Project Abstract

Project Title: Health Resources and Services Administration State Planning Grants Program, Limited Competition Planning Grant

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Current status of access to insurance in Minnesota: Minnesota has the lowest rate of uninsurance in the nation and has consistently had the lowest or among the lowest uninsurance rates for over a decade, according to results from the Current Population Survey.

Like many other states, Minnesota uses its own state-specific survey as the most reliable measure of insurance coverage in the state, and of variations in coverage among different population groups within the state. Unlike the Current Population Survey, Minnesota's survey (called the Minnesota Health Access Survey or MNHA and conducted in 1990, 1995, 1999, 2001, and 2004) is specifically designed to collect information about health insurance status. It has a much larger sample size than national surveys, which allows for detailed analyses of variation in coverage along key dimensions of interest to policymakers and also allows for an in-depth examination of the reasons for changes in the sources of insurance coverage or lack of coverage.

Minnesota's 2004 household survey, funded partially through the State Planning Grants program (SPG), allowed the state to update the 2001 uninsurance rate estimates and analyze the factors contributing to changes in health insurance coverage. The 2004 survey found that 77,000 more Minnesotans were uninsured in 2004 than in 2001. Roughly 343,000 or 6.7 percent of Minnesotans were uninsured in 2004, compared to 266,000 or 5.4 percent of Minnesotans in 2001. The increase in the number of uninsured Minnesotans was driven by a decrease in employer-based health insurance coverage, a downward shift in Minnesota's income distribution, and a change in the demographic composition of Minnesota's Hispanic/Latino population.

Earlier Efforts to Reduce the Number of Uninsured in Minnesota: Minnesota has a long tradition as a national leader in health care reform. In 1987, ten years before the creation of the federal SCHIP program, Minnesota became the first state to offer subsidized insurance coverage to low-income uninsured children through the Children's Health Plan (CHP). MinnesotaCare began in October 1992 as an expansion of CHP. MinnesotaCare eligibility has expanded over time, and the program is now available to families with children whose income is at or below 275 percent of the federal poverty guidelines and single adults or couples without children whose household income is at or below 175 percent of the federal poverty guidelines. Through high-risk pools, public and private health insurance reforms, and efforts aimed at eliminating health insurance disparities, Minnesota has worked toward reducing the number of uninsured people in the state.

Proposed Projects For Limited Competition Planning Grant: There are two primary goals for Minnesota's application for a Limited Competition Planning Grant. The first goal is to discover the reasons for a reduced level of private coverage in the state. High enrollment in private health insurance coverage is one of the reasons why Minnesota has had one of the lowest uninsurance rates in the country during the last decade. Thus, in order to maintain and increase health insurance coverage for Minnesotans it is important to understand current trends in the private health insurance market. The second goal for Minnesota's proposal for a Limited Competition Planning Grant is to examine how higher levels of uninsurance are impacting uncompensated care and how it is paid for. Minnesota is concerned about how increasing levels of uncompensated care are impacting providers and purchasers.

Minnesota's proposal for a Limited Competition Planning Grant includes three projects which seek to address the two goals described above. **First**, the state proposes to conduct a mail survey of employers to update information gathered from previous employer surveys. This survey will collect information on offer rates, eligibility, enrollment, premiums, and cost-sharing from a sample of all private employers in the state. The results from this survey will enable the state to understand and respond to the reasons behind the decrease in employer-based coverage. **Second**, Minnesota proposes to conduct a small employer and individual market survey of health plan companies in the state. This survey would allow the state to gather updated information on premiums, cost-sharing, and benefits offered in the small group and individual health insurance markets in the state. Given the fact that employer based coverage has declined in the state and that a majority of the uninsured work for small employers, it is important to collect updated information on trends in this market in order to develop solutions designed to maintain and or increase health insurance coverage for people employed by small employers. **Finally**, the state proposes to examine how uncompensated care, provided to an increasing number of uninsured Minnesotans, is being paid for in Minnesota's health care system. The goal of this project is to develop options for potentially redirecting funding streams that currently pay for uncompensated care to strengthen access to health insurance coverage for Minnesota's uninsured.

The goals for the Limited Competition Planning Grant projects listed above are focused on understanding why employer-based coverage has declined and how the resulting increase in the number of uninsured Minnesotans is impacting the provision of uncompensated care. The proposed projects build on prior State Planning Grant (SPG) funded research and would provide the updated information that is needed by the state to explore potential solutions designed to maintain and increase coverage in the private market and use funding more effectively to provide health care to the uninsured.

The Minnesota Department of Health (MDH) is the lead agency in this grant effort. Staff for the project will be located in the Health Economics Program (HEP), which is the primary program at the Minnesota Department of Health that conducts research and applied policy analysis to monitor changes in the health care marketplace. HEP has also been the responsible entity for prior work conducted using SPG funds. The main responsibilities of HEP are to understand factors influencing health care cost, quality, and access and to provide technical assistance in the development of state health care policy on these issues. HEP is recognized for its expertise in these areas by the Governor, Legislature, other policy makers, stakeholders, and the public.

Program Narrative

1. Current Status of Health Insurance Coverage

Current rate of uninsurance: Minnesota has the lowest rate of uninsurance in the nation and has consistently had the lowest or among the lowest uninsurance rates for over a decade, according to results from the Current Population Survey.

Like many other states, Minnesota uses its own state-specific survey as the most reliable measure of insurance coverage in the state, and of variations in coverage among different population groups within the state. Unlike the Current Population Survey, Minnesota's survey (called the Minnesota Health Access Survey or MNHA and conducted in 1990, 1995, 1999, 2001, and 2004) is specifically designed to collect information about health insurance status. It has a much larger sample size than national surveys, which allows for detailed analyses of variation in insurance coverage along key dimensions of interest to policymakers and also allows for an in-depth examination of the reasons for changes in the sources of health insurance coverage or lack of coverage.

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The percentage of Minnesotans covered by employer-based health insurance coverage declined from 69.7 percent in 2001 to 63.4 percent in 2004. This decrease in employer coverage was driven by a number of factors, including a decline in the percentage of employees who work for companies that offer insurance coverage and a decrease in the portion of workers eligible for coverage through their employers.

The survey also found that Minnesotans were just as likely to be employed in 2004 as in 2001, but that the proportion of Minnesotans with incomes below the poverty level increased from 6 percent in 2001 to 8.9 percent in 2004. This shift in the income distribution resulted in more Minnesotans becoming eligible for publicly-sponsored health coverage. As a result, eligibility for and enrollment in public health insurance programs increased between 2001 and 2004, with 25.2 percent of Minnesotans enrolled in public coverage in 2004 compared to 20.1 percent in 2001. Among those under 65 years of age, public program enrollment increased from 10.2 percent in 2001 to 14.8 percent in 2004.

Another key finding from the survey is that the number of uninsured Hispanics/Latinos in Minnesota increased by 34,000 and accounted for 44.2 percent of the increase in the number of uninsured Minnesotans from 2001 to 2004. The percent of Hispanics/Latinos who are uninsured increased from 17.3 percent in 2001 to 32.7 percent in 2004. A significant number of

Hispanics/Latinos moved to Minnesota within the past four years and the survey found that the demographic characteristics of the Hispanic/Latino population changed during this time period. From 2001 to 2004, the percent of Hispanic/Latino Minnesotans who are foreign-born increased from 30.9 percent to 52.1 percent. In addition, the percent of Hispanic/Latino Minnesotans with incomes below the federal poverty level increased from 17.6 percent in 2001 to 37.8 percent in 2004. This shift in the income distribution also occurred for non-Hispanic/Latino Minnesotans, but the trend was more pronounced for Hispanics/Latinos. Uninsured Hispanics/Latinos are just as likely to be working full time as all uninsured Minnesotans and the Minnesota population as a whole, but they are significantly more likely to be working in low-wage jobs. In 2004, 83.9 percent of uninsured Hispanics/Latinos in Minnesota had incomes below 200 percent of the federal poverty level, compared to 57.7 percent of all uninsured Minnesotans.

