Final Report to the Secretary

Health Resources and Services Administration
State Planning Grant Program

State of Minnesota
Department of Health

October 30, 2001

Health Economics Program
Health Policy and Systems Compliance
121 East Seventh Place, Suite 400
St. Paul, Minnesota 55101
(651) 282-6367
www.health.state.mn.us

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For more information, contact:
Health Economics Program, Health Policy and Systems Compliance
Minnesota Department of Health
121 E 7th Place
Po Box 64975
St. Paul, Minnesota 55164-0975

Phone: (651) 282-6367
Fax: (651) 282-5628

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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 nearly 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. However, the low overall rate of uninsured in Minnesota obscures the existence of higher rates of uninsurance among populations of color, American Indians, lower-income Minnesotans, and Minnesotans living in rural areas of the state.

Under the HRSA State Planning Grant, Minnesota conducted a series of research activities that has added significantly to the state's knowledge of its uninsured population. We focused our grant data collection activities around gaining a better understanding of the health insurance coverage status for groups at risk of having higher rates of uninsurance and for whom little previous information was known. In doing so, Minnesota used a variety of approaches to fill its knowledge gaps around coverage, including household and employer surveys, focus groups, key informant interviews, and surveys of former public program enrollees.

Research under the State Planning Grant

Research under Minnesota's State Planning Grant was structured to fill in knowledge gaps about Minnesota's uninsured population, with a focus on collecting better information about Minnesota's populations of color, American Indian population, and rural populations. We conducted both quantitative research, intended to statistically document coverage differences, and qualitative research, designed to gain a better understanding for some of the complex reasons why individuals in Minnesota lack health coverage. The following research projects were or are currently being conducted under the grant:

- Large-scale household telephone survey of approximately 27,000 Minnesotans;
- In-person household survey of 2,085 Minnesotans;
- Employer survey of 2,400 establishments in Minnesota;
- Focus groups (18) with Hmong, Somali, Hispanic/Latino, and American Indian Minnesotans;
- Focus groups with farm families;
- Key informant interviews with those familiar with or who work directly with the uninsured;
- Mail survey of those who have disenrolled from the MinnesotaCare subsidized health insurance program.

Summarized below are the primary findings from the various study components. Overall, however, integrating the quantitative and qualitative research yields several key themes from the SPG research:

- Minnesota's overall low rate of uninsurance masks wide disparities in coverage that exist between racial and ethnic groups , various geographic regions of the state, and among different age cohorts.
- The disparities that exist are the result of a series of complex and interrelated factors. These include:
    - A lack of awareness of public and private health offerings and eligibility requirements;
    - Complex administrative structures and applications for public health coverage;
    - Differential access to employer-based and private health coverage;
    - Differences in the cultural approach to the value of health insurance coverage;

- Lack of cultural sensitivity to the different ways in which different cultures approach health care and health coverage;
- Differences in viewpoints on the value of health coverage, relative to other expenditure choices.

✍ Access to public health insurance programs is hampered by administrative, cultural, enrollment, and eligibility barriers.

✍ Affordability emerged as a key theme.

The research conducted under the grant and findings from the research were as follows:

Household Telephone Survey:

The household telephone survey was a random-digit-dial survey of approximately 27,000 Minnesotans. The survey used a stratified random digit dial sample design; this strategy was chosen to allow for over sampling of certain geographic regions, populations of color, and American Indians. The primary findings from the Household telephone survey were:

✍ 5.4% of Minnesotans, or approximately 266,000 people, were uninsured at the time of the survey.

✍ Large disparities existed between the uninsurance rates of Minnesota's white population and racial and ethnic minority groups.
- 4.6% of Minnesota's white population lacked coverage at the time of the survey, compared to 15.6% of Minnesota's black population, 15.9% of American Indians, and 17.6% of Hispanics.
- 6.8% of white Minnesotans lack coverage at some point during the year, compared to 22.4% of black Minnesotans, 19% of American Indians, and 21.9% of Hispanic Minnesotans.

✍ Insurance disparities also exist between different regions of the State.
- The southeastern portion of Minnesota has the lowest uninsurance rate of 3.4%, while the mid-central, west-central, and northwest areas of Minnesota have rates of 8.8%, 7.6%, and 9.4% respectively

✍ Minnesotans not born in the U.S. are much more likely to lack health insurance coverage at some point during the year than those born in the U.S.
- 7.2% of Minnesotans born in the U.S. lack coverage at some point during the year, compared to 46.5% for those born in a Hispanic nation and 34.6% of those born in an African nation.

✍ Young adults are the age group most likely to lack health insurance coverage.
- 13.9% of persons age 18 to 24 lacked health insurance coverage at the time of the survey, compared to 5.4% overall.

✍ Approximately half of the uninsured in Minnesota are potentially eligible for a public health insurance program. Additional uninsured are eligible to enroll in employer-sponsored coverage.

Focus Groups with American Indians and Populations of Color:

Under the grant, Minnesota conducted focus groups averaging six to eight people per group with American Indian, Hispanic/Latino, Hmong, and Somali individuals. The purpose of the focus groups was to gain insight and information into attitudes about health coverage and why certain groups may have higher rates of uninsurance. Certain overall themes from the focus groups emerged:

- There is a general lack of knowledge about public health insurance programs;
- The stigma associated with government programs keeps people from using them;
- Opportunities to get jobs that have health insurance benefits are limited;
- Expenses associated with premiums, co-pays, and deductibles are prohibitive;
- The paperwork and recertification processes of public programs are cumbersome;
- New immigrants have difficulty understanding the health care system and the concept of insurance;
- New immigrants are fearful of encounters with government institutions, and also have concerns about deportation;
- There is limited cultural competency among professionals in public programs and the health care system in general;
- Many people believe they are treated disrespectfully by state, county, and health agency staff.

Key Informant Interviews:

MDH staff conducted a series of approximately 20 key informant interviews regarding uninsurance and access to insurance coverage. The key informant interviews consisted of qualitative, in-depth interviews of people possessing special knowledge of and access to the perceptions of people who are uninsured. The key findings from the key informant interviews were:

- For low-income people, insurance competes with many other considerations and is not always a priority.
- People who are potentially eligible for public insurance programs lack awareness of the programs, and many who know about the programs do not know they may be eligible.
- Administrative complexities keep people from enrolling in public programs, and contribute to people losing coverage after having been enrolled in a public program. The key informants also believed that enrollment workers need more training on program rules and eligibility.
- The system of public insurance and the provider system lack cultural competence. People of color and American Indians believe they are not treated respectfully, and stories about bad experiences cause some people to avoid the system as much as possible.

In addition, information from the employer survey, in-person household survey, and further analysis of the various focus groups and telephone household survey data will be available for the March report to HRSA.

Policy Options

Based on the findings from the research projects under the SPG, Minnesota has identified a number of areas for potential policy development. We have divided these into three primary areas: Private health insurance market, public programs, and options related to outreach, education, and cultural competency.

- Private market options:
  - Subsidies for low-income people to purchase private coverage;
  - Individual insurance market reform to make this market more accessible and affordable;
  - Extend ability for young adults age 18 to 24 to be covered as dependents under parents' health insurance policies.

- Public program options:
  - Expand MinnesotaCare eligibility to people whose employers subsidize less than 70% of premiums (current standard is 50%) or establish sliding employer-subsidy eligibility level;
  - Consider changing eligibility criteria for public insurance programs for seasonal workers and farmers;
  - Drop premium payment for American Indian children;
  - Improve retention of enrollees in public programs who continue to be eligible and lack other coverage options;
  - Increase administrative flexibility in application processes and in collecting premium payments;
  - Reduce frequency with which public program enrollees must recertify their eligibility.

- Options related to outreach, education, and cultural sensitivity:
  - Outreach and communication about the value of and need for health insurance;
    - Non-English outreach and education campaign
  - Improve cultural competency at all levels of the system;
  - Reduce stigma associated with public insurance programs.

RECOMMENDATIONS FOR THE FEDERAL GOVERNMENT TO EXPAND HEALTH COVERAGE

In addition to the options being considered at the state level, Minnesota has a number of recommendations for the Federal government surrounding action that could be taken at the Federal level to expand health coverage and support ongoing data collection activities of states.

The State of Minnesota proposes three coverage expansion options that involve changes in federal law or policy:

- **Offer federal tax credits for purchasing health insurance coverage.** We recommend that the federal government adopt a tax credit of sufficient size to encourage and enable individuals to purchase high quality health insurance coverage.

- **Increase the flexibility of the Centers for Medicaid and Medicare Services (CMS) in approving state Medicaid and SCHIP waivers.** Minnesota was encouraged by the recent announcement of the Health Insurance Flexibility and Accountability (HIFA) demonstration project initiative, and urges CMS to expand on initiatives such as HIFA that give states flexibility in establishing and administering health insurance programs.

- **Provide adequate funding for the Indian Health Service (IHS).** The state recommends adequate funding for IHS to ensure the provision of high quality health care services for American Indians living both on reservations and off reservations.

Minnesota also recommends that the Federal government support the work of state policy development and data collection on an ongoing basis. Specifically, we recommend the following:

- **Support for ongoing state-specific monitoring of the uninsured.** While the SPG has allowed Minnesota to collect a wealth of otherwise unavailable information, ongoing monitoring and tracking of progress at reducing the uninsured is equally important, and we recommend that the Federal government support such activities.

- **Encourage more timely and accessible release of state-specific estimates from federally-collected data sources.** While clear progress has been made recently at the federal level in improving estimates of the uninsured and conducting other research with state-specific estimates (e.g., employer surveys), information collected by the federal government needs to be available to state analysts in a manner that is both timely and allows for states to work with unaggregated data.

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

The purpose of this section is to describe (1) who the uninsured are in your State; (2) what strategy was used to obtain this information; and (3) how these findings are reflected in the coverage options that your State has selected or is currently considering. In discussing your survey findings, please be sure to link the results directly to your State's coverage expansion strategy.

More detailed survey findings (reports, spreadsheets, etc.), as well as survey instruments and other descriptions of the research methodology, should be referenced in Appendix II.

Questions 1.1 through 1.3 focus on the ***quantitative*** *research work conducted by the State. If possible, please use the Current Population Survey definitions and data breaks, even if alternate data sources are used. This will allow comparisons across all states in the summary report.*

1. Who are the uninsured in your state?

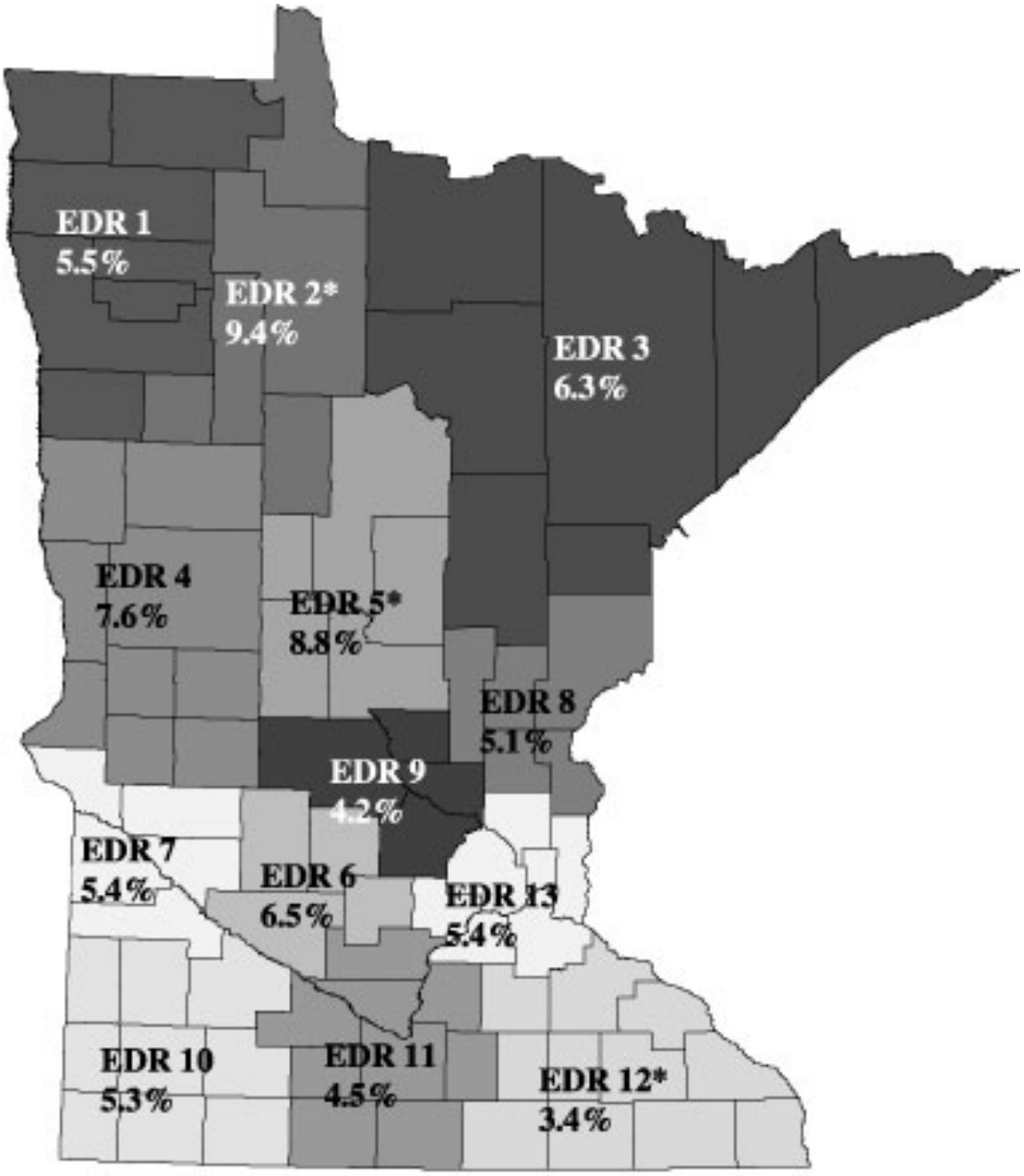
1.1 What is the overall level of uninsurance in your State?

The 2001 Minnesota Health Access Survey, funded by the State Planning Grant (SPG), is the largest and most comprehensive health insurance survey conducted in Minnesota to date. The survey results show that 5.4% of Minnesotans, or approximately 266,000 people, were uninsured at the time of the survey.

Approximately 3.1% of Minnesotans (or 152,500 people) had been uninsured for all of the previous year. In addition, about 4.7% of the population (or 231,500 people) reported having been uninsured for part of the previous 12 months, but not necessarily at the time of the survey. Thus, approximately 7.8% of Minnesotans (or 384,000 people) experienced some time during the past year when they did not have health insurance. (This percentage is the sum of the whole year and part year uninsured.)

