program. The 2001 Minnesota Health Access Survey conducted under the State Planning Grant confirmed this result. In 2001, 23% of the uninsured were eligible for employer coverage and 50% were potentially eligible for a public program; only one-third (34%) of the uninsured were not eligible for coverage through a public program or an employer. Over 90% of uninsured children and uninsured people with incomes below 200% of poverty were estimated to be eligible for employer coverage or a public program in 2001.

Funding from HRSA through Minnesota's State Planning Grant and supplemental awards has played a critical role in helping to further advance the goal of reducing uninsurance. In addition to helping the state to evaluate policy options and target our efforts to reduce uninsurance, it has played a role in helping to pass legislation to expand coverage for children and to reduce disparities in health insurance coverage:

- ***"Cover All Kids" initiative:*** In the 2001 legislative session, eligibility for Medical Assistance (Minnesota's Medicaid program, also referred to as MA) coverage was expanded to include all children ages 2 to 18 with family incomes up to 170% of FPG (the previous limits were 133% of FPG for children ages 2 to 5 and 100% of FPG for children ages 6 to 17). In addition, the income limit for parents and children ages 19 and 20 was increased to 100% of FPG. At the time this coverage expansion was enacted, it was expected to result in as many as 12,000 fewer uninsured children in Minnesota. Securing CMS approval of a waiver to receive enhanced matching funds under SCHIP to cover parents was a key component of obtaining legislative passage of this expansion. In addition, results from the SPG-funded 2001 household telephone survey that showed the number of uninsured children in Minnesota was higher than previously estimated were instrumental in passing this initiative.

- ***Eliminating health disparities initiative:*** Also during the 2001 legislative session, a $10 million initiative to reduce health disparities was enacted. Information from the SPG-funded household survey on disparities in uninsurance rates played a key role in

securing passage of this initiative. This initiative seeks to stimulate innovative approaches to reducing health disparities by awarding grant to community groups and nonprofit organizations. The Minnesota Department of Health has awarded grants to 60 organizations across the state to experiment with new approaches for reducing health disparities. The grant awardees include ten tribes, three local government agencies, and 47 nonprofit organizations, most of the based in or primarily serving communities of color.

Much of the success Minnesota had during the 1990s in stabilizing the overall rate of uninsurance and decreasing the number of uninsured children and low-income people is the result of the MinnesotaCare program. MinnesotaCare enrollment is currently about 145,000, compared to 35,000 at its inception in 1992. As of November 2003, about half (46%) of MinnesotaCare enrollees were children, 40% were parents, and the remainder (13%) were adults without children.

Another contributing factor to the low rate of uninsurance in the state is the strength of the private health insurance market. According to the Minnesota Health Access Surveys, the proportion of Minnesotans with group health insurance coverage increased from 65.4% in 1990 to 69.7% in 2001. This increase is probably due to both the strong economy during much of the 1990s as well as the success of the MinnesotaCare Act in reforming the small employer health insurance market. Enrollment in the small employer health insurance market increased from around 300,000 Minnesotans in 1994 to about 485,000 in 2001.

Together, public program expansion and private health insurance market reforms have helped to reduce the number of uninsured children and low-income people, yet some populations have not witnessed declining numbers of the uninsured. Rural residents and populations of color represent a disproportionate percentage of the uninsured and continue to experience higher rates of uninsurance than their counterparts.

2003 program changes in eligibility and benefits:

Like most states, the combination of a weak economy (rising enrollment in public programs and slow growth in tax revenues) and rapidly rising health care costs in Minnesota resulted in the need for some difficult policy decisions about health care programs. During Minnesota's 2003 legislative session, the state faced a projected budget deficit of $4.2 billion for the 2004 – 2005 biennium. In 2003, the legislature made some significant changes in the structure of Minnesota's public insurance programs, affecting both eligibility and the structure of benefits. By 2007, it is expected that 38,000 fewer Minnesotans will be enrolled in public programs than had been projected without these changes in eligibility and benefits. The following is a summary of the major changes enacted in 2003:

- Children: For children ages 1 through 18, income eligibility for MA was lowered from 170% of FPG to 150% of FPG, effective July 1, 2004. (Many of the children affected by this change may be eligible for MinnesotaCare, but would have to pay a premium.) Automatic MA or MinnesotaCare coverage for newborns of mothers who are on MA or MinnesotaCare was reduced from two years to one.

- Pregnant women: Pregnant women with incomes over 200% of FPG are no longer eligible for MA, but could be eligible for MinnesotaCare (they would be required to pay a premium).
- Parents: Parents' eligibility for MinnesotaCare coverage ends when family income exceeds $50,000 or 275% of FPG, whichever is lower.
- Adults without children: MinnesotaCare adults without children with incomes between 75% and 175% of FPG have a more limited benefit set, face a new $5,000 annual cap on non-inpatient services, and are also subject to new copayments. There is no cap on benefits for those with incomes less than 75% of FPG, but this group does face the new copayment requirements. In the General Assistance Medical Care program (GAMC, a state-only program for people who are not eligible for MA or MinnesotaCare), a catastrophic inpatient benefit is available for people with incomes between 75% and 175% of FPG and less than $10,000 in assets ($20,000 for a household of 2 or more people). Adults with incomes less than 75% of FPG and less than $1,000 in assets remain eligible for full GAMC coverage, but they are subject to new copayment requirements.
- Undocumented immigrants: GAMC coverage for undocumented immigrants was eliminated, although some undocumented immigrants could be eligible for emergency MA coverage.
- For all categories of enrollees, eligibility for coverage under MinnesotaCare will be reviewed more frequently – every 6 months instead of annually.