The work proposed under the Limited Competition Planning Grant would help the state to better understand changes in the employer market, why there has been a reduction in employer-based coverage, and how changes in health insurance coverage are impacting the level of uncompensated care and how it is paid for.

Characteristics of the uninsured: The characteristics of the uninsured in Minnesota are generally similar to the uninsured nationally. For example, the uninsured in Minnesota are most likely to be white (72 percent of the uninsured), U.S.-born (82 percent), employed (73 percent, mostly with permanent jobs and working 30 or more hours per week), and have low incomes (58 percent with incomes below 200 percent of the federal poverty guidelines).

From 2001 to 2004, the proportion of the uninsured that are non-white, immigrants, or have low incomes increased. In 2004, 28 percent of the uninsured are non-white compared to 22 percent in 2001. From 2001 to 2004 the percent of the uninsured that are immigrants increased from 13 percent to 18 percent. Those with incomes below 100 percent of the federal poverty guidelines comprised 27 percent of the uninsured in 2004, compared to 16 percent of the uninsured in 2001.

Some groups within the population are disproportionately likely to be uninsured – for example, despite the fact that a majority of the uninsured population is white, the share of the uninsured population that is nonwhite (28 percent) is disproportionately high compared to this population's representation in the overall survey population (11 percent). Other groups that make up a disproportionate share of Minnesota's uninsured include:

- young adults between the ages of 18 and 34 (44 percent of the uninsured compared to 20 percent of the survey population);
- immigrants (18 percent of the uninsured, vs. 7 percent of the survey population);
- people with low incomes (58 percent of the uninsured have incomes below 200 percent of the federal poverty guidelines, compared to 25 percent of the survey population);
- people with a high school education or less (54 percent of the uninsured, vs. 31 percent of the survey population); and
- people who are self-employed or work for a small business (of the 73 percent of the uninsured that are employed, 57 percent work for a business with fewer than 50 employees, compared to 33 percent of the employed survey population).

Key health issues related to access to care and uninsurance: Analysis of data that we collected with earlier rounds of SPG funding has shown that the uninsured in Minnesota are less likely to have a usual source of care, less likely to use health care services, more likely to receive care in an urgent care setting, and less confident in their ability to get health care when they need it than people with private insurance coverage. In our 2001 Minnesota Health Access Survey we found that more than one-third (37 percent) of the uninsured in Minnesota report having no regular source of health care, compared to 8 percent of people with private coverage. Nearly half (44 percent) of people who had been uninsured for a year or more reported having no regular source of care. Among people who do have a regular source of care, the uninsured in Minnesota are more likely than people with private coverage to report that their usual source of care is an emergency room or urgent care clinic (6.5 percent compared to 1.8 percent). The uninsured in Minnesota also reported less confidence in their ability to get needed care than people with private insurance. All of these issues have potential consequences for the health status of the uninsured; for example, the Institute of Medicine has reported that working-age Americans without health insurance are more likely to receive too little medical care and receive it too late, be sicker and die sooner, and receive poorer care when they are in the hospital even for acute situations like a car accident.[1]

Current delivery system: The health care delivery system in Minnesota varies substantially by region, both in terms of health plans and providers. Statewide, the health insurance market is dominated by three large health plans, which hold a combined market share of 84 percent of the fully-insured commercial health insurance market. All three of these firms are non-profit companies that are based in Minnesota, although they also have for-profit affiliates. In rural Minnesota, the market is dominated by Blue Cross Blue Shield of Minnesota, with very little HMO penetration; the Twin Cities region, in contrast, is more heavily dominated by HMOs. Overall, about one-fourth (26 percent) of Minnesota's population is enrolled in an HMO; in the Twin Cities metropolitan area, about one-third (32 percent) of the population is enrolled in an HMO, while less than 15 percent of populations in the rural western regions of the state are in HMOs.

Despite the variation in HMO penetration, most people in Minnesota who have health insurance are enrolled in a product that incorporates at least some features of managed care, such as incentives to visit in-network providers – by the late 1990s, only a small percentage of people with employer-based insurance coverage were enrolled in a health plan that could be characterized as a traditional indemnity plan. Even with the backlash against managed care that occurred beginning in the late 1990s, the overwhelming majority of health plan enrollment continues to be in products that use managed care tools.

Overall, Minnesota has about 91 primary care physicians per 100,000 population; not surprisingly, this figure is much lower in rural counties than urban counties (67 and 100 primary care physicians per 100,000 population in rural and urban counties, respectively). The difference between rural and urban physician resources is much larger with regard to specialty care: there are 33 specialist physicians per 100,000 population in rural Minnesota counties, compared to 115 per 100,000 population in urban counties and 92 per 100,000 population statewide.

[1] Institute of Medicine, Committee on the Consequences of Uninsurance, "Care Without Coverage: Too Little, Too Late," National Academy Press, Washington DC, 2002.

Like the market for health insurance, the hospital market in the Twin Cities is very different from the rest of Minnesota. In the Twin Cities, the 3 largest hospital systems account for over 60 percent of inpatient admissions; in the state as a whole, however, admissions are spread more evenly across a larger number of systems or hospitals with no system affiliation. Occupancy rates vary from a low of about 26 percent in the Southwest to over 70 percent in the Twin Cities metropolitan region.

Because Minnesota's uninsurance rate is low compared to other states, the burden of uncompensated care is also lower; in 2003, uncompensated care provided by hospitals was 1.6 percent of total hospital operating expenses, compared to 5.5 percent nationally. However, the burden of uncompensated care is distributed unevenly - the 10 largest providers of uncompensated care accounted for over half (54 percent) of total hospital uncompensated care in Minnesota in 2003. In addition to hospitals providing charity care, a network of community clinics across the state (but concentrated particularly in the Twin Cities) provides needed care to the uninsured for little or no charge. Despite the relatively low uncompensated care in Minnesota compared to other states, it is highly likely that the funds in the health care system that are currently used to pay for uncompensated care could be used more efficiently, by helping people to obtain appropriate care before their condition deteriorates. Minnesota has proposed a study of how uncompensated care is paid for through various funding streams and how funding for uncompensated care could be better redirected as part of our activities under the Limited Competition Planning Grant.

Gaps in knowledge on the uninsured: Previous rounds of SPG funding have enabled Minnesota to fill several key gaps and update its knowledge of the uninsured, most notably with regard to variations in coverage by region and county, disparities by race and ethnicity, changes in health insurance coverage over time, and reasons for changes in the distribution of health insurance coverage over time. 2004 SPG funding is currently being used to model the financial and enrollment impacts of various coverage options based on data collected with previous SPG funds. The results of this modeling exercise will be used to help reach consensus on one or more coverage options to help reduce the level of uninsurance in Minnesota.