Table 1.1 shows uninsurance rates for population groups of particular interest to the State of Minnesota using these four alternative definitions (point-in-time, uninsured all year, uninsured part of year, uninsured at some point during the year). In general, low-income populations, young adults, populations of color, American Indians, and foreign-born Minnesotans are more likely to be uninsured than their white, native-born counterparts. Uninsurance rates also vary widely by region of the state. Figure 1.1 shows uninsurance rates for 13 different geographic regions of Minnesota.

Table 1.1 2001 Minnesota Uninsurance Rates				
	Point-in-time	**Whole Year**	**Part Year**	**Some Point in Year**
State	5.4%	3.1%	4.7%	7.8%
Poverty Level				
0 to 100%	13.6%	8.4%	10.1%	18.5%
101 to 200%	16.0%	10.3%	11.8%	22.1%
201 to 300%	7.4%	4.3%	6.2%	10.5%
301 to 400%	3.7%	2.0%	3.9%	5.9%
401%+	1.5%	0.8%	2.0%	2.8%
Age				
0 to 17	4.5%	2.3%	4.1%	6.4%
18 to 24	13.9%	7.5%	12.9%	20.4%
25 to 34	9.2%	5.3%	8.5%	13.8%
35 to 54	4.9%	3.0%	4.0%	7.0%
55 to 64	2.9%	1.9%	1.7%	3.6%
65+	0.4%	0.3%	0.4%	0.7%
Race/Ethnicity				
White	4.6%	2.6%	4.2%	6.8%
Black	15.6%	9.9%	12.5%	22.4%
Asian	7.2%	3.2%	6.0%	9.2%
American Indian	15.9%	9.6%	9.4%	19.0%
Other Race	10.0%	6.0%	9.0%	15.0%
Hispanic	17.6%	12.4%	9.5%	21.9%
Country of Origin				
US Born	4.9%	2.7%	4.5%	7.2%
Hispanic nation	36.6%	29.4%	17.1%	46.5%
African nation	24.3%	17.8%	16.8%	34.6%
Asian nation	7.4%	3.1%	5.8%	8.9%
Other nation	6.4%	3.9%	8.7%	12.6%
Region				
1	5.5%	2.4%	5.4%	7.8%
2	9.4%	6.0%	5.8%	11.8%
3	6.3%	3.4%	6.1%	9.5%
4	7.6%	5.5%	3.8%	9.3%
5	8.8%	4.5%	7.4%	11.9%
6	6.5%	3.4%	5.3%	8.7%
7	5.4%	3.2%	4.1%	7.3%
8	5.1%	3.0%	6.8%	9.8%
9	4.2%	2.5%	4.3%	6.8%
10	5.3%	3.6%	4.1%	7.7%
11	4.5%	2.1%	3.9%	6.0%
12	3.4%	2.2%	3.3%	5.5%
13	5.4%	3.0%	4.7%	7.7%



1. Statewide average uninsurance rate: 5.4%

2. *significantly different from the statewide rate at 95% confidence level

3. EDR: Economic Develpment Region

4. Source: Minnesota Department of Health, Health Economics Program
2001 Minnesota Health Access Survey

Table 1.2 2001 Characteristics of the Uninsured in Minnesota					
	Point-in-time	**Whole Year**	**Part Year**	**Some Point in Year**	**Survey Population***
Poverty Level					
0 to 100%	13.1%	13.4%	11.0%	12.5%	5.2%
101 to 200%	35.6%	37.9%	30.0%	33.0%	12.1%
201 to 300%	27.1%	26.6%	26.0%	25.9%	19.7%
301 to 400%	11.1%	10.3%	13.6%	12.3%	16.4%
401%+	13.1%	11.8%	19.3%	16.4%	46.6%
Age					
0 to 5	4.8%	2.0%	7.0%	5.0%	7.1%
6 to 17	14.6%	15.5%	13.3%	13.7%	16.4%
18 to 24	21.8%	20.4%	22.9%	22.1%	8.6%
25 to 34	22.9%	22.9%	24.2%	23.2%	13.5%
35 to 54	30.1%	32.3%	28.4%	30.2%	33.4%
55 to 64	5.1%	6.0%	3.3%	4.7%	9.5%
65+	0.8%	1.0%	1.1%	1.1%	11.6%
Gender					
Male	52.5%	54.8%	47.1%	50.4%	48.2%
Female	47.5%	45.2%	52.9%	49.6%	51.8%
Family Composition**					
Single	39.5%	39.4%	33.7%	36.5%	16.9%
Married	40.2%	39.1%	46.3%	43.1%	69.0%
Living with Partner	10.4%	10.2%	10.6%	10.2%	3.7%
Divorced/Separated/Widowed	9.9%	11.2%	9.4%	10.2%	10.4%
Health Status					
Excellent	29.6%	30.8%	27.5%	28.6%	40.4%
Very Good	31.9%	28.3%	33.5%	31.7%	31.9%
Good	26.8%	26.6%	27.1%	27.1%	19.4%
Fair	9.3%	10.8%	10.0%	10.2%	6.2%
Poor	2.4%	3.6%	2.0%	2.5%	2.1%
Employment**					
Self Employed	19.1%	24.0%	9.5%	15.1%	10.8%
Employed by Someone Else	54.3%	51.4%	64.7%	59.5%	64.9%
Unemployed	21.0%	18.9%	19.8%	19.4%	8.0%
Retired	1.3%	1.3%	1.9%	1.7%	13.0%
Full-time Student	4.4%	4.4%	4.1%	4.3%	3.5%
Number of Jobs					
Work One Job	82.6%	81.4%	85.3%	83.7%	88.2%
Work Multiple Jobs	17.4%	18.6%	14.7%	16.3%	11.8%
Hours worked per week					
0 to 10 hours	1.8%	1.3%	1.5%	1.4%	1.5%
11 to 20 hours	7.5%	7.9%	7.0%	7.4%	5.0%
21 to 30 hours	14.1%	14.3%	10.1%	12.0%	6.8%
31 to 40 hours	48.6%	45.3%	50.5%	48.8%	48.3%

40+ hours	28.0%	31.2%	30.9%	30.4%	38.5%
Type of Job					
Permanent Job	80.9%	80.5%	88.4%	84.8%	95.4%
Temporary Job	10.8%	10.6%	6.6%	8.3%	2.5%
Seasonal Job	8.4%	8.9%	5.1%	7.0%	2.1%
Size of Employer					
1	15.3%	18.0%	8.2%	12.1%	7.2%
2 to 10	26.8%	30.9%	15.4%	21.5%	12.6%
11 to 50	17.5%	15.4%	18.9%	17.6%	14.3%
51 to 100	8.0%	6.1%	11.2%	9.5%	7.9%
101 to 500	13.5%	13.5%	15.1%	14.0%	16.6%
501+	19.0%	16.2%	31.2%	25.4%	41.4%
Race/Ethnicity* **					
White	78.0%	76.5%	82.7%	79.8%	92.1%
Black	9.5%	10.4%	8.7%	9.3%	3.3%
Asian	2.8%	2.2%	2.7%	2.5%	2.1%
American Indian	4.4%	4.6%	3.0%	3.7%	1.5%
Other Race	1.6%	1.7%	1.7%	1.7%	0.9%
Hispanic	10.4%	12.5%	6.3%	8.7%	3.2%
Country of Origin					
US Born	87.2%	84.6%	90.1%	88.1%	95.5%
Hispanic nation	6.5%	8.7%	3.3%	5.4%	1.0%
African nation	2.7%	3.4%	2.1%	2.5%	0.6%
Asian nation	1.9%	1.4%	1.7%	1.7%	1.4%
Other nation	1.8%	1.9%	2.8%	2.3%	1.5%
Region					
1	1.8%	1.4%	2.0%	1.9%	1.8%
2	2.7%	3.0%	1.9%	2.5%	1.5%
3	7.6%	7.1%	8.5%	8.0%	6.5%
4	6.0%	7.5%	3.4%	4.9%	4.3%
5	5.0%	4.5%	4.8%	4.7%	3.1%
6	2.8%	2.6%	2.6%	2.7%	2.4%
7	1.0%	1.1%	0.9%	0.9%	1.0%
8	2.6%	2.7%	4.0%	3.4%	2.8%
9	5.0%	5.3%	5.9%	5.5%	6.5%
10	2.4%	2.9%	2.2%	2.5%	2.5%
11	3.7%	3.0%	3.7%	3.7%	4.5%
12	5.7%	6.8%	6.5%	6.5%	9.4%
13	53.5%	52.2%	53.6%	52.8%	53.7%
Access/Eligibility** **					
Employer Access	22.7%	20.6%	30.9%	na	na
Public Program Eligible	49.6%	50.2%	48.1%	na	na
No Access or Eligibility	33.1%	33.9%	28.5%	na	na

* Characteristics/Demographics of the survey population to be used in comparisons to characteristics of the uninsured.

** Characteristics are based on adult responses and the responses of one parent of child respondents.

*** Distribution will add to greater than 100% as people were allowed to be categorized as more than one race/ethnicity.

**** Distribution will add to greater than 100% as some people may be eligible for public programs and have access to employer

Uninsured part year distribution is only of those part year uninsured at the time of the survey

1.2 What are the characteristics of the uninsured?

Table 1.2 shows the characteristics of the point-in-time uninsured, the whole year uninsured, the part year uninsured, and the uninsured at some point in the year from the household telephone survey. In general, the uninsured in Minnesota are more likely to:

- have incomes between 101% and 300% of the federal poverty level (62.7% of the point-in-time uninsured)
- be adults between the ages of 18 and 54 (74.8% of the point-in-time uninsured)
- be male (52.5% of the point-in-time uninsured)
- be in good to excellent health (88.7% of the point-in-time uninsured)
- be employed (73.4% of the point-in-time uninsured)
- work only one job (82.6% of the point-in-time uninsured)
- work 31 hours or more per week (76.6% of the point-in-time uninsured)
- have a permanent job (80.9% of the point-in-time uninsured)
- be either self-employed or work for an employer with 50 or fewer employees (59.6% of the point-in-time uninsured)
- be white (78.0% of the point-in-time uninsured)
- be born in the United States (87.2% of the point-in-time uninsured)
- live in the Twin Cities metropolitan area (53.5% of the point-in-time uninsured)
- be eligible for a public health insurance program (49.6% of the point-in-time uninsured)

1.3 Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?

Our survey data showed that a large proportion of the uninsured already have access to coverage, either through an employer or a public program. Therefore, a major focus of our development of options was finding ways to improve take up of employer-based coverage and to increase enrollment in public programs by people who are already eligible. We also targeted some of our options specifically to people who do not have access to employer coverage and are also not eligible for public programs (an estimated 33.1% of the point-in-time uninsured in Minnesota).

In developing coverage expansion options, Minnesota also paid particular attention to disparities in uninsurance rates across different populations. Given the disproportionately high uninsurance rates experienced by populations of color, American Indians, and foreign-born Minnesotans, several of the coverage expansion options being considered are specifically aimed at increasing health insurance coverage for these populations. Coverage options being considered in Minnesota have also been targeted for young adults and rural populations, who experience disproportionately high uninsurance rates.

*Questions 1.4 through 1.13 focus primarily on the **qualitative** research work conducted by the State:*

1.4 What is affordable coverage? How much are the uninsured willing to pay?

Our qualitative research work did not elicit any specific dollar amount as to what constitutes "affordable coverage." Focus group participants and key informants indicated that monthly premiums were a significant barrier to obtaining coverage. Many key informants also stated that they believed that people who seek health care from safety-net providers should be able to receive it at no cost.

Some of our quantitative research work was designed to provide information on "affordable coverage." Results from the survey of disenrollees from the MinnesotaCare program show that this population was generally satisfied with the amount that they had paid in premiums. However, this reflects only the opinions of people who have been in the MinnesotaCare program and not the uninsured population in general. Our in-person household survey will be completed by the end of the year and the results of this survey will include opinions about what dollar amounts constitute affordable coverage. The results from the in-person household survey will be included in the March update report to HRSA.

We are also conducting an analysis of consumer sensitivity to price in the decision to purchase health insurance. This analysis uses data from the telephone household survey to construct a model of consumer sensitivity to price in the decision to purchase individual health insurance coverage, to enroll in MinnesotaCare, or to remain uninsured. The results of this analysis will provide some insight into what consumers at various income levels consider "affordable coverage" by looking at their decision about whether to purchase coverage given the options available to them. The results of this analysis will be available for the March update report to HRSA.

We believe that it is important to further examine the question of affordability together with the issue of adequacy of coverage. We have applied for and received supplemental funding from HRSA to conduct additional research in these areas, and the results of that research will be included in the March update report to HRSA.

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

The focus groups and key informant interviews brought out many reasons why individuals and families sometimes do not participate in public programs for which they are eligible. These included:

- lack of awareness of public programs in general, and lack of awareness of one's own potential eligibility;
- finding the application process and other administrative procedures too difficult to negotiate;
- the belief that they do not need health insurance because they are healthy and not at risk for illness or injury;
- people feeling a lack of respect from the process or the people they interact with during the application process;
- shame and stigma associated with being on a public program;
- specific to American Indians, the belief that they are already entitled to health care services due to treaties between American Indian tribes and the U.S. government.

Results from the household telephone survey show that a large proportion of the uninsured who are eligible for public health insurance programs have not heard of or been given information about public programs in Minnesota. Approximately 42% of the uninsured who are potentially eligible for a public health insurance program have no knowledge of public health insurance programs in Minnesota. When asked if they would enroll in a public health insurance program if they knew they were eligible, 75.5% of the uninsured who are potentially eligible for a public health insurance program stated that they would enroll in a public program. Of those who stated that they would not enroll if they knew they were eligible for a public program, the following reasons were cited as reasons why they would not enroll: do not want to be on welfare (36.0%), do not want or need insurance/not sick (22.4%), will be getting private coverage

soon (18.6%), too much paperwork/invasion of privacy (11.8%), it is too expensive (1.4%), and various other reasons (9.8%).

1.6 Why do uninsured individuals and families disenroll from public programs?

Under the State Planning Grant, we conducted a survey of MinnesotaCare disenrollees who left the program 12 and 18 months prior to the survey. Survey results show that among those who voluntarily terminated their MinnesotaCare coverage, 64.5% obtained other health insurance coverage and 14.9% disenrolled because they could not pay the monthly premium. For disenrollees who were involuntarily terminated from the program, 31.7% indicated that they believed they were terminated because they had other health insurance coverage, 20.8% because they were no longer eligible, and 19.4% because they did not pay the premium.

Results from the MinnesotaCare disenrollee survey also show that about three-fourths (76.7%) of individuals who left the program had insurance at the time of the survey. Of those with insurance, over half (56.2%) had coverage through their own or someone else's employer. An additional 19.2% reported that they had re-enrolled in MinnesotaCare, and 13.9% indicated that they enrolled in other public programs. Of the 23.3% of disenrollees who were uninsured at the time of the survey, 38.4% had been uninsured for more than 12 months. Detailed results from the MinnesotaCare disenrollee survey are provided in Table 1.3.

1.7 Why do uninsured individuals and families not participate in employer-sponsored coverage for which they are eligible?