Current Economic and Political Outlook

Despite the actions taken by the 2003 legislature to address the budget imbalance, the State's most recent budget forecast for the 2006 – 2007 biennium is that there will be a deficit of nearly $1 billion. As a result, it is likely that additional changes to public programs will be considered in the coming legislative session.

There are several reasons why it is unlikely that large-scale expansions of coverage through public programs will be enacted. First, the 2001 SPG-funded household survey indicated that a large share of the uninsured (about two-thirds) was already eligible for either public or private coverage. Second, Minnesota already has eligibility standards for public insurance programs that are among the most generous in the nation. Finally, the current state budget situation makes it unlikely that major new initiatives to expand public coverage, if proposed, would have a strong chance of passage.

However, because of the critical importance of a strong private market in keeping the rate of uninsurance low and because of concerns that rising costs could erode private coverage (ultimately resulting in higher enrollment and costs for public insurance programs), there is interest in exploring a variety of ways in which the state could support private insurance coverage in a cost-effective manner, through subsidies (either direct or indirect) or tax credits.

There are a number of proposals to support the private health insurance market that have been advanced for consideration by key policymakers and legislators. None of these proposals has been adopted, due in part to a lack of information on the likely impact of each proposal in terms of cost (for employers, individuals, and government), potential crowdout, and reduction in the number of uninsured Minnesotans. To fill this information gap and to promote discussion and

comparison of private market options, Minnesota plans to use its recently awarded FY 2004 SPG funds to examine and consider the implementation of options to support the private health insurance market. We will contract with Dr. Jonathan Gruber of MIT and Mercer Government Human Services Consulting to perform economic modeling activities that will help to quantify the impacts of the various proposals. The results of this project will be used to promote discussion and consensus building around which policy options would be most effective.

Section 5: Consensus Building Strategies

A key component of our supplemental grant activities surrounded developing an understanding of the values and beliefs that Minnesotans hold regarding health coverage expansion and health reform issues. While our initial grant activities led to expansion of eligibility for health coverage for children in Minnesota and the establishment of a grant program to reduce coverage and health outcome disparities between Minnesota's white population and populations of color and American Indians, subsequent changes in the political makeup of the state's legislature and governor's office led to a different environment regarding the expansion of health coverage to additional uninsured populations, as philosophies regarding the role of the private sector versus public program expansion shifted.

Under supplemental funding from the SPG program, we conducted research into the values and beliefs of Minnesotans regarding the acceptability of various health care coverage expansion and health reform activities. To carry out the project, we contracted with Michael Scandrett, a well-respected and non-partisan local health care and public interaction expert. He conducted a series of 12 town hall meetings around the state of Minnesota. In total, nearly 800 people attended the town hall meetings. In addition, over one hundred people responded to an online survey on health reform issues, and approximately 150 people responded to an open invitation for comments. Finally, while not sponsored by the SPG program, our research was informed by a survey of 800 Minnesotans about their satisfaction with the health care system and their reaction to various health reform issues.

As a result of the research conducted under the supplemental SPG funds, certain key themes emerged about Minnesotans' view of the health care system. In particular, the research showed that:

- Minnesotans are concerned about health.
- Most are concerned about rising health care costs.
- Some are dissatisfied with quality and access.
- The health care system is unnecessarily complex and masks hidden costs, profits and unfair pricing.
- The way in which pharmaceuticals are priced does not make sense.
- Individual responsibility with regard to health care is important.
- Access should be assured for everyone.
- People want choices, control, and personalized health care.
- Prevention is very important.
- Government has a role in assuring access and promoting the desired characteristics of a health care system.

The research conducted under the SPG supplemental funding on values and beliefs regarding health reform and health care coverage was then used to inform the work of the Minnesota Citizens Forum on Health Care Costs, which was convened by Minnesota Governor Tim Pawlenty in the fall of 2003. In particular, the work on values and beliefs regarding Minnesota's health system was used to form a core set of guiding and desired characteristics of the future of Minnesota's health system. These characteristics include a system which is:

- Accessible to all
- Fair
- Provides safe, high-quality care
- Personalized
- Promotes health
- Affordable
- Reward personal responsibility
- Understandable

These guiding characteristics were then critical to the deliberation of the Minnesota Citizens Forum on Health Care over the course of the fall of 2003 and early winter of 2004. They provided a research-based understanding of the perspectives, values and beliefs of Minnesotans. The work of the Citizen Forum resulted in a set of recommendations to the Governor in late February 2004 on policies and methods to reduce the rate of growth in health care expenditures in Minnesota.