Results from the 2004 Minnesota Health Access Survey, funded partially through the State Planning Grants Program, highlight a few areas where more and updated information is needed. One key finding from the 2004 survey is that employer-based coverage has decreased significantly since 2001. In order to understand the reasons for this decline, preserve private market coverage, and prevent the uninsurance rate from increasing, updated information on employer-based coverage and benefits is required. Another critical question raised by the results from the 2004 Minnesota Health Access Survey is how the increasing number of uninsured Minnesotans is impacting the level of uncompensated care and how it is paid for. With more information on how uncompensated care is paid for, the state could consider ways in which these funding sources could be redirected to provide more cost-effective health care to the uninsured.

Relationship to national activities and other state approaches: In Minnesota's past SPG-funded research, a primary focus has been identifying ways to improve takeup of already available coverage. There are two main reasons why we chose this approach, rather than an

emphasis on expanding eligibility as many states have done. First, income eligibility levels for public insurance are high in Minnesota relative to other states (in fact, they are among the highest in the nation). Second, a high percentage of Minnesota's uninsured is already eligible for coverage. Results from the 2004 Minnesota Health Access Survey show that over 73 percent of uninsured Minnesotans are already eligible for health insurance either through an employer or through a public insurance program. Roughly one-fifth (21 percent) of Minnesota's uninsured population is eligible for insurance coverage through an employer but not enrolled. Of these people, a large majority report that the main reason they have not enrolled in the coverage offered by their employer is cost. We are currently exploring approaches similar to those of states that provide subsidies for private insurance coverage, either directly (e.g., Massachusetts, Rhode Island, Oregon) or indirectly (e.g., New York through reinsurance mechanism, New Mexico subsidized insurance product to be sold to small employers). 2004 SPG funds are currently being used to model the financial and enrollment impacts of various private/public coverage options similar to those enacted in other states.

The activities proposed for the Limited Competition Planning Grant will assist the state in analyzing the effectiveness of private/public coverage options. With updated information on employer-coverage, the state will be able to examine the cost and benefit trends in this market and determine the level of public subsidy that would be needed to maintain and or increase enrollment in employer-based coverage.

2. Earlier Efforts to Reduce the Number of Uninsured Residents

Efforts to develop and implement health care reforms: Minnesota has a long tradition as a national leader in health care reform. This includes the promotion of coverage expansion through state-subsidized health care programs, cost containment goals, the streamlining of public programs, and various private market reforms. Below are a few examples of the many state efforts to reduce the number of uninsured Minnesotans.

High-risk pool: Established in 1976, the Minnesota Comprehensive Health Association, or MCHA, is a high-risk pool for individuals who are unable to purchase private health insurance at standard market rates or without restrictive clauses because of pre-existing conditions. MCHA is the nation's largest high risk pool. Currently, about 34,000 Minnesotans (or 0.6 percent of the state's population) are enrolled.

MCHA also functions as the state's guaranteed conversion product under the Health Insurance Portability and Accountability Act (HIPAA). Overall, MCHA has functioned to ensure access to health insurance coverage for those who do not have access to employer coverage and who have preexisting health conditions.

Enrollees pay premiums that may range up to 125 percent of the average individual premium in Minnesota. In 2003, premium revenues of $93 million covered 53 percent of MCHA's $175 million in claims. To cover costs in excess of premium revenues, MCHA is authorized to make an annual assessment on all health plan companies doing business in Minnesota. In recent years, the number of employers choosing to self-insure has resulted in MCHA's losses being spread over a smaller share of the private health insurance market.

Children's Health Plan (CHP): In 1987, with the creation of the Children's Health Plan (CHP), Minnesota became the first state to offer subsidized health insurance coverage to low-income uninsured children ineligible for Medicaid. Minnesota's CHP pre-dated the federal SCHIP program by ten years. For an annual enrollment fee of $25, CHP provided comprehensive outpatient health care coverage for children ages 1 through 17 with incomes of up to 185 percent of the federal poverty guidelines. In July 1993, the CHP program was discontinued and all children covered at that time were converted to the MinnesotaCare program.

Health Care Access Commission: The 1989 Legislature formed the Health Care Access Commission to develop and recommend to the Legislature a plan to provide access to health care for all state residents. The group recommended moving to a more widespread use of managed care, consolidating state health care programs, strengthening rural health care, and phasing in universal coverage by 1997. The Legislature passed a health reform bill in 1991 that was vetoed by then-Governor Arne Carlson because it lacked a stable, long-term funding source.

MinnesotaCare: After the defeat of the Health Care Access Commission's health reform bill, the 1992 Minnesota Legislature passed the "HealthRight Act," which was later renamed the "MinnesotaCare Act." MinnesotaCare, a state subsidized health insurance program, is only one part of the MinnesotaCare Act, which also encompasses other health care reforms in the individual and small group health insurance markets.

MinnesotaCare was established to provide health care coverage to the growing number of low-income uninsured. MinnesotaCare was not intended as a low-cost alternative for employer-subsidized insurance nor to compete with the private health insurance market. MinnesotaCare began in October 1992 as an expansion of CHP.

MinnesotaCare is funded through a tax on health care providers and enrollee premiums. Enrollees pay a monthly premium for their health insurance coverage based on family size, the number of people covered, and income. In July 1995, MinnesotaCare also began to receive funding from the federal government through its §1115 waiver to cover children and pregnant women whose income is at or below 275 percent of the federal poverty guidelines. In June 2001, Minnesota received CMS approval of a waiver that allows the State to access SCHIP funds to cover MinnesotaCare parents with incomes between 100 percent and 200 percent of the federal poverty guidelines. The enhanced matching funds that the State receives under this waiver were instrumental in securing legislative approval for other Medicaid coverage expansions.

Eligibility for MinnesotaCare has expanded over time both in terms of allowable income and population groups covered. When MinnesotaCare began, it covered families with children whose income was at or below 185 percent of the federal poverty guidelines. In January 1993, the program was extended to cover families with children whose income was at or below 275 percent of the federal poverty guidelines. In October 1994, MinnesotaCare became available to single adults and couples without children whose income was at or below 125 percent of the federal poverty guidelines. Income eligibility for single adults and childless couples was increased in July 1996 to 135 percent of the federal poverty guidelines and to 175 percent of the federal poverty guidelines in July 1997.

Health Insurance Market Reforms: The 1992 MinnesotaCare Act also included individual and small employer health insurance reforms. The primary goals of the reforms were to improve the access to and affordability of health insurance for individuals and small employers. In the past, individuals and small employers had often found it difficult to obtain affordable health insurance coverage because of preexisting health conditions or the presence of one or two sick employees that resulted in expensive premiums or denial of coverage.

The health insurance market reforms that were implemented under the 1992 MinnesotaCare Act, included: rate bands with restricted premium increases, portability of coverage from group to individual coverage, guaranteed issue for small employers, guaranteed renewal for individuals and small employers, a minimum benefit package for small employers, restrictions on pre-existing condition limitations, and rate approval for individuals and small employers. In 1995 and 1996, extensions to the 1992 reforms were made that further restricted premium increases and allowed small employers with up to 50 employees to benefit from the reforms.

In 2002, the legislature enacted additional small employer market reforms that were intended to increase the number of insurers selling policies in the small employer market, make it easier for groups of employers to pool their purchasing power by jointly self-insuring, and reduce volatility in small employer premium rates by limiting annual premium increases.