The results from the key informant interviews and focus groups found that some people are not participating in employer-sponsored insurance because they don't know they are eligible for coverage through their employer, or they find the cost-sharing required under employer policies too high. Some employees get coverage for themselves, but cannot afford to cover the cost of the premium to cover their family members.

Results from the household telephone survey show that a majority of the uninsured who are eligible for employer coverage do not enroll because they cannot afford the cost sharing. Approximately 54% of the uninsured who are eligible for employer-based health insurance coverage stated that they have not taken up employer coverage because they cannot afford it. Other than cost, the most common reasons cited by the uninsured for not taking up employer-based coverage are that they do not need or want health insurance (4.4%), that getting helath insurance is too much of a hassle or requires too much paperwork (3.4%), they expect to be covered by a health insurance policy soon (3.2%), and that they do not like the benefits (1.9%). Over 30% reported other, non-specified reasons for not taking up employer-based health insurance coverage.

Results from Minnesota's employer survey, which is not yet complete, will provide detailed information on cost-sharing for employer-based health insurance. This information will allow for an analysis of cost-sharing requirements that may help to explain why some employees do not enroll in coverage for which they are eligible. Data from previous surveys have shown that lower-income employees have to pay a higher portion of their income for employer-based coverage than do higher-income employees, and this likely affects the take-up rate among lower-income employees. Results from the employer survey will be made available in the March update to the HRSA report.

Table 1.3
MinnesotaCare Disenrollee Survey

Current Health Insurance Coverage?	%
Yes	76.7
No	23.3
If Covered, Source of Health Insurance?	
Through someone else's job	31.8
Through my job	24.4
MinnesotaCare	19.2
MA, Medicaid, PMAP, GAMC	7.5
Bought by me or someone else	5.9
Medicare	5.4
Other	2.8
Moved	1.9
MCHA	1.0
Indian Health Service	0.0
Length of Time without Health Insurance?	
Fewer than 3 months	15.8
3 to 6 months	12.1
6 to 9 months	15.5
9 to 12 months	18.2
More than 12 months	38.4
Termination of Coverage?	
I ended my MNCare coverage	53.3
MNCare ended my coverage	39.1
Both	7.6
Reason Voluntarily Cancelled?	
Got other insurance	64.5
Could not pay monthly premium	14.9
Other	6.6
Could get free health care	4.7
Moved	3.9
Not eligible	3.7
Did not use or need health care services	0.8
Did not like MNCare	0.6
Unhappy with health care services	0.3
Language barrier	0.1
Reason MNCare Cancelled?	
Have other insurance	31.7
Not eligible	20.8
Did not pay premium	19.4
Did not renew	13.1
Other	11.1
Do not know	3.4
Moved	0.6
Did not pay child support	0.0

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

Minnesota did not address this question in its data collection efforts under the State Planning Grant.

1.9 How likely are individuals to be influenced by:

Availability of subsidies?: Minnesota did not specifically address this question in its data collection efforts under the State Planning Grant. However, our in-person survey will report opinions about what dollar amount constitutes affordable coverage. This information could potentially be used to help set subsidy levels. Our analysis of consumer sensitivity to price in the decision to purchase health insurance will also provide information that will be useful in setting subsidy levels. Results from both the in-person household survey and the consumer sensitivity to price analysis will be reported in the March update report to HRSA.

Tax credits or other incentives?: Minnesota has not attempted to quantify the impact of tax credits on the purchase of health insurance; however, we believe that tax credits have the potential to be an effective tool in making affordable coverage options available to the uninsured. Results from the in-person household survey on affordable coverage and the analysis of consumer sensitivity to price in the decision to purchase health insurance will both provide information that could potentially be used to help set tax credits that would encourage the purchase of health insurance. However, given the large differences between state and federal tax rates, this option is most likely to be effective if enacted at the federal rather than the state level.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

Besides the issue of affordability, we learned from key informant interviews and focus groups that the following issues prevent people from purchasing health insurance:

- lack of awareness of public and private options and eligibility requirements;
- complex administrative structure and application process for public programs;
- difficulty in accessing information about programs and application process;
- lack of cultural sensitivity to minority group members and their needs;
- some people do not believe they need coverage, or decide that money is better spent elsewhere;
- lack of information about the costs of private coverage.

Results from the household telephone survey show that a majority of the uninsured say that they do not purchase health insurance because of cost. Approximately 62% of the uninsured state that they have not purchased health insurance because they cannot afford it. Besides affordability, the most common reasons cited by the uninsured for not purchasing health insurance are that they expect to be covered by a health insurance policy soon (6.1%), they are not eligible or were rejected (5.6%), they do not need or want health insurance (3.7%), and that getting health insurance is too much of a hassle or requires too much paperwork (3.5%). Nearly 18% reported other, non-specified reasons for not purchasing health insurance.

1.11 How are the uninsured getting their medical needs met?

The key informant interviews and the focus groups found that the uninsured in Minnesota are getting their medical needs met, to varying degrees, in the following ways:

- safety-net clinics and hospitals;
- paying out of pocket, which often entails going into substantial debt;
- forgoing medical and dental health services, particularly preventive services;
- in specific cultural groups, using alternative providers, such as a medicine man, shaman, or curanderos (healers in the Hispanic culture).

Results from the household telephone survey show that the uninsured are three and a half times more likely to lack a regular source of health care than the privately insured. Nearly 40% of the uninsured do not have a regular place that they go to receive health care services. However, although the uninsured are more likely to lack a regular source of care, the survey revealed no difference in reported emergency room utilization between the privately insured and the uninsured. This result is not consistent with anecdotal evidence from safety net providers; further research is needed to identify more clearly whether the uninsured are more likely to seek care in hospital emergency rooms.

1.12 What is a minimum benefit?

Minnesota did not address this question in its data collection efforts under the State Planning Grant. However, we have applied for and received supplemental funds from HRSA to study the issue of adequacy of insurance benefits for those who have coverage, and will report the findings of this work in the March update report.

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

The State of Minnesota has not established a definition of the underinsured. MDH has requested and received additional funding from HRSA to study the issue of underinsurance in more depth. Under this supplemental funding, we anticipate developing a definition or definitions of underinsurance, and attempting to identify the scope of underinsurance in Minnesota. As part of this effort, we will collect information from health insurance carriers in the state on their various benefit sets and enrollment in each to evaluate adequacy of coverage.

2. What strategy was used to obtain this information?

Listed below are descriptions of the quantitative and qualitative research methods used to gain the information reported in part one of this report.

<u>Household Telephone Survey:</u>

The household telephone survey was a random-digit-dial survey of approximately 27,000 Minnesotans. The survey instrument used was based on the Minnesota Health Access Survey developed by the University of Minnesota, School of Public Health, Division of Health Services Research and Policy. Previous versions of this survey were conducted in 1990, 1995 and 1999.

For the State Planning Grant, the survey was modified to add questions related to household insurance status, dental insurance, public program stigma, reasons for lack of insurance coverage, health service utilization, country of origin, and employment. The sampling design was structured to allow for adequate sample sizes from various regions of the state, populations of color, and American Indians. The survey used a stratified random digit dial sample design; this strategy was chosen to allow for over sampling of certain geographic regions, populations of color, and American Indians. Within each stratum, households and individuals within households were randomly selected to participate in the survey. The University of Minnesota, School of Public Health, Division of Health Services Research and Policy fielded the survey from November 2000 through May 2001.

In-Person Household Survey:

The in-person household survey was designed to supplement the household telephone survey. Stakeholders that we consulted during the study design process stated that telephone survey approaches have limitations, particularly with populations of color and American Indians. These limitations occur in part because of a lack of trust in researchers, the government, and outside groups in general. In addition, telephone coverage differs within communities around the state, and there is a potential for bias to be introduced if telephone coverage is not consistent across racial and ethnic groups. To address this concern, the in-person household survey was designed to survey African American, Hispanic, Asian, American Indian and White populations in Minnesota. In order to increase the level of trust and reliability of information gathered from populations of color and American Indians through the in-person interview, survey participants were interviewed by someone of the same race/ethnicity.

The household telephone survey was modified for use as an in-person survey. We added additional questions that we believed would provide useful information in the in-person format but that would be difficult to ask in a telephone survey. These questions related to affordability, public program stigma, cultural values and health care issues, and reasons for lack of insurance coverage. The survey used a sampling approach where households and individuals within households were randomly selected from geographically clustered areas of the state. The Wilder Research Center is currently conducting the in-person household survey. The survey is expected to be completed by the end of the year, with information collected under the survey being reported in the March follow-up report.

MinnesotaCare Disenrollee Survey:

The MinnesotaCare disenrollee survey was mailed to a random sample of individuals who left the MinnesotaCare subsidized health insurance program 12 and 18 months prior to the survey. The total sample for the survey was 2,500 individuals, and the sample was stratified by program eligibility type (families with children vs. single adults) and by date of disenrollment (either 12 months prior to the survey date or 18 months prior). The overall response rate was 31.8%. Statistical weights were developed to adjust for different probabilities of being selected for the survey by family type and disenrollment date. The weights also included adjustments for response bias by age, sex, geography, and income level as determined through administrative data. The survey was fielded from May 2001 to July 2001, and was conducted by staff at the Minnesota Department of Health.

Focus Groups with American Indians and Populations of Color:

Focus groups averaging six to eight people per group were conducted with American Indian, Hispanic/Latino, Hmong, and Somali individuals. The Hispanic/Latino focus groups were conducted under a contract with the University of Minnesota and the community organization HACER (Hispanic

Advocacy and Community Empowerment through Research). The American Indian, Hmong, and Somali groups were conducted in locations across the state under a contract with the Center for Cross-Cultural Health in Saint Paul, Minnesota. The Minnesota Department of Health arranged for focus group training for the moderators that these organizations hired to facilitate the focus groups. Each focus group was facilitated by a moderator and an assistant moderator who came from the same ethnicity/culture as the people in the group. These moderators and assistants were identified by the contracted organizations' connections with local community advocacy groups that work with people from the cultures we were studying. Groups for non-English speakers were conducted in the appropriate languages.

Moderators and assistants went through intensive 6-hour training sessions with Dr. Richard Krueger and Mary Anne Casey, expert trainers in the field of focus group research. The questions used in the focus group research were developed by MDH researchers working in close collaboration with the contracted agencies, the focus group training professionals, and community organizations that work with the cultures included in the study. Focus groups were conducted starting in May 2001, and concluded in August 2001.

Focus Groups with Farmers:

Because of some of the unique issues faced by rural farm families, the Minnesota Department of Health undertook a series of focus groups with farm families in Minnesota. The focus groups that were held with Minnesota farmers were organized and moderated by staff at the University of Minnesota in Crookston, a campus which works closely with farmers and on farm issues. The UM-Crookston staff attended a two-day training with focus group training professionals Richard Krueger and Mary Anne Casey. Crookston staff gave MDH staff feedback on the focus group questions, found farmers to participate in the focus groups, organized the logistics for carrying out the groups, and carried out the focus groups. Three groups were held in rural areas of northwest Minnesota, and three in rural areas of southwest Minnesota. These focus groups were held in July and August of 2001.

Key Informant Interviews:

MDH staff conducted a series of key informant interviews regarding uninsurance and access to insurance coverage. The key informant interviews consisted of qualitative, in-depth interviews of people possessing special knowledge of and access to the perceptions of people who are uninsured. The interviews were loosely structured, based on a list of topics and broad questions. Twenty interviews were conducted with individuals who frequently work with uninsured Minnesotans and those at high risk of becoming uninsured. These people were from professions that fall into four categories: health care providers, administrators, caseworkers/social workers, and community leaders/advocates.

3. How are these findings reflected in the coverage options that your State has selected or is currently considering?

The findings reported in this section guided the development of many of the coverage expansion options. As noted earlier, Minnesota's coverage expansion options are focused on 2 main areas: populations with disproportionately high uninsurance rates and populations that comprise a large proportion of the uninsured.

Large disparities in uninsurance rates exist for populations of color, American Indians, and foreign-born Minnesotans compared to white, native-born Minnesotans. Research findings suggest that large disparities in uninsurance rates may exist among these populations for a variety of reasons, including

differences in access to employer-based health coverage, differences in socioeconomic status, a lack of knowledge and understanding of public and private sources of health insurance coverage, issues of respect and cultural competency with public health insurance programs and throughout the health care system, and differences in beliefs around the value or need for health insurance coverage. Various coverage expansion options were designed to address these barriers to health insurance coverage. These include: outreach and education campaigns for public health insurance programs targeted for populations of color, American Indians, and non-English speaking Minnesotans; reducing the administrative complexity of public health insurance programs; improving cultural competency with public health insurance programs; and general outreach campaigns on the value of health insurance.

Results from the household telephone survey also show that young adults between the ages of 18 and 24 experience much higher uninsurance rates than other age groups. Young adults tend to have higher uninsurance rates than other age groups for a variety of reasons, such as the fact that they are transitioning from parental coverage to their own coverage, they are healthy and often do not see the value of purchasing health insurance compared to other spending priorities, and the entry-level jobs they work in may not include health insurance as a benefit. For those who attend college full-time, current Minnesota law requires that parental insurance coverage can be extended to the age of 24. For those who do not attend college full-time, parental coverage ends at age 18 or when the child graduates from high school. Results from the household telephone survey show that approximately 60% of uninsured adults between the ages of 18 and 24 said that they were uninsured because they were dropped from their parents' insurance coverage. As a way to increase health insurance coverage among young adults, Minnesota is considering two coverage expansion options. First, we are considering the option of outreach campaigns on the value of health insurance, focused on young adults. Second, we are examining the option of requiring the extension of parental health insurance coverage to age 24 for all young adults regardless of college enrollment.

Some regions of the state also experience higher uninsurance rates than others, and coverage options included in this report have been designed to increase insurance coverage in these areas of the state. In general, rural areas of Minnesota have higher uninsurance rates than urban areas of the state. Rural areas tend to have more self-employed and seasonally employed people who find it more difficult to get affordable health insurance coverage. Our research reports that farmers and migrant workers in rural Minnesota have a hard time finding affordable health insurance coverage and either do not qualify for public programs or do not want to enroll in public programs because they are skeptical of receiving governmental assistance. One coverage expansion option that the state is considering as a way to increase health insurance coverage is to examine and potentially adjust eligibility and asset requirements under the MinnesotaCare program that may limit the enrollment of farm families, migrant workers, and other seasonally employed workers in rural Minnesota. In addition, the state is examining ways in which to provide subsidies for those wishing to purchase coverage in the private market.

