Report to the Secretary

Health Resources and Services Administration
State Planning Grants Program

State of Minnesota
Department of Health

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Executive Summary

Minnesota has long been a leader in health care innovations to expand access to affordable health insurance coverage. Through market reforms and the creation of MinnesotaCare, Minnesota has led the nation in implementing health care reform initiatives and served as a model for other states. As a result of efforts to reduce uninsurance through expansion of public programs, private market reforms, and above average levels of employer-sponsored health insurance coverage, Minnesota has long had among the nation's lowest overall rates of uninsurance.

Under the HRSA State Planning Grant (SPG) program, Minnesota has conducted a series of research activities that have provided valuable information on the state's uninsured population and health care markets. In Minnesota, the overall picture of health insurance coverage has changed significantly since our first SPG award in 2000. Slower economic growth, changes in employment patterns, and rising health care costs have contributed to declines in the share of the population with employer-based health insurance. Public program enrollment has increased in response to the decline in employer-based coverage, but the number of uninsured Minnesotans has also increased. The research that Minnesota has conducted with the support of the SPG program has enabled the state to gain a deeper understanding of these market trends and their impact, and critically examine the cost-effectiveness of policy options for addressing these issues.

Research Conducted Under the State Planning Grant

This report describes the research activities conducted during the most recent project period from September 2005 through August 2006. Activities conducted prior to this time period have been described in reports to the Secretary dated September 2005, November 2004, March 2002, and October 2001. Although the results of earlier work are not included in detail in this report, it is important to note that the activities described in this report build on the results of research conducted during previous project periods. The State Planning Grants program has allowed Minnesota to gain valuable new and updated information on its uninsured population and health care markets, and has enabled the state to critically examine the enrollment, cost, and market impacts of various policy options to reduce the number of uninsured Minnesotans. The following projects were conducted and/or completed during the time period covered in this report:

- Final report from the 2004 Minnesota Health Access Survey
- Study of uncompensated care funding sources
- 2006 Minnesota Employer Health Insurance Survey
- Small employer and individual market benefits survey
- Modeling of the enrollment, cost, and market impacts of different private market strategies for reducing the number of uninsured in Minnesota

In summary, the findings from these activities include the following:

- The 2004 Minnesota Health Access Survey found a significant decline in employer-based coverage from 68.3 percent 2001 to 62.9 percent in 2004. Enrollment in public health insurance programs increased from 21.2 percent in 2001 to 25.1 percent in 2004. The increase in public program enrollment did not completely offset the decline in employer-based coverage, resulting in a significant increase in the uninsurance rate from 5.7 percent in 2001 to 7.4 percent in 2004. Detailed results from this survey were provided in a February 2006 report that has been used extensively in Minnesota as a resource for discussion of the problem of uninsurance and potential ways to increase coverage.

- Results from the study of uncompensated care funding sources show that an estimated $253.9 million was spent on uncompensated care in Minnesota in 2004, including $151.3 million incurred by hospitals and $102.6 million incurred by clinics. For hospital uncompensated care, there are several sources of dedicated funding to help offset these costs. Federal, state, and local funding for hospital uncompensated care in Minnesota was approximately $131.1 million in 2004.

- Data collection for the 2006 Minnesota Employer Health Insurance Survey began in June 2006 and is expected to be complete by the end of October 2006, with initial results available in early 2007. Results from this survey will provide valuable information to policymakers regarding trends in the structure, premiums, and cost-sharing of employer-based coverage, and possible reasons for the recent decline in employer-based coverage in the state. Survey results will be included in Minnesota's final report to the Secretary in March 2007.

- Results from the small employer and individual market benefits survey show that over the past few years there has been a shift in enrollment toward plans with higher deductibles and out of pocket limits. As a result, individuals who have health insurance face a greater risk of having high out of pocket spending than they did just a few years ago.

- Among the different private market policy options modeled, the results show a wide range in the likely impact on the number of uninsured people and the cost per newly insured person. In general, the estimated cost per newly insured person is higher when income eligibility for subsidies is higher and when there are fewer crowd-out barriers included. The most cost-effective coverage option modeled to date (i.e., the option with the lowest cost per newly insured person) is a tax credit or voucher to purchase private health insurance. Other options, such as reinsurance for high-cost claims or subsidies to buy in to employer coverage, are estimated to result in fewer newly insured people at a higher cost per person.

Policy Options and Consensus-Building

Partly in response to research results showing that the uninsurance rate has increased, Minnesota is examining a range of policy options to reduce the number of uninsured Minnesotans. These options include both public health insurance programs and private market options similar to those described above. Minnesota is continuing to work with Dr. Gruber on modeling additional coverage options designed to cost-effectively enroll a greater number of uninsured Minnesotans in health insurance coverage. The modeling of alternative policy options that is currently in progress will contribute to a more in-depth understanding of the enrollment, cost, and market impacts of different coverage options. The results of this analysis will be used to advance discussion and consensus-building around increasing health insurance coverage in Minnesota. Results of this work will be included in the March 2007 final report to the Secretary.