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

Eliminating health disparities initiative: Also during the 2001 legislative session, a $10 million initiative to reduce health disparities was enacted. Information from the SPG-funded household survey on disparities in uninsurance rates played a key role in securing passage of this initiative. This initiative seeks to stimulate innovative approaches to reducing health disparities by awarding grant to community groups and nonprofit organizations. The Minnesota Department of Health has awarded grants to 60 organizations across the state to experiment with new approaches for reducing health disparities. The grant awardees include ten tribes, three local government agencies, and 47 nonprofit organizations, most of the based in or primarily serving communities of color.

2003 program changes in eligibility and benefits: Like most states, the combination of a weak economy (rising enrollment in public programs and slow growth in tax revenues) and rapidly

rising health care costs in Minnesota resulted in the need for some difficult policy decisions about health care programs. In 2003, the legislature made some significant changes in the structure of Minnesota's public insurance programs, affecting both eligibility and the structure of benefits. By 2007, it is expected that 38,000 fewer Minnesotans will be enrolled in public programs than had been projected without these changes in eligibility and benefits. The following is a summary of the major changes enacted in 2003:

- Children: For children ages 1 through 18, income eligibility for MA was lowered from 170 percent to 150 percent of the federal poverty guidelines, effective July 1, 2004. (Many of the children affected by this change may be eligible for MinnesotaCare, but would have to pay a premium.) Automatic MA or MinnesotaCare coverage for newborns of mothers who are on MA or MinnesotaCare was reduced from two years to one.
- Pregnant women: Pregnant women with incomes over 200 percent of the federal poverty guidelines are no longer eligible for MA, but could be eligible for MinnesotaCare (they would be required to pay a premium).
- Parents: Parents' eligibility for MinnesotaCare coverage ends when family income exceeds $50,000 or 275 percent of the federal poverty guidelines, whichever is lower.
- Adults without children: MinnesotaCare adults without children with incomes between 75 percent and 175 percent of the federal poverty guidelines have a more limited benefit set, face a new $5,000 annual cap on non-inpatient services, and are also subject to new copayments. There is no cap on benefits for those with incomes less than 75 percent of the federal poverty guidelines, but this group does face the new copayment requirements. In the General Assistance Medical Care program (GAMC, a state-only program for people who are not eligible for MA or MinnesotaCare), a catastrophic inpatient benefit is available for people with incomes between 75 percent and 175 percent of the federal poverty guidelines and less than $10,000 in assets ($20,000 for a household of 2 or more people). Adults with incomes less than 75 percent of the federal poverty guidelines and less than $1,000 in assets remain eligible for full GAMC coverage, but they are subject to new copayment requirements.
- Undocumented immigrants: GAMC coverage for undocumented immigrants was eliminated, although some undocumented immigrants could be eligible for emergency MA coverage.
- For all categories of enrollees, eligibility for coverage under MinnesotaCare will be reviewed more frequently – every 6 months instead of annually.

2005 proposed program changes in eligibility and benefits: Even with the changes in eligibility and benefits enacted in 2003, enrollment in Minnesota's public programs has increased and the cost of these programs has continued to increase at an unsustainable rate. In response to this, more eligibility cuts have been proposed. The proposed eligibility changes would eliminate MinnesotaCare coverage for adults without children and reduce MinnesotaCare eligibility for parents from 275 percent to 190 percent of the federal poverty guidelines. By 2008, it is estimated that the proposed eligibility changes would result in 20,000 to 40,000 fewer Minnesotans enrolled in MinnesotaCare than is projected without these changes in eligibility.

Successes and implementation problems of earlier efforts: Minnesota efforts to reduce uninsurance through expansion of public programs and private market reforms have been

rewarded. Minnesota has the lowest uninsurance rate in the country and consistently ranks at or near the top in overall health status. Over more than a decade, Minnesota has seen stable rates of uninsurance, even at times when the national uninsurance rate has increased. However, recent 2004 Minnesota Health Access Survey results show that the uninsurance rate in Minnesota is increasing in response to decreasing employer-based coverage, a weak economy, and demographic changes.

Despite the stable overall rate of uninsurance during the 1990s, some populations – particularly children and low-income people, who were the primary focus of coverage expansions during the 1990s -- have experienced declines in the number of uninsured. From 1990 to 2001, the state succeeded in reducing the uninsurance rate among children under the age of 18 from approximately 5.3 percent to 4.4 percent. Similar success occurred among low-income Minnesotans – although the overall rate of uninsurance was stable, people with incomes below 200 percent of the federal poverty guidelines made up a declining share of the total number of uninsured (62 percent in 1990 compared to 51 percent in 2001). Results from the 2004 Minnesota Health Access Survey show that as the uninsurance rate in the state increased, the number of uninsured children and low-income Minnesotans also increased. In 2004, the uninsurance rate among children under the age of 18 increased to 5.3 percent and low-income Minnesotans make up a larger percentage of the uninsured with 58 percent of the uninsured having incomes below 200 percent of the federal poverty guidelines.

Much of the success Minnesota had in stabilizing the overall rate of uninsurance and decreasing the number of uninsured children and low-income people resulted from the MinnesotaCare program. MinnesotaCare enrollment is currently about 137,000, compared to 35,000 at its inception in 1992. As of January 2005, about half (46 percent) of MinnesotaCare enrollees are children, 42 percent are parents, and the remainder (12 percent) are adults without children.

Another contributing factor to the low rate of uninsurance in the state was the strength of the private health insurance market. According to prior Minnesota Health Access Surveys, the proportion of Minnesotans with employer-based health insurance coverage increased from 65.4 percent in 1990 to 69.7 percent in 2001. This increase is probably due to both the strong economy during much of the 1990s as well as the success of the MinnesotaCare Act in reforming the small employer health insurance market. Enrollment in the small employer health insurance market increased from around 300,000 Minnesotans in 1994 to about 485,000 in 2001. Results from the 2004 Minnesota Health Access Survey show that the uninsurance rate in Minnesota has increased and that one of the main reasons for the increase is the decline in employer-based coverage. In 2004, only 63.4 percent of Minnesotans were covered by employer-based health insurance coverage. This decline in employer coverage signals a need to examine the current cost and benefit trends in employer-based coverage and small employer coverage in particular.

Together, public program expansion and private health insurance market reforms helped to reduce the number of uninsured children and low-income people during the 1990s, yet some populations did not witness declining numbers of the uninsured. Rural residents and populations of color represent a disproportionate percentage of the uninsured and continue to experience higher rates of uninsurance than their counterparts.

While many people have benefited from the MinnesotaCare Act, certain provisions of the Act were not successful. In 1997, the Legislature repealed the mandatory growth limits on health care revenues and expenditures for hospitals, providers, insurance companies, and HMOs and created voluntary cost containment goals for health plans. In 1998, the cost containment goals were allowed to sunset. The growth limits and cost containment goals did not succeed because providers and insurers did not support them and the Legislature found little value in those provisions at a time of stable and low growth in health care expenditures.

The Legislature also terminated the Minnesota Employees Insurance Plan (MEIP) in 1997. MEIP was a voluntary purchasing pool operated by the state, through which small employers could purchase group health insurance coverage. MEIP failed as a health insurance pool because of its voluntary nature and the perception that the pool was one of higher risks rated with higher premiums. Consequently, healthier groups withdrew from the pool, thereby worsening the remaining risk and resulting in a further increase of premiums to members and a subsequent premium spiral. Although small employers can no longer belong to a state operated purchasing pool, they are still protected by the small employer health insurance laws that provide for guaranteed issue and renewal of health insurance policies and rate bands, which help to mitigate against large swings in insurance premiums. However, affordability of coverage and volatility in the market remain major concerns for small employers and individuals. The projects proposed under the Limited Competition Planning Grant will help the state examine current trends in the group and individual markets, determine the causes of decreased private sector coverage, and develop and/or modify coverage options to try to reverse the decline in private health insurance coverage.