Another coverage expansion effort under consideration is to provide subsidies for low-income people to purchase private health insurance coverage. This option is targeted at increasing health insurance coverage among 3 main groups of low-income workers: workers who are self-employed; workers who do not have access to employer-based health insurance and who do not want to enroll in a public health insurance program; and low-income workers who have access to employer-based coverage, are ineligible for public health insurance programs, but do not enroll in private coverage because they cannot afford to pay the employee's share of the premium. Under this option, the state would consider subsidies for low-income people to purchase private coverage; the subsidy could be used to purchase coverage in the individual market, or it could be used to pay for the employee's share of an employer policy. Reforms in the individual market may also be considered to make this coverage more affordable or available to people who do not have the option to enroll in employer-based coverage. This option is intended to help

increase insurance rates among the majority of people who report that they have not purchased individual health insurance coverage because they cannot afford it. The enactment of federal tax credits for the purchase of health insurance would also make insurance more affordable for this group of the uninsured.

Currently, the uninsured may not enroll in MinnesotaCare if their employer offers health insurance and pays for 50% or more of the cost of dependent coverage. However, for a low-income worker who is offered insurance coverage through an employer, 50% of the premium may represent a substantial portion of the worker's income. As noted above, our research showed that many Minnesotans who have access to employer-based coverage and do not enroll say that it is because they could not afford their share of the cost. In addition to the option discussed above that would directly subsidize individuals to purchase private coverage, another option under consideration is to raise the cutoff point for employer-subsidized coverage at which families become ineligible for MinnesotaCare; for example, people whose employer subsidizes 70% or less of the cost of dependent coverage could be made eligible for MinnesotaCare rather than the current standard of 50%. Alternatively, the state could consider a sliding scale of employer subsidy for MinnesotaCare coverage; for example, a low-income person could qualify for MinnesotaCare even if their employer subsidizes 80% of the premium, while a higher-income person would only qualify if the employer subsidizes less than half of the premium.

Finally, a substantial proportion of the uninsured are also income eligible for public health insurance programs. Our research has shown that there are a variety of reasons why people do not enroll in public health insurance programs when they are eligible. Many of these reasons and related coverage options are discussed in detail above. Minnesota is also considering a variety of policy options designed to reduce the stigma associated with public insurance programs, such as changes in marketing strategies.

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

The purpose of this section is to document your State's research activities related to employer-based coverage: (1) what is the state of employer-based coverage? (2) how was the information obtained (surveys, focus groups, etc.)?; and (3) how are the findings reflected in the coverage options that have been selected (or are being considered) by the State?

*Questions within 2.1 focus on the **quantitative** research work conducted by the State:*

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do? For those employers offering coverage, please discuss the cost of policies, level of contribution, and percentage of employees offered coverage who participate.

Minnesota is conducting a survey of 2,400 employers in the state under the State Planning Grant. This survey is not yet complete, and so the information presented in this section of the report is based on Minnesota data from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.[1]

Table 2.1 summarizes the characteristics of firms that offer health insurance coverage compared to firms that do not offer coverage. About half (51%) of Minnesota establishments offer health insurance coverage. In general, establishments that are part of larger firms and higher-wage firms are more likely to offer health insurance coverage than establishments that belong to smaller, lower-wage firms. Establishments that offer coverage also have a higher percentage of their workforce employed full-time than establishments that do not offer coverage. Establishments in the Twin Cities metropolitan area are more likely to offer coverage than establishments in Greater Minnesota. The methodology employed in the 1997 RWJF survey and the 2001 survey does not allow for industry-specific estimates of offer rates of health insurance.

Table 2.2 presents information on the average cost of policies, level of employer contribution, percentage of employees who are eligible for coverage, and of those who are eligible the percentage that choose to enroll. In 1997, the average premium for single coverage was $157 per month, and the premium for family coverage was about $410. However, other data available to the State indicate that premiums have been rising rapidly with increases at or near double digits annually since 1998. The increases in premiums may also have affected employer contributions and employee take-up rates. Data from the 2001 Minnesota Employer Health Insurance Survey being conducted under the SPG will allow for an analysis of how the rapid premium increases of the last 4 years have affected the market for employer-based health insurance coverage.

On average, Minnesota employers contribute about 82% of the premium for single coverage and 70% for family coverage. As shown in Table 2.2, employer contributions vary by firm size. Among very small firms that offer health insurance coverage, the average share of the premium contributed by the employer was higher than for larger firms.

As shown in Table 2.2, a high percentage of employees who are eligible for coverage enroll. However, take-up rates vary across establishments, particularly for lower-wage vs. higher-wage establishments. For example, in establishments where the majority of permanent workers earned less than $7 per hour in 1997, only 74% of eligible employees accept an offer of employer-based health insurance. In comparison, about 89% of eligible employees in higher-wage firms enroll in coverage.

Table 2.1 Characteristics of Minnesota Establishments Offering and Not Offering Coverage

	Offering	Not Offering
Employer Size*		
Fewer than 10	44.1%	77.0%
10 to 49	29.8%	17.0%
50 to 199	11.6%	2.4%
200 or More	14.4%	3.6%
Total	100.0%	100.0%
Employee income brackets**		
Less than $10,000	2.8%	15.9%
$10,000 to $20,000	33.6%	52.8%
More than $20,000	63.8%	31.4%
Total	100.0%	100.0%
Average weekly hours worked per employee:		
0 to 19	2.3%	12.8%
20 to 34	5.1%	23.2%
35 or more	92.6%	64.0%
Total	100.0%	100.0%
Geographic location:		
Twin Cities MSA	68.8%	53.2%
Greater Minnesota	31.2%	46.8%
Total	100.0%	100.0%

Source: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey

*"Employer size" refers to total employment in the firm, rather than the establishment. Excludes self-employed.
**Based on survey data regarding wage distribution of permanent employees.

Table 2.2 Premiums, Employer Contributions, Eligibility and Takeup Rates in Minnesota

Average cost of policies (1997):	
Single coverage	$157 per month
Family coverage	$410 per month
Average level of employer contribution:	
Single coverage	82%
Family coverage	70%
Average employer contribution for single coverage, by firm size:	
Fewer than 10	91%
10 to 49	85%
50 to 199	83%
200 or more	80%
Average employer contribution for family coverage, by firm size:	
Fewer than 10	81%
10 to 49	68%
50 to 199	66%
200 or more	70%
In establishments offering coverage:	
% of employees eligible	83%
% of eligible employees who enroll (takeup rate)	88%
Takeup rates by firm size:	
Fewer than 10	85%
10 to 49	81%
50 to 199	85%
200 or more	91%
Takeup rates by wage level of firm	
Majority of employees earn:	
Less than $7 per hour	74%
$7 to $10 per hour	89%
More than $10 per hour	89%

Source: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey

*Questions 2.2 through 2.7 focus primarily on the **qualitative** research work conducted by the State:*

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

Minnesota has not yet conducted qualitative research to examine the factors that influence an employer's decision to offer coverage. However, the supplement to our original grant will allow us to conduct focus groups with small employers to determine which factors most influence their decisions. Two issues of particular importance are the factors that might influence an employer not currently offering coverage to begin to offer it, and the factors that might influence an employer to drop health insurance as a benefit. To date, we have not seen evidence of employers' dropping coverage in response to rapidly rising premiums, but there is anecdotal evidence that employers are adjusting benefit sets. In addition, there is some concern that a weakening economy could change employers' decisions about how they react to health insurance premium increases.

2.3 What criteria do offering employers use to define benefit and premium participation levels?

Minnesota has not examined this question under the State Planning Grant. Focus groups that we will be conducting with small employers under our supplemental grant will enable us to gain some insight into the criteria that employers use to define benefit and premium participation levels.

2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

When data from the 2001 Minnesota Employer Health Insurance Survey are available, the State will be able to compare this data to data from the 1997 RWJF employer survey to assess the effect that 4 years of rapid premium growth has had on employer offers of health insurance coverage, what types of policies and benefit sets are offered and how these have changed over time, as well as how employer contributions may have changed.

Other data available to the state suggest that the rapid premium increases have had a limited impact on employer coverage to date. For example, the number of Minnesotans covered under small group employer policies has continued to grow (although growth has leveled off, and there was a small reduction in the number of employer policies in place in the market during 2000).[2] However, recent deterioration in economic and labor market conditions lead the State to be concerned about future impacts on employer-based health insurance markets.

Employers have shown some interest in the concept of changing health insurance benefits to a system of "defined contribution," where the employer makes available a given dollar amount per employee, perhaps in the form of a voucher to be used in the individual market, an MSA account to be used at an employee's discretion, or as a fixed dollar amount per employee to be used towards the cost of health plans made available by the employer. Despite widespread discussion of this type of approach, there is no evidence to date of a significant shift in this direction in the employer-based health insurance market. Our 2001 Minnesota Employer Health Insurance Survey includes questions designed to measure the degree to which employers are seriously considering these approaches or have begun to implement them.

2.5 What employer and employee groups are most susceptible to crowd-out?

Minnesota did not directly address this question in our grant activities. However, we believe it is likely that employers who currently offer coverage and have a high percentage of low-wage workers would be most likely to drop coverage in response to an expansion of public programs. Evidence from the 1997 RWJF employer survey shows that among all employees who worked in establishments that offer health insurance coverage, only 6% were in establishments that are primarily very low-wage (less than $7 per hour) and an additional 17% worked for establishments where the majority of workers earn between $7 and $10 per hour.[3]

2.6 How likely are employers who do not offer coverage to be influenced by:

Expansion/development of purchasing alliances: We did not directly examine the issue of whether expansion or development of purchasing alliances would result in employers who do not currently offer coverage to begin offering insurance. The focus groups that we will be conducting under our supplemental grant will be helpful in examining this question, although national experience with and research into purchasing alliances suggests that their ability to make it significantly easier for employers to offer coverage is limited.

Individual or employer subsidies: Our research to date under the State Planning Grant does not directly address this question. The focus groups with small employers that we will be conducting this fall and winter will help to answer this question. We believe it is unlikely that subsidies directed at individuals would have a great impact in inducing employers to offer coverage who do not currently do so. Employer subsidies, if large enough, have a greater potential effect on employers' motivation to offer coverage. What is unclear is the degree of subsidy necessary to induce employers to offer coverage.

Additional tax incentives: Again, our grant activities have not directly addressed this question. The qualitative research we will be conducting with small employers will include questions related to this issue.

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

During Minnesota's 2001 legislative session, an initiative to create a reinsurance fund for small businesses that buy coverage through purchasing alliances was enacted. The reinsurance fund was created to partially cover large medical claims (the fund will pay 90% of claims in excess of $30,000 but the subsidy stops once the claim reaches $100,000). The reinsurance fund is only available to cover claims from firms with 10 or fewer employees that have not offered health benefits for at least a year prior to joining the purchasing alliance. It is hoped that the availability of funds to reduce large risks will make health insurance coverage more affordable to employers not currently offering coverage. There are 4 purchasing alliances currently registered with the State, but none has yet begun to sell insurance coverage.

2. How was the information obtained (surveys, focus groups, etc.)?

Employer Health Insurance Survey:

The 2001 Minnesota Employer Health Insurance Survey, funded by the State Planning Grant, is a survey of approximately 2,400 employers in Minnesota. Because comparability to previous Minnesota

employers was a primary goal of our research, the survey was based on the 1993 and 1997 Robert Wood Johnson Foundation Employer Health Insurance Surveys. The survey is stratified by establishment size and region of the state. The survey is being conducted by the University of Minnesota, School of Public Health, Division of Health Services Research and Policy.

Because of delays in fielding the survey due to the complexity of the survey and the need to first complete the telephone household survey, data collection for the 2001 Minnesota Employer Health Insurance Survey is expected to begin in November 2001.

Data on Minnesota's market for employer-based health insurance included in this report is from the 1997 RWJF Employer Health Insurance Survey.

3. How are the findings reflected in the coverage options that have been selected (or are being considered) by the State?

One coverage option that is being considered would provide subsidies for low-income people to purchase private coverage (either employer-based coverage or individual coverage). As described in section 1 of this report, this option is targeted at 3 main groups of people: self-employed workers; low-income workers whose employer does not offer coverage but who do not want to enroll in a public program (currently, low-income families and adults without access to employer-subsidized coverage are eligible for MinnesotaCare); and low-income workers who are offered coverage through their jobs but do not enroll because they cannot afford their share of the costs. Evidence from employer surveys and household surveys indicates that a significant portion of the uninsured in Minnesota (23%) have access to employer-based health insurance but do not enroll. The fact that take-up rates of health insurance in low-wage firms are low relative to other firms suggests that cost is a primary reason why some employees fail to take up coverage; this conclusion is also supported by data from the household survey in which a majority (56%) of the uninsured who are eligible for employer-based coverage stated that they did not enroll because of cost. Making the subsidy available to individuals rather than employers would make the subsidy invisible to employers, therefore limiting potential crowd out and potentially making individuals who may be concerned about the "stigma" associated with public subsidies more likely to sign up. In addition, rather than being tied to a particular employer, the subsidy would be portable so that individuals who leave their jobs are better able to retain access to insurance coverage.

Currently, people who have access to employer-based coverage where the employer contributes 50% or more to the cost of dependent coverage are ineligible for MinnesotaCare. However, 50% of a family health insurance premium can amount to a significant share of income for a low-income family (for example, at current premium levels it could be about 10% of income for a family with annual income of $30,000). In other words, some low-income families are ineligible for MinnesotaCare because of the fact that their employer makes coverage available at a subsidy level, but the employer coverage may not be affordable to them at that level. In addition to the option discussed above that would directly subsidize individuals to purchase private coverage, another option under consideration is to raise the cutoff point for employer-subsidized coverage at which families become ineligible for MinnesotaCare; for example, people whose employer subsidizes 70% or less of the cost of dependent coverage could be made eligible for MinnesotaCare rather than the current standard of 50%. This option could be implemented on a sliding scale so that the cutoff point is raised only for lower-income families and individuals.

Finally, as noted earlier in this section, rapid premium growth is leading employers to consider shifting to a defined contribution system for health insurance, rather than the current system which more closely resembles a defined benefit. If this type of shift begins to occur and the demand for coverage in the individual market rises, it is important to have an individual insurance market that functions well. This consideration is one factor that motivated the State to include individual insurance market reform as a policy option for reducing uninsurance.

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

The purpose of this section is to document your State's research activities related to the State's health care marketplace. The State should discuss (1) findings related to the marketplace; (2) how the information was obtained; and (3) how the findings affected policy deliberations in the State.

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?

To date, the State of Minnesota has not directly examined the question of adequacy of insurance coverage under our State Planning Grant. We will be examining issues surrounding the adequacy of insurance coverage this fall and winter using the supplemental funds that we have been awarded. The starting point for this analysis will be development of a definition of "inadequate insurance coverage."

3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?

The employer survey that we are conducting under the State Planning Grant will enable us to examine variation in benefits between small groups and large groups. While data from the 2001 employer survey funded by the SPG are not yet available, previous employer surveys in Minnesota have shown that benefits do vary by firm size; in particular, average deductibles are higher for employees in small firms than larger ones.[4] Other questions on Minnesota's employer survey about benefit levels, such as questions about benefits for physician and hospital services, are too general to provide a detailed picture of how coverage for specific services varies by firm size.