At the request of the Governor's Health Cabinet in July 2006, the Minnesota Department of Health prepared and released a discussion paper on how much it would cost to cover the uninsured in Minnesota. In addition, health plans and physician groups have begun calling for policies to achieve universal health insurance coverage in Minnesota: Blue Cross and Blue Shield of Minnesota (BCBSM) has recently released a discussion paper on the need for universal coverage in Minnesota and has also been doing some modeling of various policy options; the Minnesota Medical Association (MMA) has also called for comprehensive health care reforms including universal coverage, and has convened several workgroups of key stakeholders to develop specific recommendations for reform proposals. Both BCBSM and MMA have used data produced by SPG-funded research in their reports and research on this issue. These activities by key stakeholder groups, along with high interest in health care reform as an election issue in Minnesota this year, are likely to lead to renewed discussion and debate about policy proposals to reduce uninsurance in Minnesota in the 2007 legislative session.

Lessons Learned, Recommendations, and Overall Assessment of SPG Program

In Minnesota, state-specific data and analysis have historically been an important part of health policy decision-making. Minnesota has a long tradition of using state-collected and state-analyzed data to better understand its own health care market, and policymakers and stakeholders have come to rely on the availability of state-specific data to consider coverage expansions and make health policy decisions. Support from the State Planning Grants program since FY 2000 has been critical to Minnesota's ability to collect and update state-specific information on health insurance coverage and health care markets; without this support, we would not have the high quality, up-to-date information that we need to support policy decisions. Data sources such as the CPS and BRFSS do not provide the level of detail that is necessary to monitor trends below a state level or understand the factors influencing health insurance coverage.

While the research that Minnesota has conducted using State Planning Grant funding has provided an invaluable source of data and information, equally important is the support for states to monitor trends in their uninsured populations and health care markets. For example, the ability to conduct a 2004 update to our 2001 household survey provided crucial information on changes in insurance coverage (and the reasons for those changes) that is not available from any other source. Without funding of data collection efforts through the SPG program, the outlook for future rounds of these valuable household and employer health insurance surveys in Minnesota is unclear.

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

A. Update on Project Activities Since September 2005 Report to the Secretary

Section 1: Uninsured Individuals and Families

The 2004 Minnesota Health Access Survey was partially funded by Minnesota's FY 2003 State Planning Grant. This telephone survey of 13,800 Minnesota households was completed in December 2004 and results from this survey were reported in Minnesota's September 2005 report to HRSA. A report providing detailed information on health insurance status, access to coverage, and characteristics of the uninsured by income, race/ethnicity, age, family status, and geography was released in February 2006. The survey results showed a significant decline in employer-based coverage, from 68.3 percent in 2001 to 62.9 percent in 2004. During the same period, enrollment in public health insurance programs increased from 21.2 percent of the population to 25.1 percent. The increase in public program enrollment did not completely offset the decline in employer-based coverage, resulting in a statistically significant increase in the percent of Minnesotans uninsured at the time of the survey (from 5.7 percent in 2001 to 7.4 percent in 2004). This is the first significant increase in the level of uninsurance in Minnesota that has been measured in over a decade of large household surveys. An in depth discussion of changes in health insurance status between 2001 and 2004 was provided in Minnesota's September 2005 report to the Secretary. Some detailed results from the 2001 and 2004 surveys are included in the Appendix to this report, and a link to the full report is provided as well.

In response to the results from the 2004 household survey, Minnesota has focused on examining the reasons for the decline in employer-based coverage and exploring policy options designed to increase private coverage. Minnesota is currently conducting an update to its 2002 employer health insurance survey using FY 2005 SPG funds in order to learn more about changes in Minnesota's employer-based health insurance market that may have contributed to the decline in employer-based coverage in the state. With FY 2004 and FY 2005 SPG funds, Minnesota contracted with Dr. Jonathan Gruber of MIT to create a microsimulation model based on the 2004 Minnesota Health Access Survey data to estimate enrollment and cost impacts of various coverage options. Results from the employer survey and modeling will be important to policymakers as they consider strategies to maintain or increase coverage.

With a rising number of uninsured in the state, it is important to gain a better understanding of how uninsured Minnesotans are currently getting care and how it is paid for. With FY 2005 SPG funds, Minnesota estimated the level of uncompensated care in the state and how it is funded. Using a method similar to that used by Hadley and Holahan[1], Minnesota estimated the amount and sources of funding for uncompensated care for 2004. An estimated $253.9 million was spent on uncompensated care in Minnesota in 2004, including $151.3 million incurred by hospitals and $102.6 million incurred by clinics. For hospital uncompensated care, there are several sources of dedicated funding to help offset these costs. Federal, state, and local

[1] Jack Hadley and John Holahan, "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?" Kaiser Commission on Medicaid and the Uninsured Issue Update, May 2004, and Jack Hadley and John Holahan, "How Much Medical Care Do The Uninsured Use, and Who Pays For It?" Health Affairs Web Exclusive, February 2003.

funding for hospital uncompensated care in Minnesota was approximately $131.1 million in 2004. Dedicated sources of funding for uncompensated care in clinics are more difficult to identify. Minnesota's Community Health Centers, where the uninsured represent about 40 percent of total patients, received about $24.2 million in federal, state, and local grant funding in 2004.