Current political, economic and social impediments to expansion: During Minnesota's 2003 legislative session, the state faced a projected budget deficit of $4.2 billion for the 2004 - 2005 biennium. This projected deficit was the driving force behind many of the changes to public program eligibility and benefits that were enacted in 2003. Despite the actions taken by the 2003 legislature to address the budget imbalance, the State's most recent budget forecast for the 2006 – 2007 biennium is that there will be another deficit, though not as large.

In 2004, Minnesota's Democratic-controlled Senate and Republican-controlled House of Representatives were unable to come to agreement on a plan to address a projected $160 million budget shortfall for fiscal years 2004 - 2005. As a result, the Governor took executive action to bring the budget into balance. Despite the lack of agreement on the budget, the legislature did pass a bill that is intended to promote the diffusion and dissemination of clinical best practices among Minnesota's health care providers. In addition, the Governor has formed a "Smart Buy Purchasing Allowance" that includes health care purchasers representing three-fifths of Minnesota's health care consumers whose goal is to promote health and contain costs by changing the way that health care is purchased. These types of initiatives reflect a growing belief on the part of legislators, the current administration, and private purchasers that health care dollars are not being spent in the most cost-effective way, and that it may be possible to both improve health outcomes and contain costs by spending more wisely.

Because of the relative generosity of Minnesota's eligibility standards for public programs, it is unlikely that large-scale expansions of coverage through public programs will be implemented.

Current proposals for the 2005 legislative session are seeking to reduce eligibility for Minnesota's public health insurance programs. However, because of concerns that rising costs are eroding private coverage (resulting in higher enrollment and costs for public insurance programs), there is interest in exploring a variety of ways in which the state could support private insurance coverage in a cost-effective manner, through subsidies (either direct or indirect) or tax credits. Activities proposed under the Limited Competition Planning Grant would allow the state to collect updated information on the private insurance market that is needed to develop effective private/public coverage options.

Existing policy processes to expand coverage: As noted above, the current budget situation in Minnesota (along with the fact that eligibility for public programs is already among the most generous in the nation, and the fact that a majority of the uninsured is already eligible for insurance coverage) makes it difficult for the State to consider expanding coverage to new populations. Increases in public program enrollment and spending have caused the Governor to call for changes to the MinnesotaCare program that would reduce eligibility for parents and eliminate coverage for adults without children. In addition, rising costs in the private sector and the erosion of employer-based coverage have compounded the cost pressures currently faced by public programs. As a result, much of the focus of current initiatives is on finding ways to *maintain* coverage, by looking at initiatives to support the private market and to find ways of spending public health care dollars more effectively.

Awareness of approaches in other states to reduce the uninsured and how they may apply to Minnesota: As described above, Minnesota has a long history as a national leader in health care reform and efforts to expand coverage to the uninsured. Given the current emphasis and interest in options that build on and maintain the strength of Minnesota's private insurance markets, we have focused on gathering information about other states' activities in this area. Previously, we have used SPG funding to gather information on subsidies for the purchase of employer-sponsored insurance (ESI) in Massachusetts, Oregon and Rhode Island and to model the financial and enrollment impacts of various private/public coverage options in Minnesota. However, given the decline in employer-based coverage in Minnesota, it is important to gather updated information on private sector coverage to use in modeling and decision making.

HRSA quarterly grant meetings have been a helpful tool for formally learning about other states' activities and for creating an informal network of peers. In addition, Minnesota places high value on the assistance that the State Coverage Initiatives program of AcademyHealth and the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota have provided to state efforts to reduce uninsurance.

3. Progress on SPG Program Funded Activities

Accomplishments to date and how they have contributed to the goals of the SPG program:
Minnesota was first awarded funding from the SPG program in federal fiscal year 2000, with supplemental awards in FY 2001, FY 2003, and FY 2004. This section of the application describes how the work conducted with SPG funds has contributed to Minnesota's project goals and the overall SPG program goals.

Minnesota's work conducted under its State Planning Grant has had three major goals: **first**, to fill gaps in the state's knowledge about health insurance coverage, with a particular focus on disparities by race/ethnicity and geographic region of the state; **second**, to analyze the dynamics of public program enrollment and disenrollment in order to understand why people eligible for public programs do not enroll and what strategies might promote higher participation and continuity of coverage; and **third**, to identify trends in the private health insurance market and opportunities for increasing the rate of private coverage. Progress toward each of these major goals is described below. The progress report matrix that begins on page 41 provides detailed information on the specific tasks undertaken with previously awarded grant funds, the status of these projects, and their impact.

Filling the knowledge gaps: The 2001 Minnesota Health Access Survey documented, for the first time, large disparities in health insurance status by race and ethnicity. These quantitative estimates from the survey were complemented by results from focus groups with populations of color and American Indians, which helped to identify reasons for coverage disparities. This new information about health insurance disparities contributed to the enactment of a $10 million initiative to reduce health disparities during our 2001 legislative session.

The survey data also enabled us to estimate, for the first time, uninsurance rates for thirteen regions in the state and for each of Minnesota's 87 counties. This information has proven to be very valuable, particularly to people involved in local efforts to reduce uninsurance rates. Some groups have used this data to target particular areas of the state for public program outreach efforts. In addition to being able to document variation in uninsurance rates by region, we were also able to document variation in the sources of health insurance coverage, such as areas of the state where individual market enrollment is particularly high or areas where Medicare and other public programs play a particularly important role.

One surprising result from the 2001 survey was that the estimated number of uninsured children was higher than we had previously thought. This new knowledge contributed to the enactment of an expansion of Medicaid eligibility for children in 2001, to 170 percent of the federal poverty guidelines for children under nineteen. As described earlier, as of July 2004 this expansion was rolled back to 150 percent of the federal poverty guidelines due to the state's budget deficit.

The recently completed 2004 Minnesota Health Access Survey updated the results from the 2001 survey and provided insight into the impact of a weak economy and rising health care costs. From 2001 to 2004, the uninsurance rate in Minnesota increased from 5.4 percent to 6.7 percent. The survey findings show that the increase in the number of uninsured Minnesotans was not concentrated in any particular area of the state but that uninsurance rates increased throughout the entire state. In addition, the 2004 survey found that uninsurance rates among White and Hispanic populations increased and that the uninsurance rates for Black, Asian, and American Indian populations were similar to the results from the 2001 survey. The 2004 survey also documented a significant decline in employer-based coverage with 63 percent enrolled in employer-based coverage in 2004, compared to 70 percent in 2001. Data from the 2004 Minnesota Health Access Survey is currently being used to model the financial and enrollment impacts of various coverage options under consideration in Minnesota. The results from this

modeling exercise will be used to develop consensus on one or more coverage options and assist in planning for potential implementation.

Public program dynamics: Several of the projects funded under Minnesota's State Planning Grant contributed to an enhanced understanding of why people who are eligible for public programs do not enroll, how these reasons vary among different population groups, and what happens to people who leave public programs. Most of the uninsured (77 percent) indicated that they would enroll in a public program if they knew they were eligible; however, our research also identified a significant lack of awareness of public programs, particularly among populations of color and American Indians. In addition, administrative complexity was identified as a barrier to enrollment in public programs. The Minnesota Department of Human Services has used this information to develop and justify simpler and faster electronic enrollment and premium collection systems.