The area of greatest policy concern surrounding differences in benefits between fully-insured and self-insured firms is the degree to which coverage in self-insured plans includes state-mandated benefits. The employer survey data that we are collecting under our SPG project does not contain enough detail on benefits to address this question. Outside of the scope of our SPG project, we have reviewed both state-specific and national evidence on the degree to which benefits vary between fully-insured and self-insured employer plans. We concluded that self-insured firms do tend to include state-mandated benefits in their health plans.[5]

The State of Minnesota has not yet conducted a detailed analysis of differences in benefits between health insurance purchased in the individual market vs. the group market in Minnesota. The analysis of adequacy of coverage described in section 3.1 above will include an analysis of differences in benefits between individual and group policies, to the degree that this is possible with existing data sources.

3.3 How prevalent are self-insured firms in your state? What impact does that have in the state's marketplace?

Among firms that offer health insurance coverage in Minnesota, the share that offer a self-funded plan was 12 percent in 1997. However, employees in these firms represented 50 percent of enrollees in employer-based coverage in that year.[6] Since the 1997 employer survey, other data available to the State have indicated a rise in the percentage of Minnesotans with private health insurance who are enrolled in a self-funded plan, from 48 percent of the private health insurance market in 1997 to 51 percent in 1999.[7] However, it is not clear whether the rise is due to increasing numbers of employers choosing to self-fund, rising employment/enrollment at firms that already self-fund, or both. We will be able to better analyze this shift when data from the SPG-funded 2001 employer survey are available.

Self-funding of health benefits impacts the market in Minnesota in two primary ways. First, it limits the degree to which state policymakers can affect the type of coverage and benefits received by over one-third of the state's population, and over one-half of the private market; and second, it creates an inequity among firms that offer coverage because those that purchase coverage contribute to taxes and assessments that self-funded firms do not pay. These assessments include an assessment for the Minnesota Comprehensive Health Association (MCHA) and provider taxes.

3.4 What impact does your state have as a purchaser of health care (e.g., for Medicaid, SCHIP and state employees?)

Analysis of the State's impact as a purchaser of health care was beyond the scope of Minnesota's State Planning Grant. Substantial changes in the state's purchasing strategy for state employees have occurred over the last few years, including a shift to self-funding and proposed (still pending) changes to the benefit structure.

In addition, the State's decision to deliver the majority of Medicaid health care services via managed care plans has spurred reaction in more localized areas of the state in examining direct purchasing arrangements, which potentially have market effects.

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

The need for changes in current regulations will vary depending on the State's choice of policy options to reduce uninsurance (e.g. subsidies for low-income people to purchase private coverage; market reforms; improving take up of public programs or changing eligibility requirements). The option that would require the most regulatory change would be reforms in the individual market; it is not yet clear to what degree options to subsidize purchase of private coverage might also require market reforms and/or changes to state and federal regulations.

In addition, policy options such as subsidizing the purchase of individual coverage, or employer-sponsored insurance and other options will require the state legislature to act to give authority for such plans and therefore will require changes to current regulations, in addition to appropriate funding for these initiatives, should the legislature choose to undertake them.

3.6 How would universal coverage affect the financial status of health plans and providers?

The studies conducted under Minnesota's State Planning Grant did not directly address this issue. However, universal coverage would eliminate the significant financial difficulties faced by providers with high numbers of uncompensated care encounters. Health plans would also benefit from increased enrollment.

3.7 How did the planning process take safety net providers into account?

The State Planning Grant Advisory Committee extensively considered the role of safety net providers in delivering adequate health care services to Minnesotans. Some of the central goals for improving and supporting the safety net system included: securing adequate and consistent funding sources to deal with varying levels of demand, defining an acceptable level of uninsurance, equalizing service standards with those of the non-safety net system, developing a shared patient database for safety net providers, and formulating a method to cover medication costs.

In addition, the key informant interviews conducted under the grant included significant discussions with safety net or social service providers. Safety net providers were also consulted in the stages leading up to the submission of the grant application. Finally, concerns expressed about adequacy of insurance coverage, leading persons to seek services at safety net providers, helped to spur, in part, Minnesota's supplemental fund request to examine the adequacy of insurance coverage.

3.8 How would utilization change with universal coverage?

The State of Minnesota did not address this question within the scope of our State Planning Grant.

3.9 Did you consider the experience of other States with regard to: expansions of public coverage, public/private partnerships, incentives for employers to offer coverage, regulation of the marketplace?

We found other states' experience with regard to various approaches to subsidizing the purchase of private coverage (both individual and employer-based) to be particularly informative and valuable in designing our own policy options. We paid close attention to the experiences of Oregon, Massachusetts and others in this area, and many of the models under consideration grew directly out of the experiences of these states. We also learned from the experience of states that implemented various types of reform in the individual health insurance market during the last decade.

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

The purpose of this section is to provide specific details about the policy options selected by the State. Those states that have not reached a consensus on a coverage expansion strategy may answer questions 4.1 through 4.15 as applicable, but should focus primarily on questions 4.16, 4.18, and 4.19.

4.1 Which coverage options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

Minnesota has not yet selected specific strategies for reducing the rate of uninsurance. We have developed a set of options, each of which is targeted at a different aspect of the problem. In reviewing the options presented in this section, the following caveats should be kept in mind:

- Not all of the data collection efforts that were funded by the State Planning Grant are complete. As additional data is received and analyzed, we will be able to further refine our list of options. In addition, we will incorporate the results of activities we will be conducting under the supplement to our grant as they become available.
- Many of the options being considered require legislative changes before they could be implemented. Many of the options also require additional funding, which will have to be considered in the context of the State budget as a whole and other priorities of the Governor and the Legislature.

We received input on the options from a variety of sources, including the advisory committee for the State Planning Grant, staff at other state agencies (in particular, the Minnesota Department of Human Services), and the Governor's Health Policy Council.

The remainder of this section of the report presents detailed information on 12 policy options that are currently under consideration. These include:

- Private market options:
  - Subsidies for low-income people to purchase private coverage
  - Individual insurance market reform
  - Extend ability for young adults age 18 to 24 to be covered as dependents under parents' health insurance policies
- Public program options:
  - Expand MinnesotaCare eligibility to people whose employers subsidize less than 70% of premiums (current standard is 50%) or establish sliding employer-subsidy eligibility level
  - Consider changing eligibility criteria for public insurance programs for seasonal workers and farmers
  - Drop premium payment for American Indian children
  - Improve retention of enrollees in public programs who continue to be eligible and lack other coverage options
  - Increase administrative flexibility in application processes and in collecting premium payments
  - Reduce frequency with which public program enrollees must recertify their eligibility

- Options related to outreach, education, and cultural sensitivity:
  - Outreach and communication about the value of and need for health insurance
    - Non-English outreach and education campaign
  - Improve cultural competency at all levels of the system
  - Reduce stigma associated with public insurance programs

Private Market Coverage Options:			
4.1 Description of option	1. Subsidies for low-income people to purchase private health insurance	2. Individual insurance market reform, potentially including guaranteed issue, risk adjustment, and pooling	3. Extend ability for young adults who are not full-time college students to be covered as dependents under parents' policies
4.2 Target eligibility group	Uninsured people with incomes below 275% of the poverty level who: - Do not have access to employer-based coverage; or - Cannot afford cost-sharing requirements of employer-based coverage. Eligibility for subsidies for purchasing private coverage may include people who are currently eligible for public insurance programs but choose not to enroll; that is, option may allow for people to be given choice of enrollment in either public programs or employer-sponsored coverage .	All Minnesotans who are potential participants in the individual market. May include: - Current buyers of individual coverage; - Uninsured who could become eligible to receive subsidies to purchase private coverage; - Individuals receiving defined contribution/vouchers for health benefits from their employers.	Young adults ages 18 to 24 who are uninsured. Current Minnesota law allows dependents to be enrolled up to age 24 if they are full-time students. This proposal would extend eligibility as a dependent through age 24 regardless of school enrollment status.
4.3 Program administration	Subsidies would be paid to individuals, making the subsidy invisible to employers. Program may be administered by the MN Department of Human Services, which already administers the state's Medical Assistance program, or could also be administered by a private firm.	This proposal would create a single pool for coverage in the individual market. Coverage through the pool would be guaranteed-issue. Enrollees would have a choice of plans/providers through the pool. Payments to plans participating in the pool would be risk-adjusted. The pool would be administered through a private firm contracted by the State.	N/A

Private Market Coverage Options:			
4.1 Description of option	1. Subsidies for low-income people to purchase private health insurance	2. Individual insurance market reform, potentially including guaranteed issue, risk adjustment, and pooling	3. Extend ability for young adults who are not full-time college students to be covered as dependents under parents' policies
4.4 How will outreach and enrollment be conducted?	For people without access to employer coverage, outreach could be conducted through private insurance agents and brokers, as well as through the general outreach and marketing campaign described in option 10.	Not yet determined; enrollment and marketing could be done through agents/brokers.	Employers would notify their employees of the ability to keep their dependents enrolled through age 24.
4.5 What will the enrollee (and/or employer) premium-sharing requirements be?	Amount of subsidy not yet determined. One option would be to cap enrollee premium contributions at 5% of income and require employee to pay all insurance-related copayments and deductibles.	Will vary depending on policy chosen and enrollee income (see option 1).	To be determined by the private employer-based insurance market.
4.6 What will the benefits structure be (including copayments and other cost-sharing)?	Will vary, depending on policies chosen in individual market or policies offered by employer.	Products in the individual market would be standardized, but details have not yet been determined.	Will vary, depending on policies offered by employers.
4.7 What is the projected cost of the coverage expansion? How was this estimate reached?	Not yet determined. Two key considerations will be: - Subsidy level; and - Degree to which program enrollment is capped.	Not yet determined. Costs will include expenses related to start-up of the pool, developing standardized products, and developing risk adjustment mechanism.	Not yet determined. Maintaining younger, healthier people into the insurance pool may help to reduce the overall risk in the pool, but no actuarial estimates have been obtained yet. Most costs would be in the private sector, but there would be some cost to the State for the state employee group.
4.8 How will the program be financed?	Specifics have not been determined, but some combination of enrollee premiums, employer contributions, and state funds would be used. The state would also explore the possibility of obtaining federal match under SCHIP or Medicaid for this proposal.	Financing source for pool start up and other administrative costs undetermined.	Not yet determined.

Private Market Coverage Options:			
4.1 Description of option	1. Subsidies for low-income people to purchase private health insurance	2. Individual insurance market reform, potentially including guaranteed issue, risk adjustment, and pooling	3. Extend ability for young adults who are not full-time college students to be covered as dependents under parents' policies
4.9 What strategies to contain costs will be used?	No explicit cost containment strategy is built into this proposal, although most employer and individual policies require enrollees to pay copays and deductibles, which will help to contain cost by providing incentives for appropriate utilization of services.	No explicit cost-containment mechanism, but individuals will need to balance between benefit structure and premium costs.	N/A
4.10 How will services be delivered under the expansion?	Will vary, depending on the private health plan chosen by the enrollee.	Will vary, depending on the private health plan chosen by the enrollee.	Will vary, depending on the private health plan chosen by the enrollee.
4.11 What methods for ensuring quality will be used?	Not yet determined.	Not yet determined. The pool administrator would likely be expected by the State to meet certain targets or goals. The pool administrator would also be expected to provide comparative quality information to prospective enrollees in the various health plans participating in the pool..	Will vary, depending on the private health plan chosen by the enrollee.
4.12 How will the coverage program interact with other existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?	The subsidy program would be a private sector-oriented strategy for low-income individuals, some of whom may already be eligible for public programs but not enrolled. The subsidy program would provide an alternative for the uninsured who do not wish to enroll in a public program. Subsidy can be integrated with existing MNCare program to give people more options and to close gaps for those ineligible for MNCare.	With a subsidy for low-income individuals as proposed under option 1, the pool could become an alternative to public programs for some people. After the pool has matured, it might eventually become possible to fold in the State's high-risk pool.	As more young adults are able to maintain coverage through parental policies, this may reduce enrollment in Medical Assistance and MinnesotaCare. Potentially also would allow some persons currently in the MCHA high-risk pool to remain on employer policies. One limitation of this proposal is that state-level legislation would only apply to fully-insured employer plans, which enroll about half of employees who get coverage through their jobs in Minnesota.

Private Market Coverage Options:			
4.1 Description of option	1. Subsidies for low-income people to purchase private health insurance	2. Individual insurance market reform, potentially including guaranteed issue, risk adjustment, and pooling	3. Extend ability for young adults who are not full-time college students to be covered as dependents under parents' policies
4.13 How will crowd-out be avoided and monitored?	Not yet determined. Although strategies to monitor and avoid crowd-out will be needed, we believe that the potential for crowd-out on a large scale is limited. Depending on how the subsidy structure is established, will need to monitor to ensure that employers do not scale back on subsidy levels.	Strategies are still being developed to monitor and avoid crowd-out, although we believe that the potential for large-scale crowd-out is limited.	This change would encourage enrollment in private sector health insurance policies. Therefore, concern over crowd-out is limited.
4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?	Not yet determined.	Enrollment data to be collected by pool administrator.	Enrollment data to be collected by private employers and health plans.
4.15 How (and how often) will the program be evaluated?	Not yet determined, but evaluation strategy will need to consider several key issues, including: - Whether the subsidy is of an appropriate size to encourage low-income uninsured to purchase coverage; - Impacts on both the employer-based and individual health insurance markets; - Effectiveness of the subsidy program in reaching target populations; and - Administrative costs per person enrolled.	Evaluation strategy will need to include several key issues: - Monitoring enrollment and premiums in the individual market - Evaluating the effectiveness of the risk adjustment mechanism - Monitoring the effect of the pool on the number of health plans participating in the individual market - Estimating effect of pool on uninsured.	Not yet determined, but potential for future survey research to measure impact on uninsurance rates among young adults. The employer-based market would also be monitored to assess potential impacts in terms of changes in offer rates and benefits.

Private Market Coverage Options:			
4.1 Description of option	1. Subsidies for low-income people to purchase private health insurance	2. Individual insurance market reform, potentially including guaranteed issue, risk adjustment, and pooling	3. Extend ability for young adults who are not full-time college students to be covered as dependents under parents' policies
4.16 Major political and policy considerations, both for and against	Requires legislative change. Need to build support among private insurers and employers for this proposal. One major political and cost issue to decide would be whether subsidies will be available only to people who were previously uninsured, or also to low-income people who are currently paying a high percentage of their income to obtain coverage. Potential cost of proposal and source of financing would also need to be decided.	Requires legislative change. Need to build support among private insurers, agents and brokers for this proposal. Many key issues would need to be negotiated by the various stakeholders.	Requires legislative change. Current Minnesota law excludes young adults who are not full-time students from being enrolled as dependents on their parents' polices; at the same time, for young adults living with their parents MinnesotaCare eligibility requirements count the parents' income making it likely that some of these young adults are ineligible for employer-based insurance and also ineligible for MinnesotaCare. Employers would likely have some increased costs from dependents remaining on parents' policies. The extent of this cost is not yet known. Insurers may also have some concerns about potential risk selection among the group of young adults who would take advantage of this option.
4.17 Steps toward implementation (actions taken, remaining challenges)	No steps taken, although legislation has been introduced in the past several legislative sessions, but not enacted.	Initial evaluation of options for structuring the pool has been conducted; further study needed, including actuarial work to estimate impact on costs and coverage.	No steps taken.
4.18 Which policy options were not selected, and what factors led to this decision?	N/A	N/A	N/A

Private Market Coverage Options:			
4.1 Description of option	1. Subsidies for low-income people to purchase private health insurance	2. Individual insurance market reform, potentially including guaranteed issue, risk adjustment, and pooling	3. Extend ability for young adults who are not full-time college students to be covered as dependents under parents' policies
4.19 How will your State address the eligible but unenrolled in existing programs?	This private coverage initiative is, in some ways, specifically targeted to reach some of the uninsured who are eligible for public programs but choose not to enroll.	This initiative to make coverage in the individual market more available and affordable, in combination with potential for subsidies for low-income people, may be successful in reaching some people who are currently eligible for public programs but not enrolled.	N/A, this option is an expansion of coverage to people who are not currently eligible.