Table 1
Uncompensated Care

Estimated Cost of Uncompensated Care, 2004	
Hospitals	$151.3 million
Physicians and Clinics	$102.6 million
Total	$253.9 million
Dedicated Sources of Uncompensated Care Funding for Hospitals:	
Medicaid DSH	$42.2 million
Medicare DSH	$65.9 million
Local Tax Appropriations	$23.0 million
Philanthropy	$1.3 million
Total dedicated funding sources	$132.4 million

Section 2: Employer-Based Coverage

Minnesota is currently using FY 2005 SPG funds to conduct its 2006 Minnesota Employer Health Insurance Survey. The purpose of this survey is to update 2002 information on employer-based coverage and to explore the reasons for the significant decline in employer-based coverage discovered with the 2004 household survey. Minnesota has employer survey data from 1993, 1997, and 2002. As in prior years, the 2006 survey is collecting information from employers regarding offer rates, eligibility, enrollment, premiums, and enrollee cost sharing from a sample of all private employers in Minnesota. New information collected in the 2006 survey includes questions pertaining to the availability and structure of health savings accounts (HSAs). Data collection began in June 2006 and is expected to be complete by the end of October 2006, with initial results available in early 2007. Results from this survey will provide valuable information to policymakers regarding changes in the structure, premiums, and enrollee cost sharing requirements of employer-based coverage, and the possible reasons for the decline in employer-based coverage in the state. This information will be crucial for policymakers to have in considering policy options. Results from the survey will be included in Minnesota's final report to the Secretary in March 2007.

Section 3: Health Care Marketplace

With FY 2005 SPG funds, Minnesota conducted a survey of health plan companies to collect information on plans offered in the small group and individual health insurance markets

in the state. This survey was an update to a 2003 survey that was also conducted with SPG funds. The purpose of this survey was to collect detailed information on premiums, enrollee cost sharing, and benefits that is not feasible to collect through a survey of employers. The reason for focusing on the small group and individual markets for this study is related to concerns about the concentration of uninsured Minnesotans working for small employers, the adequacy of coverage in these markets, and the lack of a feasible mechanism to collect this information from health plans for large employer groups with fully insured and self insured plans. To our knowledge, Minnesota is the only state that has such extensive information on the benefit sets being purchased in its private health insurance markets, and the changes in benefit sets that have taken place over the past several years.

Results from the small employer and individual market benefits survey show that over the past few years there has been a shift in enrollment toward plans with higher deductibles and out of pocket limits. Figures 1 and 2 present summary information on benefit trends in the small group and individual markets, and how the benefit sets purchased in these markets have changed over the past few years. Enrollees in individual market products typically have less comprehensive benefits in comparison to the small group market in Minnesota. Unlike the small group market, nearly all enrollees in the individual market have a deductible and a majority of enrollees have a deductible of $1,000 or more. In both the small group and individual markets, there was a shift toward higher deductible plans between 2002 and 2005. These results are described in more detail in a February 2006 issue brief (referenced in the Appendix to this report).