Private insurance market: Results from our 2002 employer survey indicate that the percentage of employers offering health insurance in Minnesota is stable compared to our 1993 and 1997 surveys, but that there is substantial regional variation within the state in the availability of employer coverage. The data also suggests that eligibility and takeup rates are slightly lower than in previous years, but the overall decline is not statistically significant. Employer and employee shares of premium costs are similar to national averages and have been stable over time; however, the level of cost-sharing (deductibles and copayments) has increased.

Results from the 2004 Minnesota Health Access Survey show that employer-based coverage in Minnesota has declined since 2001. This finding implies that changes have occurred in the private market since the 2002 employer survey was conducted. The projects proposed for the Limited Competition Planning Grant seek to collect updated information on the private health insurance market to examine trends and determine potential solutions for preserving and increasing enrollment in private health insurance coverage.

How Minnesota's SPG research has informed the development of policy options: 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 Minnesota Health Access Survey conducted under the State Planning Grant confirmed this result. In 2001, 23 percent of the uninsured were eligible for employer coverage and 50 percent were potentially eligible for a public program; only one-third (34 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 percent of the federal poverty guidelines were estimated to be eligible for employer coverage or a public program in 2001.

The fact that a large share of Minnesota's uninsured population was already eligible for employer coverage or a public program, combined with the state's low uninsurance rate (5.4 percent) and the fact that Minnesota's income thresholds for public programs were already among the most generous in the nation, led us to focus on identifying ways to improve takeup and continuity of already available coverage. The potential strategies identified with the help of our advisory committee ranged from simplifying administrative processes to subsidizing employer coverage for people who had access to private coverage but did not enroll due to cost.

Like most states, however, Minnesota's budget situation has changed dramatically since we were awarded a State Planning Grant in September 2000. As a result, maintaining existing coverage has become a primary focus, rather than strategies to expand coverage. Despite the setbacks related to the state's budget deficit, the knowledge gained through the research funded under the State Planning Grant to date has been extremely valuable and will be useful in informing future efforts to reduce uninsurance.

Minnesota is fairly unique among states in that it has a long history of commitment to investing in the technical capacity within state government to apply quantitative research to the development of health policy in the state. The data gathered under the State Planning Grant has enabled us to expand the range of our capabilities, both by filling gaps in our knowledge about the uninsured and by enabling us to do more detailed analyses than other state level estimates (such as the Current Population Survey or the MEPS Insurance Component) currently allow. The capacity that we have within state government to perform this type of analysis enables us to continue to provide real-time support in the policy development process, as well as ongoing research and analysis of health policy issues.

Remaining tasks to be completed: As noted in the progress report matrix, the project titled "Cost Effectiveness of Private Market Options" is currently in progress. Dr. Jonathan Gruber, a professor of economics at MIT is currently working to develop the microsimulation model using state, regional, and national data sources. Mercer Government Human Services Consulting is currently conducting actuarial analyses to develop premium estimates for use in the microsimulation model for some of the coverage options. The goal of this project is to estimate the financial and enrollment impacts of various private market coverage options. The results from this project will be critically important to policy makers as they consider the cost effectiveness of different coverage options designed to maintain and expand private health insurance coverage in Minnesota. Initial results from the microsimulation model are expected by July 2005. These results will be presented to the Governor and Legislators and feedback from policy makers will be used to refine the microsimulation model. Final estimates from the microsimulation model are expected before the end of the contract period and these estimates will be used by policy makers to decide which coverage options should potentially be implemented in Minnesota to maintain and expand private sector coverage. The total expenditure for this project is expected to be $187,000.

Progress Report Matrix:

Project Component/Primary Goals	Major Tasks	Timetable	Responsible Party	Results/Status
FY 2000 State Planning Grant				
1. 2001 Minnesota Health Access Survey: To update estimates of uninsurance in MN; obtain estimates of disparities in insurance coverage by race/ethnicity and geographic region.	Collect data from 27,000 households, oversampling by race/ethnicity and region; data cleaning, imputation and weighting; analysis; report.	Complete	MDH and University of Minnesota	Large disparities in insurance status by race /ethnicity and by region. Results contributed to the enactment of a public program expansion for children and a $10 million state initiative to eliminate health disparities.
2. In-Person Household Survey: To supplement information from the household telephone survey. This project was undertaken as a result of stakeholder concerns about under coverage of telephone surveys among vulnerable populations, and concerns that telephone surveys do not work well with populations of color and American Indians.	Develop survey instrument based on household telephone survey; develop sampling strategy for targeted populations (American Indian, Hispanic, Asian, African American, and White); hire and train interviewers; conduct interviews with approx. 2,000 households; data entry, cleaning, and weighting; analysis.	Complete	MDH and Wilder Research Center	The in-person and telephone surveys produced different uninsurance estimates; however, the differences are not statistically significant. Both surveys found that White and Asian populations have lower uninsurance rates and that Black, American Indian, and Hispanic populations have much higher uninsurance rates. The results show that populations of color and American Indians may be more likely to be uninsured because they do not see a need for health insurance, there is a stigma associated with public health insurance programs, and they do not feel they are treated well by health care providers.
3. Focus Groups with Populations of Color: To gain qualitative insight into experiences with health insurance and the health care system among populations of color and American Indians in Minnesota. Focus groups conducted with Somali, Hmong, Hispanics, and American Indians.	Develop focus group questions; train moderators; conduct focus groups; analyze results; produce written reports summarizing results.	Complete	MDH; Center for Cross-Cultural Health for Somali, Hmong, and American Indians; U of MN and HACER for Hispanic groups	Barriers to obtaining coverage for these populations include: lack of awareness of options; difficulty navigating the system; believing coverage is not needed; other financial needs taking higher priority; negative past experiences with health insurance or health care systems.
4. Farmer Focus Groups: To gain insight into the experiences of farm families regarding health insurance.	Develop questions; conduct focus groups; analyze results; summarize results in report.	Complete	MDH and University of MN, Crookston	Participants believed that coverage is important. The most common barrier is cost. Participants wanted a more understandable coverage system.
5. Key Informant Interviews: To gain insight into barriers to insurance coverage from professionals who routinely interact with people who are uninsured, and to get input on possible solutions.	Develop questions; identify interviewees from 4 groups: health care providers, clinic administrators, caseworkers and social workers, and community advocates; conduct interviews; summarize results in report.	Complete	MDH	Many uninsured lack awareness of coverage options; administrative complexity is a barrier to enrolling and staying enrolled; health insurance may not be a high priority for the uninsured, until they need it; enrollment workers need to be better trained about program rules and changes; many people believe that the system lacks cultural competence.
6. MinnesotaCare Disenrollee Survey: To analyze dynamics of public coverage by determining why enrollees leave the program and what happens to them after they leave.	Develop sampling strategy; develop survey questionnaire; administer mail survey; data entry, cleaning and weighting; analysis of survey results; publish report summarizing results.	Complete	MDH, Minnesota Department of Human Services	Over ¾ of former enrollees had health insurance; most had positive opinions of the program and thought the premium was reasonable. Former enrollees who were uninsured at the time of the survey were more likely to have been terminated from the program for failure to pay the premium.