Public Health Insurance Program Options:			
4.1 Description of option	4. Change MinnesotaCare eligibility to include people with access to employer-subsidized coverage where the employer subsidizes 70% or less of the premium, or establish a sliding scale of employer-subsidy based on income.	5. Change MinnesotaCare eligibility criteria for seasonal workers and farmers. Specifics not yet determined, but could include: -considerations for seasonal workers; - examination of asset requirements for farmers	6. Eliminate enrollee premium requirements for American Indian children on MinnesotaCare
4.2 Target eligibility group	Low-income individuals who cannot afford their employer based coverage, but who are currently ineligible for MNCare because their employer subsidizes more than half the premium cost.	Seasonal workers and farmers who do not qualify for current public insurance programs.	This change would make MNCare consistent with SCHIP requirements that do not allow states to impose cost-sharing requirements. for American Indian children.
4.3 Program administration	Same as current MinnesotaCare program.	Same as current programs.	Same as current program.
4.4 How will outreach and enrollment be conducted?	Outreach would be conducted as part of general, broad-based outreach campaign described under option 10.	Outreach would be conducted as part of general, broad-based outreach campaign described under option 10.	Outreach strategy both as part of broad-based campaign, but also specific to American Indian communities in Minnesota
4.5 What will the enrollee (and/or employer) premium-sharing requirements be?	Same as current program.	Potential modifications to timing of premium payments to better reflect income of seasonal workers.	Enrollee premium payments for American Indian children would be eliminated under this option.
4.6 What will the benefits structure be (including copayments and other cost-sharing)?	Same as current program.	Same as current program.	Same as current program.
4.7 What is the projected cost of the coverage expansion? How was this estimate reached?	Not yet determined.	Not yet determined.	Not yet determined.
4.8 How will the program be financed?	Same as current program.	Same as current program.	Same as current program.
4.9 What strategies to contain costs will be used?	Same as current program.	Same as current program.	Same as current program.
4.10 How will services be delivered under the expansion?	Same as current program.	Same as current program.	Same as current program.
4.11 What methods for ensuring quality will be used?	Same as current program.	Same as current program.	Same as current program.

Public Health Insurance Program Options:			
4.1 Description of option	4. Change MinnesotaCare eligibility to include people with access to employer-subsidized coverage where the employer subsidizes 70% or less of the premium, or establish a sliding scale of employer-subsidy based on income.	5. Change MinnesotaCare eligibility criteria for seasonal workers and farmers. Specifics not yet determined, but could include: -considerations for seasonal workers; - examination of asset requirements for farmers	6. Eliminate enrollee premium requirements for American Indian children on MinnesotaCare
4.12 How will the coverage program interact with other existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?	Interacts with outreach, education and marketing initiatives. Obviously has an impact on current MinnesotaCare program.	This option interacts with proposals to increase flexibility in administrative processes, and with outreach, education and marketing campaigns.	Interaction with Governor's "Cover All Kids" initiative, and is a direct change to the current MinnesotaCare program. Also interacts with outreach, education and marketing initiatives, as well as initiatives to better retain public program enrollees who continue to meet eligibility requirements.
4.13 How will crowd-out be avoided and monitored?	Existing measures to deter crowd-out will likely be sufficient. It is possible that some employers could reduce their contribution to premium, but this is unlikely to be a widespread direct result of this proposal. We did not see large scale reductions in contribution when the existing MinnesotaCare program was established.	There would be a need to monitor crowd-out, but given the relatively small group of individuals involved, crowd-out is expected to be limited.	We would anticipate limited crowd-out, based on relatively small number of potentially eligible, and higher rates of uninsured among American Indians.
4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?	Same as current program.	Same as current program.	Same as current program.
4.15 How (and how often) will the program be evaluated?	Potential for survey research to monitor employee take-up rates, particularly among low-income workers.	Not yet determined.	Not yet determined.

Public Health Insurance Program Options:			
4.1 Description of option	4. Change MinnesotaCare eligibility to include people with access to employer-subsidized coverage where the employer subsidizes 70% or less of the premium, or establish a sliding scale of employer-subsidy based on income.	5. Change MinnesotaCare eligibility criteria for seasonal workers and farmers. Specifics not yet determined, but could include: -considerations for seasonal workers; - examination of asset requirements for farmers	6. Eliminate enrollee premium requirements for American Indian children on MinnesotaCare
4.16 Major political and policy considerations, both for and against	Requires legislative change. Many low-income workers are currently ineligible for MinnesotaCare, yet unable to afford their share of the cost of employer-based coverage. Some would be concerned about expansion of public health insurance program and its associated costs.	Requires legislative change. -Low-income seasonal workers may find it difficult to meet public program requirements such as length of residency or 4 months without coverage. -Farmers find it difficult to meet asset tests of MinnesotaCare because farm assets are counted toward the limit. -Would create special considerations that might raise some concerns about having consistent policies across populations. -Cost of program could also be a consideration.	Requires legislative change. This change would make MinnesotaCare more consistent with SCHIP requirements, which do not allow states to impose cost-sharing for American Indian children. Potential concerns with exempting a given group from paying MinnesotaCare premiums.
4.17 Steps toward implementation (actions taken, remaining challenges)	No actions taken.	No actions taken.	No actions taken.
4.18 Which policy options were not selected, and what factors led to this decision?	N/A	N/A	N/A
4.19 How will your State address the eligible but unenrolled in existing programs?	N/A, since this is a program expansion to people who are not currently eligible.	N/A, since this is a program expansion to people who are not currently eligible.	This option may encourage more eligible American Indian children to enroll in MinnesotaCare.

Public Program Options, continued			
4.1 Description of option	7. Improve retention of enrollees in public programs who continue to be eligible and lack other coverage options. Options likely to include ways to reduce "churning" of program enrollees.	8. Increase administrative flexibility in application processes and in collecting premium payments. This could include: - More flexibility in payment options: timing, payment method (e.g. credit/debit card), and location (e.g. retail stores). - Coordination of health insurance eligibility with other government programs, such as subsidized school lunch, WIC, housing subsidies, and earned income tax credit. -Lump sum payments for multiple months of enrollment at a reduced rate.	9. Establish 12-month recertification time period for those enrolled in Medicaid.
4.2 Target eligibility group	Public program enrollees who lose their coverage due to factors such as late premium payments/failure to pay premiums or non-compliance with recertification process.	Current public program enrollees, and people who are eligible but not enrolled in public programs.	Medical Assistance enrollees are currently required to re-certify their eligibility every 6 months. This results in some amount of "churning" in enrollment, some of which is directly related to recertification requirements.
4.3 Program administration	Administration would be done by DHS, as under current program.	Administration would be done by DHS, as under current program.	No additional program administration necessary; could save administrative work involved in re-enrolling people at a later point.
4.4 How will outreach and enrollment be conducted?	N/A, as this option pertains to current public program enrollees.	Outreach would be conducted as part of broader outreach and education campaign; additional outreach efforts through other government programs that provide assistance to low-income people.	N/A, as this option pertains to current public program enrollees
4.5 What will the enrollee (and/or employer) premium-sharing requirements be?	Same as current program.	Same as current program; however, would consider discount for lump-sum payment of premiums in advance.	Same as current

Public Program Options, continued			
4.1 Description of option	7. Improve retention of enrollees in public programs who continue to be eligible and lack other coverage options. Options likely to include ways to reduce "churning" of program enrollees.	8. Increase administrative flexibility in application processes and in collecting premium payments. This could include: - More flexibility in payment options: timing, payment method (e.g. credit/debit card), and location (e.g. retail stores). - Coordination of health insurance eligibility with other government programs, such as subsidized school lunch, WIC, housing subsidies, and earned income tax credit. -Lump sum payments for multiple months of enrollment at a reduced rate.	9. Establish 12-month recertification time period for those enrolled in Medicaid.
4.6 What will the benefits structure be (including copayments and other cost-sharing)?	Same as current program.	Same as current program.	Same as current program.
4.7 What is the projected cost of the coverage expansion? How was this estimate reached?	Not yet determined.	Not yet determined.	Not yet determined.
4.8 How will the program be financed?	Same as current program	Same as current program	Same as current program.
4.9 What strategies to contain costs will be used?	Same as current program.	Same as current program.	Same as current program.
4.10 How will services be delivered under the expansion?	Same as current program.	Same as current program.	Same as current program.
4.11 What methods for ensuring quality will be used?	Same as current program.	Same as current program.	Same as current program.
4.12 How will the coverage program interact with other existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?	Interaction with initiatives to increase administrative flexibility, and with outreach, education and marketing campaign.	Requires coordination with outreach, education and marketing campaign; and with activities to reduce stigma.	Interacts with and complements other efforts to retain public program enrollees who continue to be eligible and lack other coverage options.
4.13 How will crowd-out be avoided and monitored?	N/A	No specific plans in place, but monitoring would occur as now.	N/A

Public Program Options, continued			
4.1 Description of option	7. Improve retention of enrollees in public programs who continue to be eligible and lack other coverage options. Options likely to include ways to reduce "churning" of program enrollees.	8. Increase administrative flexibility in application processes and in collecting premium payments. This could include: - More flexibility in payment options: timing, payment method (e.g. credit/debit card), and location (e.g. retail stores). - Coordination of health insurance eligibility with other government programs, such as subsidized school lunch, WIC, housing subsidies, and earned income tax credit. -Lump sum payments for multiple months of enrollment at a reduced rate.	9. Establish 12-month recertification time period for those enrolled in Medicaid.
4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?	Same as current program.	Same as current program.	No data collection efforts planned.
4.15 How (and how often) will the program be evaluated?	Potential for future research similar to the MinnesotaCare Disenrollee Survey to determine reasons for leaving the program and what share of disenrollees may still be eligible and lack other coverage options. Also, since many people who disenroll frompublic programs end up re-enrolling, analysis could be done using administrative data to measure the degree to which "churning" of enrollment has been reduced.	Potential for research using administrative data to document changes in coverage patterns (enrollment, disenrollment, and length of enrollment spells), but frequency as yet undetermined.	Potential for research using administrative data to document changes in coverage patterns (enrollment, disenrollment, and length of enrollment spells), but frequency of evaluation as yet undetermined.

Public Program Options, continued			
4.1 Description of option	7. Improve retention of enrollees in public programs who continue to be eligible and lack other coverage options. Options likely to include ways to reduce "churning" of program enrollees.	8. Increase administrative flexibility in application processes and in collecting premium payments. This could include: - More flexibility in payment options: timing, payment method (e.g. credit/debit card), and location (e.g. retail stores). - Coordination of health insurance eligibility with other government programs, such as subsidized school lunch, WIC, housing subsidies, and earned income tax credit. -Lump sum payments for multiple months of enrollment at a reduced rate.	9. Establish 12-month recertification time period for those enrolled in Medicaid.
4.16 Major political and policy considerations, both for and against	May require legislative changes. Evidence from the MinnesotaCare Disenrollee Survey suggests that a sizable proportion of MinnesotaCare disenrollees have lost their coverage inadvertently, only to re-enroll after several months. Taking steps to better retain enrollees who remain eligible will reduce administrative costs and reduce "churning." It may also help to reduce the burden of uncompensated care in the state, as many people choose to re-enroll only after a medical need arises. One significant challenge will be in balancing the need to reduce administrative complexity with the need to maintain policies that deter crowd-out and ensure that the program is well targeted toward particular groups of uninsured. Also, potential costs will be consideration.	May require legislative changes. Providing flexibility with regard to premium payments would improve continuity of coverage and reduce "churning" in the program. Coordinating eligibility with other government programs offers significant potential for reaching people who are currently eligible but not enrolled in health insurance programs. Could be viewed as an expansion of existing program, and that may be a consideration given likely budget shortfall.	Requires legislative change. Stakeholders in Minnesota have long believed that the 6-month recertification requirement in Medical Assistance has resulted in unnecessary "churning" in the program and interruptions in coverage. The major policy consideration with this proposal is cost, which some past estimates have shown to be substantial.