C. Recommendations to States and Federal Government

Section 6: Lessons Learned and Recommendations to States

In Minnesota, state-specific data and analysis have been a crucial part of health policy decision-making for over a decade. Minnesota has a long tradition of using state-collected and state-analyzed data to better understand it own health care market, and policymakers and stakeholders have come to rely on the availability of state data to make coverage expansion and other health policy decisions. Support from the State Planning Grants program since FY 2000 has been critical to Minnesota's ability to collect and update state-specific information on health coverage and health care markets; without this support, we would not have the high quality, up-to-date information that we need to support policy decisions.

Minnesota has a long history of commitment to creating and maintaining the technical capacity within state government to apply quantitative research to the development of health policy. Having in-house staff with the expertise to use the state-specific data collected with SPG funding is a critically important aspect of health policy development. The ability for in-house staff to use the data to respond to real-time, ad hoc requests as the policy development process unfolds is a key part of making sure that the research and data collection efforts supported by the SPG are successfully translated into policy. In addition, it is important that this type of research be viewed as credible and objective in order for it to be most effective.

Section 7: Recommendations to the Federal Government

Funding that Minnesota has received through the SPG program has been critically important in enabling the state to expand and update its knowledge of health care access and health care markets in Minnesota and to apply this research to the development of policy. The State of Minnesota continues to strongly support federal funding for state-specific data collection around the uninsured. While our initial State Planning Grant award and supplemental awards have provided an invaluable source of data and information, equally important is the support for states to conduct ongoing monitoring of their uninsured populations. Since most states experienced economic downturns and budget deficits, the ability to analyze and understand the impact that these downturns had on coverage and access is critical, and we expect that the results of the 2004 household survey which is currently nearing completion will prove to be invaluable. We therefore recommend that the federal government continue to provide funding so that those states that have received past funding to establish baseline information on their uninsured can update their analyses in order to monitor the effect of changing economic conditions and any policy changes implemented.

D. Appendix: List of Publications and Research Findings Supported by SPG Funding

The findings of research supported by State Planning Grant funds have been used in a large number of publications, and also in many presentations to conferences and meetings of health policy stakeholders across the state. The following is a list of publications that have been produced using information collected under Minnesota's State Planning Grant. Unless indicated otherwise, all of these publications can be accessed through the Health Economics Program website at http://www.health.state.mn.us/divs/hpsc/hep/hepindex.htm:

- "Accessing Health Insurance in Minnesota: Report of Focus Group Discussions with American Indian, Hmong and Somali Community Members," completed by the Center for Cross-Cultural Health for the Minnesota Department of Health, December 2001. (Available at http://www.crosshealth.com/HlthCare.pdf)

- "Disparities in Health Access: Voices from Minnesota's Latino Community," Hispanic Advocacy and Community Empowerment Through Research (HACER) and University of Minnesota, Division of Health Services Research and Policy, School of Public Health, January 2002. (Available at http://www.hacer-mn.org/)

- "Minnesota's Uninsured: Findings from the 2001 Health Access Survey," Minnesota Department of Health, Health Economics Program, April 2002.

- "Accessing Health Insurance in Minnesota: Barriers for the Farming Community," Minnesota Department of Health, Health Economics Program, May 2002.

- "Listening to Small Business Owners: Summary of Focus Groups on Health Insurance," conducted by Krueger and Associates for the Minnesota Department of Health, Health Economics Program, June 2002.

- "Understanding Uninsured Young People: Summary of Focus Groups on Health Insurance," conducted by Krueger and Associates for the Minnesota Department of Health, Health Economics Program, June 2002.

- "MinnesotaCare Disenrollee Survey Report," Minnesota Department of Health, Health Economics Program, July 2002.

- "Employer-Based Health Insurance: Family Decisions to Enroll," Minnesota Department of Health, Health Economics Program, September 2002.

- "2001 Health Insurance Coverage for Minnesota Counties," Minnesota Department of Health, Health Economics Program, December 2002.

- "A Brief Overview of Medicare Supplemental Coverage in Minnesota and the United States," Minnesota Department of Health, Health Economics Program, December 2002.

- "Medicare Supplemental Coverage in Minnesota," Minnesota Department of Health, Health Economics Program, December 2002.

- "Uninsured in Minnesota: Perspectives of Key Informants," Minnesota Department of Health, Health Economics Program, December 2002.

- "Prescription Drug Coverage and Spending in Minnesota," Minnesota Department of Health, Health Economics Program, February 2003.

- "Trends in Employer Sponsored Health Insurance: Preliminary Results from the 2002 Minnesota Employer Health Insurance Survey," Minnesota Department of Health, Health Economics Program, March 2003.

- "Trends in Minnesota's Individual Health Insurance Market," Minnesota Department of Health, Health Economics Program, October 2003.

- "Comprehensiveness of Benefits in the Small Group and Individual Markets," Minnesota Department of Health, Health Economics Program, October 2003.

- "Use of Health Services in Minnesota: Results from the 2001 Minnesota Health Access Survey," Minnesota Department of Health, Health Economics Program, February 2004.