Project Component/Primary Goals	Major Tasks	Timetable	Responsible Party	Results/Status
7. Employer Survey: To analyze private health insurance market, and compare to prior MN employer surveys to gauge employer /employee reactions to rising costs. In relation to MEPS IC state estimates, this survey has several advantages: a larger sample size that allows for regional analysis, data is available on a more timely basis and analysts have access to raw data for analyzing policy options.	Develop and program survey tool based on 1997 RWJF survey; develop sampling strategy; collect data from 2,400 MN employers; data cleaning and imputation; develop statistical weights; analyze data; publish survey results.	Complete	MDH, University of Minnesota	This project experienced several delays, initially related to the need to wait until the household telephone survey was complete, and later to the amount of time needed to program such a complex survey. Data collection was completed in 2002. Results indicate that the percentage of employers offering health insurance is stable compared to our 1993 and 1997 surveys, but that there is substantial regional variation within the state. Eligibility and takeup are slightly lower than in previous years. Employer and employee shares of premium have been stable, but the level of cost-sharing has increased.
FY 2001 Supplemental Funds				
8. Evaluation of Employer Buy-In Options: To evaluate how other states (MA, RI, and OR) have implemented employer buy-in programs and potential opportunities for structuring an employer buy-in program that would be approved to receive federal matching funds.	Identify key areas of concern in developing employer buy-in programs; interview officials in other states about their strategies, experiences and lessons learned; develop options and recommendations for making an employer buy-in program in MN.	Complete	Oliven Analytics	Analysis focused on four areas of concern: benchmark equivalents, cost sharing, crowd-out, and cost-effectiveness. Given the complexity of administering employer buy-in programs, more analysis of the size of the target population and potential program cost is needed. The report contains recommendations for structuring an employer buy-in program.
9. Focus Groups with Uninsured Young Adults: To build on findings from the household telephone survey, which revealed a high rate of uninsurance among 18 to 24 year olds.	Develop focus group questions; conduct focus groups; analyze results and prepare written report.	Complete	MDH and Mary Anne Casey (consultant)	For those who are interested in health insurance, cost is a major barrier; for many, health insurance is not a priority because they are healthy and would prefer to spend their money in other ways; some had tried to enroll in public programs but were not eligible or found the process too difficult.
10. Focus Groups with Small Employers: To supplement findings from the household and employer surveys with qualitative information on why small employers offer or do not offer health insurance.	Develop focus group questions; conduct focus groups; analyze results and prepare written report.	Complete	MDH and Mary Anne Casey (consultant)	For small employers not offering coverage, cost is major barrier, but administrative hassle is another; many who do not offer coverage do not view it as important to attracting and retaining employees. Those that offered coverage worried about their ability to do so, given high premium increases.
11. Study of Provider/Health Plan Relationships: To study how market consolidation has affected health care access and cost, and how potential policy changes could affect provider networks and access to care.	Identify major health care providers in different regions of the state, and their relationships with the major health plans.	Complete	Allan Baumgarten (consultant)	In most regions of the state, and especially in rural areas, large multispecialty group practices or health care systems dominate the provider market; as a result, providers have substantial negotiating leverage with health plans, and the networks of health plans overlap significantly.

Project Component/Primary Goals	Major Tasks	Timetable	Responsible Party	Results/Status
12. Study of Insurance Coverage Adequacy: To obtain information on the generosity of benefits in the small group and individual health insurance markets in order to further develop a concept of what constitutes "adequate" coverage.	Conduct literature review of prior research on coverage adequacy; design data collection form; collect data from health plans in MN's small group and individual markets; create alternative standards of coverage "adequacy" and compare plans to the standard; analyze enrollment by benefit generosity; prepare summary.	Complete	MDH, University of Minnesota	Enrollees in Minnesota's small group market have coverage that is generally quite comprehensive; for example, in 2002 2/3 had no deductible and most had limited cost sharing. In the individual market, deductibles are much higher, and coinsurance is much more prevalent (vs. co-payments). Enrollees in the individual market are much more exposed to having to pay high out of pocket costs for medical claims.
13. Study of Policy Options for Individual Health Insurance Market: To analyze policy options for reforming the individual market in Minnesota.	Analyze design, implementation, and operational issues to be considered in evaluating a guaranteed-issue individual pool; written report from contractor.	Complete	Deborah Chollet	Addresses choices that would need to be made in establishing and operating an individual market pool, and identifies issues for further research.
14. Communications Consultant: To communicate study findings back to groups that participated in the research.	Develop information to be distributed; design and translation of materials; identify and mail information to communities.	Complete	MDH and Policy Studies Inc.	Contractor developed materials for distribution to community leaders and community members that summarize research results, with particular focus on disparities by race/ethnicity.
FY 2003 Supplemental Funds				
15. 2004 Minnesota Health Access Survey: To 1) update previous estimates of uninsurance; 2) evaluate how insurance coverage in MN has changed since 2001, given slow economic growth, job losses, and rising health care costs; 3) collect data to analyze, for the first time, the degree to which public program enrollees have access to employer coverage and how variation in employee contributions to premiums affects takeup of employer coverage.	Modify 2001 survey instrument; collect data from over 13,000 households, oversampling by race/ethnicity and region; data cleaning, imputation and weighting; analysis; report.	Complete	MDH and University of Minnesota	The survey was completed in December 2004 and initial survey results were reported in February 2005. Roughly 343,000 or 6.7 percent of Minnesotans were uninsured in 2004, compared to 266,000 or 5.4 percent of Minnesotans in 2001. The increase in the number of uninsured Minnesotans was driven by a decrease in employer-based health insurance coverage, a downward shift in Minnesota's income distribution, and a change in the demographic composition of Minnesota's Hispanic/Latino population. More results from this survey will be released throughout the year.
16. Town Meetings/Community Input on Coverage Expansion and Health Reform: To solicit community input on the topics of health care coverage, alternative approaches to coverage expansion, and Minnesotans' views on how to preserve coverage in the face of rapidly rising health care costs.	Compile educational/background materials for use in public meetings; facilitate public meetings and citizen input; report.	Complete	Michael Scandrett (consultant)	Major findings of the report include: Minnesotans are deeply concerned about access to health care and rapidly rising health care costs; Minnesotans believe that everyone should have access to basic health care services, but are not supportive of a government-run single payer system; Minnesotans want a health care system that is easier to understand and offers more information about cost and quality of care. Partly in response to these findings, Governor Pawlenty formed a "Health Cabinet" to develop strategies for addressing problems with health care access, cost and quality.

Project Component/Primary Goals	Major Tasks	Timetable	Responsible Party	Results/Status
FY 2004 Supplemental Funds				
17. Cost Effectiveness of Private Market Options: To estimate the impact of various coverage options on takeup, crowd-out, and private and public sector costs.	Develop a microsimulation model to estimate the financial and enrollment impacts of various coverage options using existing state, regional, and national data; conduct actuarial analyses for the development of premium estimates for certain coverage options to be used in the model; estimate takeup, crowd-out, and private and public sector costs of coverage options; report to Governor and Legislators; refine model based on initial feedback; write final report.	Project is currently in progress. Initial results are expected by July 2005.	MDH, Dr. Jonathan Gruber of MIT, and Mercer Government Human Services Consulting	The microsimulation model is currently under development. The creation of actuarial premium estimates is currently in progress. Initial results from the microsimulation model are expected by July 2005.