Figure 1: Small Group Market Benefit Trends

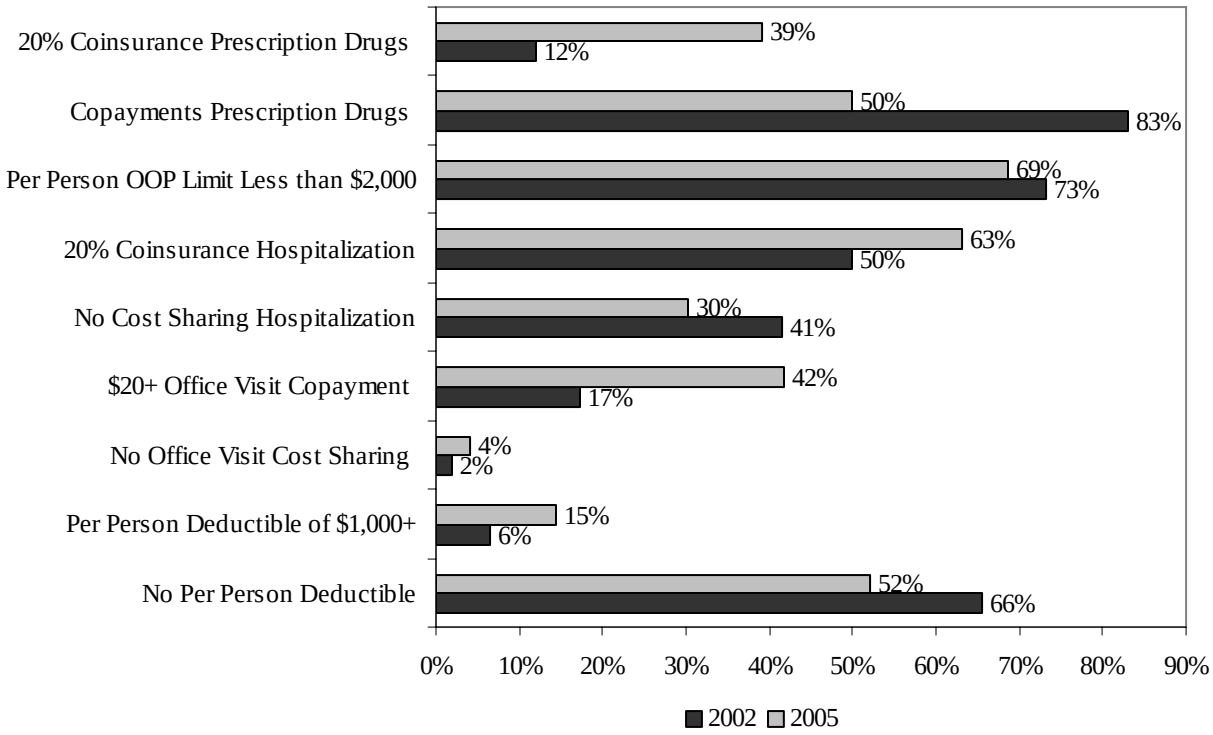
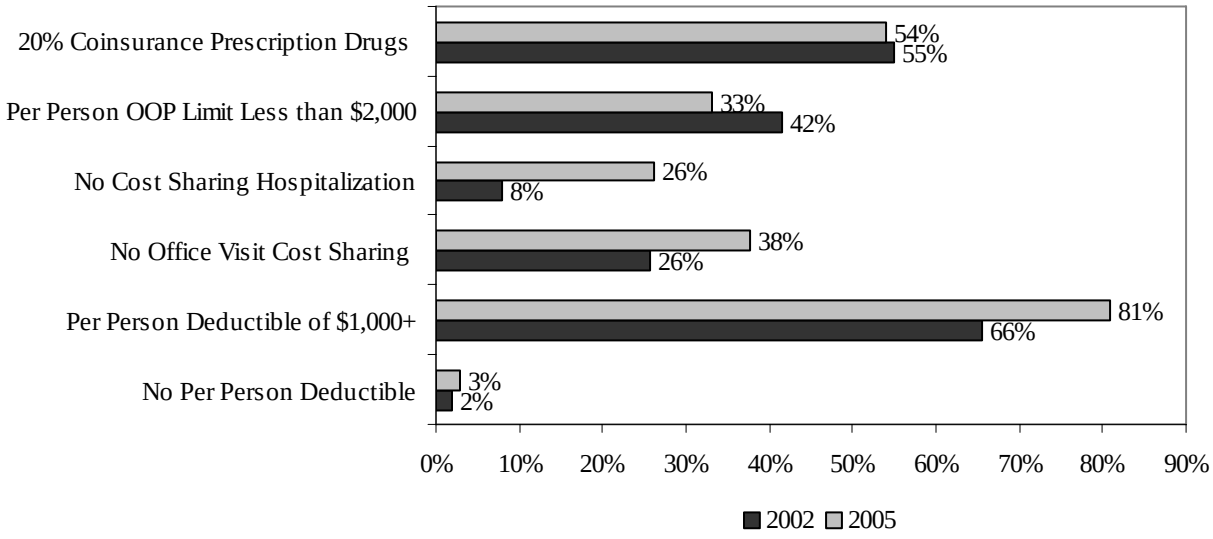


Figure 2: Individual Market Benefit Trends



Results from this study have shown that Minnesotans in the small group and individual markets are choosing health plans with more enrollee cost sharing. This trend is likely the result of health care cost increases and the desire of employers and individuals to reduce premium increases. As cost sharing increases, however, there is concern among some policymakers that it discourages people from seeking needed health care. Others see this trend and the growing enrollment in HSA products as a way to deter misuse of services, contain health care costs, and encourage small employers and the uninsured to purchase health insurance coverage with lower premiums.

B. Update on Policy Developments and Progress in Expanding Coverage

Section 4: Progress in Expanding Coverage and Policy Options

Minnesota has historically been a leader in expanding access to health insurance coverage. From the creation of the nation's first high-risk pool in 1976, to the creation of the Children's Health Plan (which eventually became MinnesotaCare) in 1987 ten years in advance of the federal SCHIP legislation, to market reforms that improved the availability and affordability of coverage in the small group and individual markets, Minnesota has led the nation in implementing health care reform initiatives designed to increase access to affordable health insurance coverage. These efforts to reduce uninsurance through expansion of public programs and private market reforms have been successful. Minnesota has the lowest uninsurance rate in the country and consistently ranks at or near the top of all states in health status.

For more than a decade, Minnesota saw stable rates of uninsurance when the national uninsurance rate was increasing. However, the 2004 household survey documented the first significant rise in the state's uninsurance rate since the survey was first conducted in 1990. Employer-based coverage declined from 68.3 percent in 2001 to 62.9 percent in 2004. During the same period, enrollment in public health insurance programs increased from 21.2 percent of the population to 25.1 percent. However, the increase in public program enrollment did not completely offset the decline in employer-based coverage, resulting in a statistically significant increase in the uninsurance rate (from 5.7 percent to 7.4 percent).

Research conducted in Minnesota during the 1990s suggested that most of Minnesota's uninsured population was eligible for coverage, either through an employer or a public program. The 2001 household survey conducted under the State Planning Grant confirmed this result, and the 2004 survey showed that this continues to be the case in Minnesota. In 2004, 20.1 percent of the uninsured were eligible for employer coverage and 59.1 percent were potentially eligible for a public program; only 25.9 percent of the uninsured were not eligible for coverage through a public program or an employer. Over 90 percent of uninsured children and uninsured people with incomes below 200% of poverty were estimated to be eligible for employer coverage or a public program in 2004.