Public Program Options, continued			
4.1 Description of option	7. Improve retention of enrollees in public programs who continue to be eligible and lack other coverage options. Options likely to include ways to reduce "churning" of program enrollees.	8. Increase administrative flexibility in application processes and in collecting premium payments. This could include: - More flexibility in payment options: timing, payment method (e.g. credit/debit card), and location (e.g. retail stores). - Coordination of health insurance eligibility with other government programs, such as subsidized school lunch, WIC, housing subsidies, and earned income tax credit. -Lump sum payments for multiple months of enrollment at a reduced rate.	9. Establish 12-month recertification time period for those enrolled in Medicaid.
4.17 Steps toward implementation (actions taken, remaining challenges)	No actions taken.	No actions taken.	No actions taken.
4.18 Which policy options were not selected, and what factors led to this decision?	N/A	N/A	N/A
4.19 How will your State address the eligible but unenrolled in existing programs?	N/A, as this strategy concerns current public program enrollees.	Improving and streamlining enrollment processes will help to encourage people who are eligible but not currently enrolled to apply for coverage; coordinating with other government programs will increase awareness of public insurance programs among people who may be eligible but not enrolled.	N/A

Options Related to Outreach, Education and Cultural Sensitivity			
4.1 Description of option	10. Outreach and communication about the value of health insurance and prevention; including a non-English outreach and education campaign	11. Improve cultural competency at all levels of the system	12. Reduce stigma associated with public programs
4.2 Target eligibility group	All Minnesotans, with focus on those groups of people who are least likely to be insured. This includes young adults (age 18-24), populations of color, American Indians, and new immigrants.	Populations of color and American Indians.	People who are eligible for public programs but do not enroll.
4.3 Program administration	Not yet determined.	Not yet determined.	N/A
4.4 How will outreach and enrollment be conducted?	Not yet determined, but parts of the campaign could be modeled on creative and successful "Target Market" campaign to reduce youth smoking.	N/A	Marketing campaigns that emphasize, for example, MinnesotaCare as "insurance for working families."
4.5 What will the enrollee (and/or employer) premium-sharing requirements be?	N/A	N/A	In MinnesotaCare, enrollee premium requirements have proven to be a powerful strategy to reduce potential stigma. This rationale is also part of the reason for considering subsidies for low-income people to purchase private coverage.
4.6 What will the benefits structure be (including copayments and other cost-sharing)?	N/A	N/A	For public insurance, same as current program; for subsidized purchase of private coverage, benefits will vary.
4.7 What is the projected cost of the coverage expansion? How was this estimate reached?	Not yet determined.	Not yet determined.	Not yet determined.
4.8 How will the program be financed?	Not yet determined.	Not yet determined.	Not yet determined.
4.9 What strategies to contain costs will be used?	N/A	N/A	N/A
4.10 How will services be delivered under the expansion?	N/A	N/A	N/A
4.11 What methods for ensuring quality will be used?	N/A	N/A	N/A

Options Related to Outreach, Education and Cultural Sensitivity			
4.1 Description of option	10. Outreach and communication about the value of health insurance and prevention; including a non-English outreach and education campaign	11. Improve cultural competency at all levels of the system	12. Reduce stigma associated with public programs
4.12 How will the coverage program interact with other existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?	Interacts with nearly all of the other options being considered.	These efforts will interact with: - Public health insurance programs, particularly the enrollment process; - Outreach, education and marketing campaigns; and - Efforts to reduce stigma associated with public programs.	This initiative would work to reduce stigma associated with public programs, and to create private market alternatives for the low-income uninsured. It also interacts with other education, outreach and marketing proposals.
4.13 How will crowd-out be avoided and monitored?	N/A	N/A	N/A
4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?	N/A	N/A	N/A
4.15 How (and how often) will the program be evaluated?	Not yet determined.	Not yet determined.	Potential for future survey research to evaluate effectiveness.
4.16 Major political and policy considerations, both for and against	To date, outreach and marketing campaigns have mostly been focused on public programs such as MinnesotaCare. This initiative differs in that it places an emphasis on: - Communicating the value of having health insurance; - Providing education about private coverage options that may be available as well as public programs; - Reducing confusion about the health care system and providing information on where to turn for help.	Many people avoid enrolling in public insurance because they believe they are treated disrespectfully or know someone who has been treated disrespectfully; in addition, some people avoid seeking medical care at all due to distrust of the system and a belief that the health care system does not understand their needs or culture.	Research under the State Planning Grant has documented the fact that some people do not participate in insurance coverage for which they are eligible because there is a stigma associated with the program.

Options Related to Outreach, Education and Cultural Sensitivity			
4.1 Description of option	10. Outreach and communication about the value of health insurance and prevention; including a non-English outreach and education campaign	11. Improve cultural competency at all levels of the system	12. Reduce stigma associated with public programs
4.17 Steps toward implementation (actions taken, remaining challenges)	While direct implementation has not occurred, discussions have begun within the Administration on how best to re-engage the public on the issue of health care reform and health coverage. We expect that this initiative would building on these previous initiatives.	2001 Legislature enacted a major initiative to reduce health disparities experienced between whites and populations of color and American Indians.	No steps taken yet.
4.18 Which policy options were not selected, and what factors led to this decision?	N/A	N/A	N/A
4.19 How will your State address the eligible but unenrolled in existing programs?	Outreach and education will increase awareness of the need for insurance and the options available, and thus encourage uninsured people who are currently eligible for coverage to enroll.	Improving cultural competency throughout the health care system will encourage some people who are currently eligible but not enrolled to apply for coverage.	This strategy is directly targeted toward currently uninsured who are eligible for public programs.

SECTION 5. CONSENSUS BUILDING STRATEGY

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved?

How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

The governance structure used in the planning process included the Uninsurance Study Advisory Committee that the State of Minnesota put together for guidance on our research of uninsured Minnesotans. The advisory committee is made up of representatives of local advocacy, provider, and governmental organizations. These include organizations that work with people from the following communities: Somali, Hmong, African-American, American Indian, Asian Pacific, Hispanic/Latino, immigrant, farmer, metropolitan county health agencies, community health, academic, and migrant worker. The committee has been meeting every six weeks, and has had a mediator from the Mediation Center at Hamline University to help guide the decision-making process.

The committee has worked quite well in reviewing the research data available thus far, pulling out key themes and barriers, and developing policy recommendations to address the issues. The committee plans to continue to meet after the submission of the final report to HRSA, in order to continue to refine options.

The Minnesota Department of Health identified the Minnesota Department of Human Services from previous working relationships as a key agency for involvement with our study. DHS has been working closely with MDH by reviewing and giving feedback on our research proposal, instruments, audiences, and other factors of the project. In addition, the Health Policy Council, a group made up of the commissioners of key state agencies, including the Minnesota Departments of Health, Human Services, Commerce, Finance, Revenue, Corrections, and other departments has provided an overall framework of guidance for the project.

Key constituencies (especially advocacy groups) were incorporated into the governance design by participating in the advisory committee. Special emphasis was given during the research design to ensure proper participation of ethnic and racial minority groups. MDH contracted with three organizations who work closely with such groups:

- The University of Minnesota School of Public Health, which subcontracted with HACER (Hispanic Advocacy and Community Empowerment through Research) to assist in the development of research questions and hire Hispanic/Latino moderators to lead Hispanic/Latino focus groups;
- The Center for Cross-Cultural Health, an educational, training, research, and consulting center, who worked with local minority advocacy groups to assist in the development of research questions, and to hire Hmong, Somali, and American Indian moderators to lead focus groups;

- ✍ The University of Minnesota Crookston, whose staff from the Farm Wrap program worked with local farmer organizations to assist in the development of research questions.

The Office of the Governor was involved in the application process for HRSA funding, and has been kept up to date about the project through the Commissioner of Health. Key officials from the legislative branch, especially members of health care committees, were kept informed of our study findings and process. We also briefed key members of the Legislature on the results of our telephone survey.

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meeting, policy forums, focus groups, or citizen surveys)?

The Uninsurance Study Advisory Committee was developed to obtain input from the public and key constituencies. Members of the committee have given input throughout the process. In addition, our contractors have worked with local advocacy organizations to get feedback from ethnic and racial minority groups on the study questions and procedures.

In addition, key study components discussed elsewhere in this report include focus groups and key informant interviews, in which participants were asked to share stories, experiences, and perspectives from constituencies. Finally, MDH will be meeting with key stakeholder groups this fall to brief them on the results of the surveys and studies, and to get their views and report on the best ways to move forward to implement policy options developed under the grant.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?

The organizations with which we contracted raised community awareness of the project by working closely with local advocacy groups. In addition, MDH has been involved in training interviewers and moderators, and has worked with these individuals to explain not only the particular study components, but the goals and methods of the overall project. MDH and one of our contractors, Wilder Research Center, has distributed news releases to the communities where the in-person survey is taking place, and explained the studies being conducted, and showed the early results of our telephone household survey. MDH has also traveled around the state to meet with chairs and tribal councils of many of the state's American Indian Reservations. This was done not only to get permission to carry out surveys on Indian lands, but also to build understanding of and support for our research projects and the usefulness of the information we will be gathering. This is part of MDH's broader goal of improving its relationships with the state's tribal governments.

MDH is also in the process of developing a public relations campaign to disseminate the results of the study projects once we have more data. Supplemental funds awarded to Minnesota under the SPG will help us continue to build on relationships that were developed during the study design and implementation, and especially follow up with study participants to make sure that they do not feel we have just used them as subjects and have then forgotten about them.

An MDH staff member hired under the SPG has also developed a Web site for the public to access information about our study. The web site address is: http://www.health.state.mn.us/divs/hpsc/hep/hrsa/spg.htm

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the state and the likelihood that the coverage expansion proposals will be undertaken in full.

The planning effort put into developing this research project on the uninsured in Minnesota has already had an effect on the overall policy environment. The department, along with the commitment of the Governor, has launched a major effort to reduce health disparities among racial and ethnic minorities in Minnesota.

While Minnesota continues to rank as one of the healthiest states in the nation, American Indians, populations of color, and foreign-born populations do not have the same levels of health as other Minnesotans. MDH is working hard to eliminate disparities and close health gaps, and ensure that all Minnesotans experience health parity. Public health at the state and local levels will be expanding our partnerships with those communities most adversely affected by health disparities. During the 2001 session, the Minnesota Legislature passed a major new initiative to reduce health disparities experienced between whites and American Indians and racial and ethnic minorities.

Overall, on a health policy level, the planning process and data developed under the SPG has become well-known and highly visible, and the information collected will shape policy in the state for years to come. Much of the information collected, particularly around populations of color and American Indians, is the first data available on these populations, and as such, will likely be useful and influential in the future.

Minnesota is still in the process of considering various policy options. Many of these options will require legislative change, and therefore the ability to build consensus around these options will be critical to their success. In addition, the degree to which coverage expansions can be undertaken will depend on the State's overall budget situation. Minnesota currently operates under tri-partisan government, with a Democratic Senate, Republican House, and Independent Governor. As a result, there is a variety of and often conflicting positions on a number of health policy issues, including the issue of expansion of health coverage. The planning grant brings valuable information to inform the debate around the issues.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

6.1 How important was state-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the state population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

State-specific data is critical to any decision-making process in Minnesota. Minnesota has a long tradition of using state-collected and -analyzed data to better understand its own health care market, and policy makers and stakeholders have come to rely on the availability of state data to make coverage expansion and other health care policy decisions. One of the purposes, in fact, of our decision to apply for a State Planning Grant was to develop better local-level information and better information about populations of color in Minnesota. This was done in order to give stakeholders and policy makers information on which to base decisions. In summary, state-specific data is absolutely critical in Minnesota to the policy-making process, and something Minnesota policymakers have come to expect.

Detailed information on specific subgroups of the population was very important in helping to identify the most appropriate coverage expansion options. The higher rates of uninsured in certain areas of rural Minnesota led us to emphasize the development of private insurance subsidies and individual market reform as options. Information on disparities in health insurance coverage and access, which were evident among sub-populations, led to a series of policy options around improving culturally-appropriate outreach and the redesign of some of the existing public health insurance programs.

The qualitative research, including focus groups and key informant interviews, was also very important in identifying stakeholder issues. The quotes from various participants in the qualitative research gave voice to the people behind the issues and illuminated particular perspectives from the various sub-populations who were participants in our research. This kind of research helps facilitate MDH's relationships with various local communities; the direct conversations that took place with groups and individuals helps to provide more effective follow-up, an important aspect of our program design, which is harder to achieve with some of the quantitative methods used. The qualitative research has proven to be most valuable in thinking about ways in which the cultural competency of the enrollment process for public health insurance programs can be achieved.

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

It is difficult to place a cost-benefit analysis on the various pieces of the data collection strategy. By design, Minnesota used a mixed approach to collecting data and information, with each piece -- whether qualitative or quantitative -- designed to elicit information that built upon or expanded another area of research. Our research design was intended to gain detailed demographic information about the uninsured from household surveys, and then to expand on our understanding of the reasons why certain groups might have higher rates of uninsurance. We did this by conducting focus groups and key informant interviews. To better understand why people

leave health coverage, we conducted the MinnesotaCare disenrollment survey. Therefore, because of the design of the research project, it really is not possible to separate out the pieces.

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g. excessive cost or methodological difficulties)?

Two of our data collection methods that were originally proposed and were not conducted have been postponed due to time constraints, and three projects that were originally proposed will not be conducted. Our survey of employers will go into the field in Novmber. The delay was largely due to the complexity of the survey tool. The analysis of consumer sensitivity to price has not yet commenced because the lead researcher on the project was heavily involved in activities growing out of the state Legislature.

We also had three activities that we originally proposed but did not conduct. We were unable to successfully conduct the employer-household link study because we were unable to get a high enough response rate from people when we asked them who their employers were. The study of the future of Minnesota's health care market place was unable to go forward because the proposed contractor was unable to find sufficient time to do the project due to other commitments, and a suitable alternative contractor could not be found in sufficient time. Finally, the longitudinal mail survey was dropped because the principal investigator on that study was unable to secure anticipated outside funding.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

For our telephone survey we designed the survey and the sample to improve our data collection from populations of color, American Indians, and rural populations. We oversampled certain geographic areas of the state to increase our sample size from populations of color, American Indians, and rural populations so that we could report results for these populations. We also conducted the telephone survey in English, Spanish, and Hmong to capture respondents who would otherwise not be able to participate in the survey.

For both the focus groups and the in-person survey, we used interviewers of the same ethnic/cultural background as the respondents. This helped to make the respondents feel more comfortable and at ease in participating in the research and in answering individual questions. We also conducted the research in the native languages of those whose first language was not English: Hispanic/Latinos, Hmong, and Somali people. This allowed people from these cultures to participate, when they would not have been able to if the questions were asked only in English.

In addition to our telephone survey, we conducted in-person surveys to elicit participation from those who do not have telephones, and those who prefer not to participate in telephone surveys. We anticipate that the in-person survey will increase participation from populations of color and American Indians. Stakeholders from these populations have stated that in-person surveys likely work better than telephone surveys in capturing the responses of these populations.

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does the state have plans to conduct that research?

To date, the State of Minnesota has not directly examined several issues relating to health insurance coverage. The following additional data collection activities are needed:

- Ongoing analysis of the uninsured and employer coverage;
- The ability to track, longitudinally, the encounters of the uninsured with the health care system;
- Preliminary analysis of options for reforming the individual health insurance market in Minnesota;
- Analysis of attitudes of young adults (18- to 24-year-olds) toward health insurance;
- Study of provider/health plan network arrangements;
- Study of the adequacy and comprehensiveness of health care coverage;
- Collection of information on small employers' offers of insurance coverage, the factors that influence decisions to offer coverage, their views on the importance of health coverage as an employee benefit;
- Exploration of employer buy-in model, with the possibility of increased federal funding flexibility.

The State of Minnesota has received supplemental funds from HRSA to examine some of these issues, and plans to conduct research on these topics during the fall and winter. Through this additional research and ongoing analysis of data already collected under the SPG, we anticipate conducting additional research over the course of the next several years to continue to explore ways to make coverage more available. The longitudinal tracking of the uninsured and their encounters with the health care system is something Minnesota proposed under our original SPG. We were unable to obtain expected outside funding for this project, and we will likely seek additional foundation dollars to conduct this research. Finally, tracking the uninsured is critical to measuring progress. We believe it is important to track both employer-based coverage and uninsurance over time, and believe the federal government should examine ways to support this on an ongoing basis.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the state proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

Throughout the process of working on the grant, MDH has learned the importance of working closely with, and getting input from, local advocacy and health care organizations that are dedicated to improving the health of specific populations of color and American Indians.