Modeling of Coverage Options

As noted earlier, Minnesota used FY 2004 SPG funds to contract with Dr. Jonathan Gruber of MIT to create a microsimulation model based on the 2004 household survey data to estimate the enrollment and cost impacts of various coverage options. Six main coverage options have been evaluated. Some of the six main options also include variations on the size of employers eligible for the programs, income eligibility for the programs, and crowd-out barriers. The options focus primarily on private market strategies for reducing uninsurance, and are based on proposals that have been made in Minnesota in the past several years.

The six coverage options included:

- Tax credits or vouchers for low-income people to purchase individual coverage or pay the employee portion of an employer premium

- State paid reinsurance of a certain portion of claims as a way to reduce premiums for employers and especially small employers

- Subsidy to small employers to offer coverage to employees

- Elimination of mandated benefits as a way to reduce premium levels

- Allow small employers to participate in MinnesotaCare

- Subsidy to public program enrollees eligible for employer coverage to pay the employee portion of an employer premium

Among the different private market policy options modeled, the results show a wide range in the likely impact on the number of uninsured people and the cost per newly insured person. In general, the estimated cost per newly insured person is higher when income eligibility for subsidies is higher and when there are fewer crowd-out barriers included. The most cost-effective coverage option modeled to date (i.e., the option with the lowest cost per newly insured person) is a tax credit or voucher to purchase private health insurance. However, although the tax credit/voucher option is the most cost-effective of the coverage options modeled, it is estimated that up to half of the state cost of the tax credits would be spent on Minnesotans who already have health insurance coverage and the tax credits would only entice 11% of the uninsured to enroll in health insurance coverage. Other coverage options that have been modeled so far (such as reinsurance for high-cost claims or subsidies to buy in to employer coverage) are estimated to result in fewer newly insured people at a higher cost per person.

With FY 2005 SPG funding, Minnesota is continuing to work with Dr. Gruber on modeling and refining additional coverage options designed to cost-effectively enroll a greater number of uninsured Minnesotans in health insurance coverage. The modeling of alternative policy options that is currently in progress will contribute to a more in-depth understanding of the enrollment, cost, and market impacts of different coverage options. The results of this analysis will be used to advance discussion and consensus-building around increasing health insurance coverage in Minnesota, and will be included in Minnesota's March 2007 report to the Secretary.

Other Activities Related to Policy Options

At the request of the Governor's Health Cabinet, the Health Economics Program at the Minnesota Department of Health published a discussion paper on the cost to cover the approximately 383,000 Minnesotans who lack health insurance. Two very simplified examples of different policy approaches were used to illustrate the magnitude of the potential cost to the state to cover the uninsured population. The details that were used in preparing the estimates were chosen to represent two different approaches, and do not represent specific policy recommendations or proposals that have been made. In an approach that would use the existing

MinnesotaCare program to cover the uninsured, the potential cost to the state is estimated at $663 million. Under an alternative approach that would use sliding scale subsidies for the purchase of private coverage, the estimated cost is $851 million but could be less if the state were to structure this policy in a manner that would qualify for federal matching funds. These estimates were prepared as a means of providing broad guidance on the cost to cover the uninsured under different approaches, and to serve as a potential starting point for more detailed discussion about the likely impact of specific proposals.

Section 5: Consensus Building Strategies

During the time period covered by this report, Minnesota has not used SPG funds for any project activities specifically related to consensus building. However, results from the 2004 household survey have renewed interest in health care reform discussions and the development of coverage options. Results from the 2004 household survey have spurred discussions and the development of proposals from a variety of stakeholder groups including insurers, providers, and advocacy groups. Within the past year, each of these groups has proposed policy changes designed to increase insurance coverage. A wide range of options has been proposed, including changes to eligibility, benefits, and enrollee premiums for MinnesotaCare, providing universal public coverage for children, and mandating health insurance coverage. All of these groups have used data produced by SPG-funded research in their reports and research on this issue. These activities by key stakeholder groups, along with high interest in health care reform as an election issue in Minnesota this year, are likely to lead to renewed discussion and debate about policy proposals to reduce uninsurance in Minnesota in the 2007 legislative session.

C. Lessons Learned, Recommendations, and Overall Assessment of SPG Program

Section 6: Lessons Learned and Recommendations to States

In Minnesota, state-specific data and analysis have historically been an important part of health policy decision-making. Minnesota has a long tradition of using state-collected and state-analyzed data to better understand its own health care market, and policymakers and stakeholders have come to rely on the availability of state-specific data to consider coverage expansions and make health policy decisions. Support from the State Planning Grants program since FY 2000 has been critical to Minnesota's ability to collect and update state-specific information on health insurance coverage and health care markets; without this support, we would not have the high quality, up-to-date information that we need to support policy decisions. Data sources such as the CPS and BRFSS do not provide the level of detail that is necessary to monitor trends below a state level or understand the factors influencing health insurance coverage.

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

Section7: Recommendations to the Federal Government

While the research that Minnesota has conducted using State Planning Grant funding has provided an invaluable source of data and information, equally important is the support for states to monitor trends in their uninsured populations and health care markets. For example, the ability to conduct a 2004 update to our 2001 household survey provided crucial information on changes in insurance coverage (and the reasons for those changes) that is not available from any other source. Without funding of data collection efforts through the SPG program, the outlook for future rounds of these valuable household and employer health insurance surveys in Minnesota is unclear.

Section 8: Overall Assessments of SPG Program Activity

This section provides information on the policy impact that Minnesota's activities under the SPG program have had in Minnesota, the value of data collection activities that were funded by the SPG program, and feedback to HRSA on the technical assistance resources that were available to states as part of the SPG program.

Policy Impact

Minnesota has been an SPG grantee since the program began in 2000, and has conducted a wide range of activities using SPG funding, mainly focused on quantitative and qualitative research to inform thinking around a range of options for reducing uninsurance coverage. Like nearly all states, Minnesota experienced severe budget shortfalls during this time period, which created pressure to control state health care spending by changing eligibility, benefits, and other cost containment methods. At the same time, rapidly rising costs for private health insurance coverage, along with other changes in labor markets, made it difficult to sustain the strong market for private health insurance coverage that Minnesota has historically enjoyed.

Minnesota's early SPG research activities contributed to enactment of coverage expansions for children in 2001. At that time, eligibility for Medicaid was expanded to include all children ages 2 to 18 with family incomes up to 170% of federal poverty guidelines (the previous limits were 133% FPG for children ages 2 to 5 and 100% of FPG for children ages 6 to 17). In addition, the income limit for parents and children ages 19 and 20 was increased to 100% of FPG. Also in 2001, results from Minnesota's SPG-funded research contributed to enactment of a $10 million initiative to reduce health disparities.

As a result of a large projected budget shortfall for fiscal years 2004 and 2005, the 2003 legislature enacted changes in eligibility for public programs (partial rollback of 2001 coverage expansions for children, reducing automatic coverage for newborns from two years to one, elimination of coverage for undocumented immigrants in the state-funded General Assistance Medical Care program, and more frequent reviews of eligibility in MinnesotaCare). In addition, benefits for adults without children in MinnesotaCare were reduced – for example, new copayments were introduced and a $5,000 cap on benefits for outpatient services was put in place. The $5,000 cap on outpatient benefits was repealed in the 2005 legislative session.

In February 2006, the Minnesota Department of Health and the University of Minnesota School of Public Health jointly released a final report on the 2004 health insurance survey of Minnesota households, which was partially funded by the SPG program; the report on the 2004 survey included extensive comparisons to the 2001 SPG-funded household survey. As noted above, the report and its finding that the rate of uninsurance has increased in Minnesota have contributed to renewed interest and public debate on health insurance coverage and uninsurance in Minnesota. At the request of the Governor's Health Cabinet, the Minnesota Department of Health prepared and released a discussion paper on how much it would cost to cover the uninsured in Minnesota. In addition, health plans, providers, and advocacy groups have begun calling for policies to achieve universal health insurance coverage in Minnesota: for example, Blue Cross and Blue Shield of Minnesota (BCBSM) has recently released a discussion paper on the need for universal coverage in Minnesota and has also been doing some modeling of various policy options. The Minnesota Medical Association (MMA) has also called for comprehensive health care reforms including universal coverage, and has convened several workgroups of key stakeholders to develop specific recommendations for reform proposals. Both BCBSM and MMA have used data produced by SPG-funded research in their reports and research on this issue. These activities by key stakeholder groups, along with high interest in health care reform

as an election issue in Minnesota this year, are likely to lead to renewed discussion and debate about policy proposals to reduce uninsurance in Minnesota in the 2007 legislative session.

Value of Data Collection Activities

Compared to many states, Minnesota is heavily dependent on the availability of reliable, state-specific information for use in making policy decisions. Prior to Minnesota's first grant under the SPG program in 2000, much of the data on health insurance coverage came from surveys that were funded sporadically by foundations during the 1990s (for example, the Robert Wood Johnson Foundation household survey in 1993 and employer surveys in 1993 and 1997, along with state-specific surveys funded by the Blue Cross Blue Shield of Minnesota Foundation in 1995 and 1999).

Funding that Minnesota received through the SPG program enabled the State to update key sources of information on health insurance coverage and the employer-sponsored health insurance market, as well as to fill in key gaps in our knowledge of these areas. For example, the 2001 household insurance survey was designed to allow for analysis of racial and ethnic disparities in insurance coverage, as well as variation across geographic regions within Minnesota. As noted earlier, data from the 2001 household survey was instrumental in the passage of a coverage expansion initiative for children and an initiative aimed at reducing health disparities.

The household survey was updated in 2004, with partial support from the SPG program. The 2004 update showed that the rate of uninsurance had risen from 5.7 percent in 2001 to 7.4 percent in 2004, the first statistically significant increase recorded since the first large Minnesota-specific health insurance survey was conducted in 1990. The value of these large state-specific surveys of health insurance is difficult to overstate: it is virtually impossible to detect year to year changes in the overall level of uninsurance using other publicly available state-level estimates (e.g., Current Population Survey), nor is it possible to use these data sources to analyze variations and changes within different population groups or to detect the impact of policy changes. Similarly, the large Minnesota-specific surveys of employer health insurance conducted using SPG funds (a telephone survey in 2002, and a mailed survey in 2006 that is currently in its final stages) have enabled the state to monitor and analyze trends in employer health insurance coverage, variation within the state, and the reasons for change over time, in a manner that is more detailed and more useful to policymakers than is possible using data from other sources (e.g., MEPS Insurance Component). Data from both the household and employer surveys are widely used by many stakeholder groups within Minnesota as the most reliable sources of information on health insurance coverage in the state.