One of the lessons learned during the course of the study was the value of taking the time and efforts necessary to understand and establish relationships with cultural and ethnic groups who were the focus of the study. In particular, the Minnesota Department of Health invested a great deal of time and effort to gain the understanding and trust of the American Indian reservations and their tribal leadership. We believe this has paid off in their willingness to let us conduct our

research on their land. Especially at a time when many reservations believe they are "studied to death" and get no information back about the results of the studies, MDH invested much effort (especially from the Office of the Commissioner) to visit each reservation we proposed to work with, explain our study and its goals, and begin to build a relationship. This was done in conjunction with the department's larger goal of eliminating disparities and improving the relationships between the department and Minnesota's American Indian tribes.

Similarly, MDH chose to partner with contractors who had experience working with local community organizations whose mission is to improve the health of their population. Our contractors, in turn, worked with local community leaders at these organizations to help them recruit members of their communities to serve as both moderators and participants of our focus groups. The time and effort that went into forming these relationships and working with these organizations paid off in the quantity of participants and the quality of the results that were collected.

While most of the options under consideration have not directly resulted in changes to the health insurance programs in Minnesota, the data collected will bring some light to the issues of the uninsured and will potentially lead to changes into the future.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your state?

We are not yet at the point of determining key lessons learned about the insurance market and employer community because policy options are still at the "options" stage. Our employer survey has not been carried out yet, and we have not communicated with the insurance industry about our preliminary study results. These are issues which will be addressed in the March report.

6.8 What are the key recommendations that your state can provide other states regarding the policy planning process?

Minnesota has several key recommendations regarding the policy planning process:

- ✍ It is critical to have an advisory committee that is reflective of the populations being studied. We worked very hard to ensure that persons represented on the advisory committee were representative of populations such as the Hmong, Somali, Hispanic/Latino, rural, and American Indian—groups that were the focus of many of our grant activities. This has helped to foster a sense of buy-in on behalf of the advisory committee representatives and we hope, by extension, this will help to foster broader community buy-in.
- ✍ We found it important to brief and include key legislators during the process. While our advisory committee did not include direct legislative representation, it was important for MDH to keep certain key legislators aware of the progress of the studies and to brief them in advance of any data or new releases. We found support from both Democrats and Republicans for research that was being done.

- ✍ We also found that it was important to let the research findings guide the policy discussions. Had MDH or others ignored the data in developing policy options and recommendations, it is unlikely that broader consensus would have been reached. As a result, many of the policy options under consideration will need further refinement as more data are collected.

- ✍ The importance of having an unbiased group lead the analysis is important for buy-in from all groups. Because Minnesota operates under a tri-partisan government, the need for an unbiased, balanced group to lead the analysis was important for all parties to accept the findings of the study. While different groups may interpret or "spin" the data differently, no one has questioned the validity of the information, nor the importance of conducting the research. We believed this grant was an excellent opportunity to collect information to bring to policymakers about Minnesota's uninsured population, and to inform the policy debates around this issue.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

7.1 What coverage expansion options selected require federal waiver authority or other changes in federal law?

In addition to reforms the state is considering, The State of Minnesota proposes three coverage expansion options that involve changes in federal law or policy:

- ✍ Offer federal tax credits for purchasing health insurance coverage. In recent years, tax credits for the purchase of health coverage have been proposed as a way of expanding health insurance. The state believes that the federal government must take a leadership role in funding such credits. We therefore recommend that the federal government adopt a tax credit of sufficient size to encourage and enable individuals to purchase high quality health insurance coverage.

- ✍ Increase the flexibility of the Centers for Medicaid and Medicare Services (CMS) in approving state Medicaid and SCHIP waivers. Minnesota has long been a leader in creatively approaching the issues of health insurance coverage expansions. The MinnesotaCare program established in the early 1990s to provide coverage to working families is one example of this leadership. As we have made progress in reducing our rates of uninsured, and as we focus our efforts on further reductions, we must tailor solutions to meet the situations of the remaining uninsured.

  In the past, there has been limited flexibility given to states around issues such as benefit sets and cost-sharing related to the Medicaid program. Minnesota was encouraged by the recent announcement of the Health Insurance Flexibility and Accountability (HIFA) demonstration project initiative, and urges CMS to expand on initiatives such as HIFA that give states flexibility in establishing and administering health insurance programs.

- ✍ Provide adequate funding for the Indian Health Service (IHS). One of the clearest findings gathered during the development of research proposals for the grant application and from the research itself was the dissatisfaction among the American Indian community in Minnesota (comprising 55,000 people) with the way the federal government funds Indian health care and the Indian Health Service. There is a strong conviction in the American Indian community that treaty rights have guaranteed American Indians access to adequate health care services. Yet, the IHS lacks the funding it needs to deliver on this commitment.

  The state recommends adequate funding for IHS to ensure the provision of high quality health care services for American Indians living both on reservations and off reservations.

7.2 What coverage expansion options not selected require changes in federal law? What specific federal actions would be required to implement those options, and why should the federal government make those changes?

Recommendations for changes in federal law are described in section 7.1.

7.3 What additional support should the federal government provide in terms of surveys or other efforts to identify the uninsured in states?

The State of Minnesota has requested and received supplemental funds from HRSA to conduct more in-depth studies in several areas. These research activities build on the activities that were approved by HRSA in FY 2000, and they are necessary for the successful completion of our study project.

We also believe that support for on-going survey work for states that have a proven track record of effectively collecting and using survey and other health care research is critical. While the SPG has allowed for Minnesota to collect a wealth of otherwise unavailable information, ongoing monitoring and tracking of progress at reducing the uninsured is equally important.

Finally, while clear progress has been made recently at the federal level in improving estimates of the uninsured and conducting other research with state-specific estimates (e.g., employer surveys), information collected by the federal government needs to be available to state analysts in a manner that is both timely and allows for states to work with unaggregated data.

7.4 What additional research should be conducted (either by the federal government, foundation, or by other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

One research project that Minnesota was unable to conduct as part of the State Planning Grant activities was creating a link between employer and household survey data in order to better analyze the types of coverage available to the uninsured. Due to a low response rate to the question on our household telephone survey that asked participants to give us the name of their employer, we had to drop this part of the project. We would be interested in seeing more analysis and publication of the results of this portion of the Medical Expenditure Panel Survey (MEPS). We also believe that better information needs to be developed about actual encounters of the uninsured with the health care system. We therefore believe research that longitudinally tracks cohorts of the uninsured should be conducted.

Finally, we believe that more research is needed in order to adequately define and measure affordability of health insurance and the concept of underinsurance.

Endnotes

[1] Minnesota results from the 1997 RWJF Employer Health Insurance Survey are presented in more detail in "Employer-Based Health Insurance in Minnesota," Minnesota Department of Health, Health Economics Program, February 2000.

[2] "Health Insurance Premiums – An Update," Minnesota Department of Health, Health Economics Program, August 2001.

[3] "Employer-Based Health Insurance in Minnesota," p. 48.

[4] Based on results from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey. "Employer-Based Health Insurance in Minnesota," Health Economics Program, Minnesota Department of Health, February 2000, p. 26.

[5] "Mandated Health Insurance Benefits and Health Care Costs," Health Economics Program, Minnesota Department of Health, Issue Brief 2001-01, July 2001.

[6] "Employer-Based Health Insurance in Minnesota," February 2000.

[7] Health Economics Program estimates. 1999 is the most recent year for which estimates are currently available.

APPENDIX I: BASELINE INFORMATION

PLEASE PROVIDE THE FOLLOWING BASELINE INFORMATION ABOUT YOUR STATE (IF POSSIBLE). ALSO INCLUDE ANY ADDITIONAL BASELINE INFORMATION ESPECIALLY RELEVANT TO YOUR COVERAGE EXPANSION STRATEGIES.

- Population: 4,919,479 (2000 Census)
- Number and percentage of uninsured: 5.4%, or approximately 266,000 people (2001 Minnesota Health Access Survey, funded by State Planning Grant)
- Average age of population: Median age in 2000 was 35.4 (2000 Census)
- Percentage of population living in poverty (<100% FPL): 7.2% (2000 Census Supplementary Survey)
- Primary Industries: The top four industries as a share of Minnesota's Gross State Product are services (20.8%); finance, insurance and real estate (18.5%); manufacturing (18.1%); and wholesale and retail trade (17.6%). (1999 data from U.S. Department of Commerce, Bureau of Economic Analysis)
- Number and percent of employers offering coverage: Approximately 51% of private establishments in Minnesota offer health insurance coverage. This translates to approximately 65,000 employers. These estimates will be updated when the SPG-funded 2001 Minnesota Employer Health Insurance Survey is complete. (Offer rates from1997 RWJF Employer Health Insurance Survey; number of employers is data for fourth quarter 2000 from Minnesota Department of Economic Security).
- Payer mix: Outside of the scope of the State Planning Grant, Minnesota has developed estimates of health care spending in Minnesota by payer and type of service. Our estimates for the share of health care spending by payer in 1999 are as follows:

Public Sources	**40.2%**
Medicare	15.8%
Medicaid	17.7%
Other Public	6.7%
Private Sources	**59.8%**
Private Health Insurance	37.7%
Out of Pocket	18.3%
Other Private	3.8%

- Provider competition: As has happened across the country, the hospital market in Minnesota (in particular the Twin Cities metropolitan area) became increasingly consolidated during the

1990s. In 1999, three large multi-hospital systems controlled about 60 percent of the inpatient hospital market in the Twin Cities. Physician groups have also become increasingly consolidated, particularly in specialty care.[7] Because of concerns about the impact of consolidation on access to health care services and health care costs, Minnesota will be conducting additional analysis of provider competition and network arrangements between providers and health plans under the supplement to the original State Planning Grant.

- Insurance market reforms:

    - Small group market: Guaranteed issue and guaranteed renewal for small employer groups of size 2 to 50. Premiums may vary only by region, age, and health of the group. Premium rate bands and minimum loss ratios also apply.
    - Individual market: Guaranteed renewal, but no guaranteed issue. After initial underwriting, premiums vary only by age and region. Premium rate bands and minimum loss ratios apply.
    - High-risk pool: The Minnesota Comprehensive Health Association (MCHA) is the nation's oldest and largest high-risk pool. Consumers who are denied coverage in the individual market are eligible to enroll in MCHA. MCHA also functions as Minnesota's mechanism for complying with HIPAA's guaranteed availability of coverage for people leaving group plans. MCHA is funded through enrollee premiums and an assessment on private insurers; premiums cover approximately half of claims.

- Eligibility for existing coverage programs (Medicaid/SCHIP/other):

    - Medical Assistance (MA): provides coverage for children and families, low-income senior citizens, and people with disabilities. Total enrollment as of August 2001 was approximately 392,000.
        - Current income limits for children are as follows: under age 2, 280% of FPG; ages 2 to 5, 133% of FPG; ages 6 to 17, 100% of FPG.
        - Program expansions enacted in 2001 will make children ages 2 through 18 eligible for MA up to 170% of FPG beginning in July 2002. The income limit for parents and children ages 19 and 20 will also be increased to 100% of FPG. Asset limits for adults with children will also increase in July 2002.
        - Beginning in July 2002, children in families below 217% of FPG who lose MA eligibility can enroll in MinnesotaCare for one year without a premium, if they pay a $5 co-payment for some non-preventive services.
        - These changes enacted in the 2001 legislative session are projected to result in as many as 12,000 fewer uninsured children in Minnesota.
    - MinnesotaCare: provides coverage for Minnesota residents who do not have access to affordable health care coverage. Total enrollment as of August 2001 was approximately 138,000.
        - Families with children are eligible up to 275% of FPG, adults without children are eligible up to 175% of FPG.

- With certain exceptions, an individual must have been uninsured for at least 4 months and lack access to employer-subsidized coverage where the employer subsidizes 50% or more of the cost of coverage.

- General Assistance Medical Care (GAMC): provides coverage for low-income Minnesotans who do not qualify for MA or other state and federal programs – primarily low-income, non-elderly adults with no dependent children. Total enrollment as of August 2001 was about 27,000.
  - Income eligibility standard is currently 70% of FPG; increases to 75% of FPG in July 2002.

- Use of Federal waivers:

  - In June 2001, Minnesota received approval of a proposed waiver that would allow the State to access SCHIP funds to cover parents with incomes between 100% and 200% of federal poverty guidelines (FPG) in MinnesotaCare. While the approval of this waiver was not technically an expansion of coverage, the enhanced match that the State will receive under this waiver was instrumental in securing legislative approval in June 2001 for other Medicaid coverage expansions.
  - Other Section 1115 waivers that have been approved for Minnesota include the following coverage expansions:
    - Incorporation of MinnesotaCare coverage for pregnant women and children with income at or below 275% of FPG into the Medical Assistance (MA) program. This was later expanded to include parents enrolled in MinnesotaCare as well.
    - MA eligibility for one-year-olds determined using income standard of 275% FPG with no asset standard. (Also applies to pregnant women and children under age 1 under a state plan amendment.)
    - MA eligibility extended for one month for managed care enrollees determined ineligible for not submitting a completed household income report form or an eligiblity re-determination form.
    - Certain infants automatically eligible for MA up to age two without any reevaluation of eligibility.
    - Eligibility reviews postponed for certain postpartum women.

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

Indicate the web site addresses for any additional sources of information regarding your State's research work, including detailed data spreadsheets, cross-tabs, focus group and key informant interview summary reports, survey instruments, and summaries of research methodology.

Minnesota maintains a web site that provides information related to our work under the State Planning Grant. The web site can be accessed at:

http://www.health.state.mn.us/divs/hpsc/hep/hrsa/spg.htm

The web site provides background information on the project as a whole, the advisory committee to the project, and each of the data collection efforts that Minnesota has conducted under the State Planning Grant:

- Overall project description and factsheet, http://www.health.state.mn.us/divs/hpsc/hep/hrsa/projdesc.htm and http://www.health.state.mn.us/divs/hpsc/hep/hrsa/hrsafact.pdf
- Advisory committee, http://www.health.state.mn.us/divs/hpsc/hep/hrsa/uninsur.htm
- Household telephone survey, http://www.health.state.mn.us/divs/hpsc/hep/hrsa/telesurv.htm
- In-person household interview, http://www.health.state.mn.us/divs/hpsc/hep/hrsa/househld.htm
- Focus groups, http://www.health.state.mn.us/divs/hpsc/hep/hrsa/focusgrp.htm
- Employer survey, http://www.health.state.mn.us/divs/hpsc/hep/hrsa/emplsurv.htm

The SPG web site is still under construction, and additional materials will be added as they become available.

Other documents that are referenced in this report can also be located on the web site of the Health Economics Program, Minnesota Department of Health:

- "Employer-Based Health Insurance in Minnesota," February 2000, http://www.health.state.mn.us/divs/hpsc/hep/miscpubs/employersurvey.pdf
- "Health Insurance Premiums – An Update," August 2001, http://www.health.state.mn.us/divs/hpsc/hep/issbrief/2001-05.pdf

✍ "Mandated Health Insurance Benefits and Health Care Costs," July 2001, http://www.health.state.mn.us/divs/hpsc/hep/issbrief/2001-02.pdf