Without funding of data collection efforts through the SPG program, the outlook for future household and employer health insurance surveys in Minnesota is unclear. It may be possible to repeat the mailed employer survey in the future at minimal cost, but the household telephone survey is very expensive and it is not clear at this point whether there will be a source of funding for future rounds of data collection.

Value of Technical Assistance

Without a doubt, Minnesota benefited substantially from the technical assistance resources that were available to SPG grantees. Participation in Academyhealth's State Coverage Initiatives meetings provided excellent opportunities to learn about other states' policy initiatives related to health care coverage, and to hear from experts about emerging trends and their implications for health care coverage and cost containment. HRSA SPG grantee meetings were also useful, although they may have been most useful for states with less history of expanding health insurance coverage and less experience in collecting and analyzing data to inform policy. Minnesota benefited significantly from the technical assistance provided by SHADAC, including efforts specific to our SPG-funded projects as well as general technical assistance available to all states (e.g., conference calls). AHRQ's MEPS-IC staff were also very helpful as a resource for states. Minnesota did not participate in the Arkansas Multi-State Integrated Database System project.

D. Appendix:

Table 1: Summary of Minnesota Uninsurance Rates by Population Group		
	2001	2004
Total Population	5.7%	**7.4%**
Age		
0 to 17	4.6%	5.4%
18 to 24	13.7%	**18.9%**
25 to 34	9.7%	**13.0%**
35 to 54	5.3%	**6.8%**
55 to 64	2.8%	3.5%
65+	0.4%	0.3%
Race/Ethnicity		
White	4.8%	**5.9%**
Black	16.4%	12.8%
Asian	6.8%	9.8%
American Indian	16.8%	21.0%
Hispanic/Latino	17.6%	**34.2%**
Region		
1 Northwest	6.0%	8.0%
2 Headwaters	10.7%	10.9%
3 Arrowhead	6.5%	8.5%
4 West Central	7.3%	10.0%
5 North Central	9.2%	11.2%
6 Mid-Minnesota	7.3%	7.3%
7 Upper MN Valley	5.5%	9.4%
8 East Central	5.0%	**9.3%**
9 Central	4.3%	5.2%
10 Southwest	5.1%	9.1%
11 South Central	6.0%	5.0%
12 Southeast	3.4%	5.4%
13 Twin Cities	5.7%	**7.4%**
Family Income, as % of Poverty Guidelines		
0-100%	14.0%	**20.5%**
101-200%	13.2%	14.1%
201-300%	6.7%	**8.6%**
301-400%	3.7%	4.7%
401%+	1.9%	1.9%

Sources: 2001 and 2004 Minnesota Health Access Surveys
Bold indicates statistically significant difference between 2001 and 2004 at the 95% level

Table 2: Demographic Characteristics of the Uninsured				
	Uninsured		Total Population	
	2001	2004	2001	2004
Age				
0 to 5	5.6%	7.2%	8.2%	7.8%
6 to 17	15.7%	**10.9%**	18.2%	17.0%
18 to 24	22.4%	25.9%	9.4%	10.2%
25 to 34	23.1%	23.3%	13.7%	13.3%
35 to 54	28.3%	28.0%	30.3%	30.5%
55 to 64	4.0%	4.3%	8.2%	**9.2%**
65+	0.9%	0.4%	12.1%	12.1%
	100.0%	100.0%	100.0%	100.0%
Race/Ethnicity[1]				
White	75.7%	**70.1%**	90.7%	**88.7%**
Black	12.0%	**7.6%**	4.2%	4.4%
Asian	3.9%	4.8%	3.2%	3.6%
American Indian	5.1%	5.6%	1.7%	2.0%
Other Race	1.0%	**0.2%**	0.4%	**0.1%**
Hispanic/Latino	9.0%	**15.1%**	2.9%	3.3%
	see note	see note	see note	see note
Family Income, as % of Poverty Guidelines				
0-100%	17.1%	**26.3%**	6.9%	**9.5%**
101-200%	35.4%	31.5%	15.3%	**16.6%**
201-300%	22.9%	20.6%	19.6%	**17.7%**
301-400%	11.1%	11.9%	17.2%	**18.9%**
401%+	13.5%	**9.8%**	40.9%	**37.3%**
	100.0%	100.0%	100.0%	100.0%
Marital Status[2]				
Married	35.7%	41.9%	63.4%	**66.8%**
Not Married	64.3%	58.1%	36.6%	**33.3%**
	100.0%	100.0%	100.0%	100.0%
Education[3]				
Less than high school	12.8%	**18.9%**	6.9%	7.1%
High school graduate	34.8%	36.3%	26.6%	**24.4%**
Some college/tech school	36.6%	32.1%	32.7%	34.0%
College graduate	12.5%	10.7%	23.2%	23.0%
Postgraduate	3.4%	2.0%	10.7%	11.4%
	100.0%	100.0%	100.0%	100.0%
Health Status				
Excellent	29.6%	29.1%	41.0%	39.5%
Very Good	32.1%	28.7%	31.4%	31.0%
Good	26.7%	28.5%	19.2%	19.9%
Fair	9.4%	11.0%	6.3%	**7.1%**
Poor	2.2%	2.7%	2.2%	**2.6%**
	100.0%	100.0%	100.0%	100.0%

Sources: 2001 and 2004 Minnesota Health Access Surveys

Bold indicates statistically significant difference between 2001 and 2004 at the 95% level

Notes: 1) Distribution adds to more than 100% since individuals were allowed to choose more than one race/ethnicity; 2) Marital status is only reported for individuals 18 and older; 3) For children, education refers to the parent's highest level of education

Table 3: Geographic Distribution of the Uninsured				
	Uninsured		Total Population	
	2001	2004	2001	2004
Region				
1 Northwest	1.9%	1.9%	1.7%	1.7%
2 Headwaters	2.9%	2.3%	1.5%	1.5%
3 Arrowhead	7.4%	7.3%	6.4%	6.4%
4 West Central	5.6%	5.7%	4.2%	4.2%
5 North Central	5.0%	4.7%	3.1%	3.1%
6 Mid-Minnesota	3.0%	2.3%	2.3%	2.3%
7 Upper MN Valley	0.9%	1.2%	1.0%	1.0%
8 East Central	2.4%	3.7%	3.0%	3.0%
9 Central	4.9%	5.0%	7.0%	7.0%
10 Southwest	2.2%	2.9%	2.4%	2.4%
11 South Central	4.8%	3.0%	4.4%	4.4%
12 Southeast	5.5%	6.9%	9.4%	9.4%
13 Twin Cities	53.5%	53.2%	53.6%	53.6%
	100.0%	100.0%	100.0%	100.0%

Sources: 2001 and 2004 Minnesota Health Access Surveys
Note: Differences across years are not statistically significant.

Table 4: Employment Characteristics of the Uninsured				
	Uninsured		Total Population	
	2001	2004	2001	2004
Employment Status				
Employed	72.6%	69.9%	75.0%	**72.3%**
Not Employed	27.5%	30.1%	25.0%	**27.7%**
	100.0%	100.0%	100.0%	100.0%
For Those Who Are Employed:				
Employment Type				
Self Employed	25.4%	**16.4%**	14.1%	**11.4%**
Employed By Someone Else	74.6%	**83.6%**	85.9%	**88.6%**
	100.0%	100.0%	100.0%	100.0%
Number of Jobs				
One Job	81.4%	**87.8%**	88.0%	88.6%
Multiple Jobs	18.7%	**12.2%**	12.0%	11.4%
	100.0%	100.0%	100.0%	100.0%
Hours Worked Per Week				
0 to 10 hours	1.3%	1.2%	1.4%	1.4%
11 to 20 hours	7.9%	7.2%	5.0%	5.6%
21 to 30 hours	15.0%	16.7%	6.7%	7.0%
31 to 40 hours	47.7%	45.9%	48.4%	50.0%
More than 40 hours	28.1%	29.0%	38.4%	**36.0%**
	100.0%	100.0%	100.0%	100.0%
Type of Job				
Permanent	79.1%	77.4%	95.1%	**91.7%**
Temporary	10.6%	13.5%	2.6%	**4.4%**
Seasonal	10.4%	9.2%	2.2%	**4.0%**
	100.0%	100.0%	100.0%	100.0%
Size of Employer				
Self Employed, no employees	13.4%	**9.3%**	6.5%	**5.2%**
2 to 10 employees	26.8%	26.8%	13.1%	13.4%
11 to 50 employees	16.5%	19.6%	14.4%	13.4%
51 to 100 employees	10.1%	15.0%	8.0%	**10.6%**
101 to 500 employees	14.0%	12.8%	16.6%	17.6%
More than 500 employees	19.2%	16.7%	41.4%	39.7%
	100.0%	100.0%	100.0%	100.0%

Sources: 2001 and 2004 Minnesota Health Access Surveys
Bold indicates statistically significant difference between 2001 and 2004 at the 95% level
Note: For children, employment refers to the parent's employment status.

List of Publications and Research Findings Supported by SPG Funding

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

- "Medicare Supplemental Coverage and Prescription Drug Use, 2004." Minnesota Department of Health, Health Economics Program, August 2006.

- "Background Paper: How Much Would It Cost to Cover the Uninsured in Minnesota? Preliminary Estimates." Minnesota Department of Health, Health Economics Program, July 2006.

- "Health Insurance Coverage in Minnesota, Trends From 2001 To 2004." Minnesota Department of Health, Health Economics Program, February 2006.

- "Health Insurance Coverage in Minnesota, 2001 vs. 2004: Fact Sheet." Minnesota Department of Health, Health Economics Program, February 2006.

- "Benefit Trends in Minnesota's Small Group and Individual Insurance Markets." Minnesota Department of Health, Health Economics Program, February 2006.

- "Employer-Based Health Insurance in Minnesota: Results from the 2002 Employer Health Insurance Survey," Minnesota Department of Health, Health Economics Program, March 2005.

- "Health Insurance Coverage in Minnesota, 2001 vs. 2004," Fact Sheet, Minnesota Department of Health, University of Minnesota School of Public Health, and Minnesota Department of Human Services, February 2005.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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