Four projects were originally proposed as part of our FY 2000 State Planning Grant but were dropped for budget or logistical reasons: First, we had proposed to obtain employment information from a subset of participants in the household telephone survey and to contact these employers to participate in the employer survey in order to "link" the household and employer data; however, the project was dropped due to low cooperation with the employment information question in the household survey. Second, we had proposed to conduct a longitudinal mail survey of people identified as low income and uninsured by the household telephone survey to track the dynamics of coverage status and use of health care services. The budget for this project was $230,000, of which $29,000 was to be funded by the State Planning Grant and the remainder by a private source; the project was dropped when the contractor was unable to obtain private funding. Third, we had proposed to contract with a consultant to prepare projections of the future health care marketplace in Minnesota; this project was dropped due to concerns over cost and timing. Finally, we had proposed contracting with the Minnesota Department of Human Services to estimate the price elasticity of demand for health insurance as part of our initial grant. Due to staffing changes at the Department of Human Services, this analysis was not done. The 2004 Minnesota Health Access Survey includes new questions related to employee premium contributions and cost sharing that will enable us to analyze this critically important issue.

4. Statement of Project Goals

There are two primary goals for Minnesota's application for a Limited Competition Planning Grant. The first goal is to discover the reasons for a reduced level of private coverage in the state. High enrollment in private health insurance coverage is one of the reasons why Minnesota has had one of the lowest uninsurance rates in the country during the last decade. Thus, in order to maintain and increase health insurance coverage for Minnesotans it is important to understand current trends in the private health insurance market. The second goal for Minnesota's proposal for a Limited Competition Planning Grant is to examine how higher levels of uninsurance are impacting uncompensated care and how it is paid for. Minnesota is concerned about how increasing levels of uncompensated care are impacting providers and purchasers. One project proposed for funding under the Limited Competition Planning Grant would analyze how uncompensated care is paid for in Minnesota and examine potential ways to redirect the funds to provide more cost effective health care for the uninsured. Minnesota's proposal for a Limited Competition Planning Grant includes the following three projects which seek to address the two goals described above:

- **Mail Survey of Employers:** This survey would enable the state to update information on employer-based coverage and explore the reasons for the significant decline in employer-based coverage during the past few years. Minnesota has employer survey data from 1993, 1997, and 2002. The 2002 survey was funded through the State Planning Grants Program. As in prior years, this survey would collect information on offer rates, eligibility, enrollment, premiums, and cost-sharing from a sample of all private employers in the state.

- **Small Employer and Individual Market Survey:** This project is a survey of health plan companies. This survey would allow the state to update information on premiums, cost-sharing, and benefits offered in the small group and individual health insurance markets in the state. SPG funds were used to conduct this survey in 2003. The title of this survey project conducted in 2003 was "Study of Insurance Coverage Adequacy." Given the fact that employer based coverage has declined in the state and that a majority of the uninsured work for small employers, it is important to collect updated information on trends in this market in order to develop solutions designed to maintain and or increase health insurance coverage for people employed by small employers.

- **Study of Uncompensated Care Funding Sources:** The purpose of this project is to analyze the funding streams that pay for uncompensated care provided to the uninsured and examine the feasibility and options for more explicitly using those uncompensated care resources for coverage purposes. Given the recent increase in the number of uninsured Minnesotans, it is important to understand the impact of this increase on uncompensated care and look at innovative ways for using uncompensated care funding to provide more cost effective care to the uninsured.

The goals for the Limited Competition Planning Grant projects listed above are focused on understanding why employer-based coverage has declined and how the resulting increase in the number of uninsured Minnesotans is impacting the provision of uncompensated care. The

proposed projects build on prior SPG funded research and would provide the updated information that is needed by the state to explore potential solutions designed to maintain and increase coverage in the private market and use funding more effectively to provide health care to the uninsured. In order to create effective solutions for maintaining and increasing health insurance coverage in Minnesota, the state needs to understand why the distribution of health insurance coverage has changed.

5. Project Description

A. Detailed Project Narrative: As noted above, Minnesota is applying for a Limited Competition Planning Grant. The state proposes to use Limited Competition Planning Grant funds to support three research projects designed to collect more and updated information to assess changes in the distribution of health insurance coverage in Minnesota. The results from all three of these projects will be reported to the Governor, Legislators, the Health Cabinet, and the public in general. In addition, results from these research projects will also be incorporated into the refinement of the microsimulation model currently under development by Dr. Jonathan Gruber of MIT to assess the cost effectiveness of various coverage options. Descriptions of the three projects proposed for the Limited Competition Planning Grant are detailed separately below.

Mail Survey of Employers: As described earlier, the 2004 Minnesota Health Access Survey found that Minnesotans were significantly less likely to be covered by employer-based coverage in 2004 than in 2001. Minnesota's historically high level of employer-based health insurance coverage is one of the reasons why Minnesota has had one of the lowest uninsurance rates in the country. Given the decline in employer-based coverage over the past few years, it is imperative for the state to understand the causes of the decline in this market in order to maintain and increase the level of health insurance coverage in Minnesota. Updated information on employer-based coverage is needed to understand the decline in group coverage and develop potential solutions to address the rising rate of uninsurance in the state.

Minnesota proposes to conduct a mail survey of employers in the state to collect updated information on employer-based health insurance coverage. Researchers in the Health Economics Program at the Minnesota Department of Health have extensive experience working with employer survey data collected through telephone surveys in 1993, 1997, and 2002. These telephone employer surveys collected information on which employers offer coverage, how many employees are eligible and enrolled in that coverage, the premiums paid by employers and employees for coverage, and the levels of cost-sharing faced by employees enrolled in employer-based coverage. The proposed mail survey of employers will be conducted in 2006 and will collect similar information to that collected in prior years, however, the survey will be a mail survey instead of a telephone survey. The primary reasons for conducting a mail survey instead of a telephone survey of employers are cost and sample size. A telephone survey would cost significantly more than a mail survey and the level of funding available through the Limited Competition Planning Grant would not cover the full cost of a telephone survey. In addition, the state would like to increase the sample size of employers in order to do more detailed size and regional analyses and the cost of a mail survey would allow the state to increase the sample size.

A state level mail survey of employers is also needed because national surveys do not provide the level of information that the state requires. The Medical Expenditure Panel Survey (MEPS) collects state level information on employer-based coverage from employers. However, the sample size for states is small, has large standard errors, often shows large and seemingly unreliable changes in results from year to year, and does not allow for detailed analyses desired by the state.

The anticipated result of this survey is that updated information on employer-based health insurance will help to explain why fewer Minnesotans have group coverage and help frame policy options to increase the number of Minnesotans with employer-based coverage. Results from this employer survey will allow the state to analyze changes in the number and type of employers offering coverage, changes in eligibility policy for employees, and how changes in premiums and cost-sharing are impacting the level of employee enrollment in employer-based coverage. The types of policy options proposed to increase group coverage will depend on the sources of change in the employer market that are causing a decrease in employer-based coverage.

The mail survey will be conducted by the Health Economics Program at the Minnesota Department of Health. Two full-time staff members will be hired with Limited Competition Planning Grant funds and in-kind support from current staff with employer survey experience will be provided to conduct the mail survey and analyze the results. Existing scanning technology will be used to develop the mail survey, scan the completed surveys, and create a database of survey responses. The mail survey will start in January 2006, and it is expected that the survey will be completed by June 2006 and that results will be reported by August 2006. The timeline for specific tasks is detailed in the project matrix. The results of this survey, along with a discussion of policy options, will be included in the report to the Department.

Small Employer and Individual Market Survey: The small employer and individual market survey is a survey of health plan companies. The purpose of this project is to collected detailed information on premiums, cost-sharing, and benefits that is not feasible to collect through a survey of employers. This survey would allow the state to update information on premiums, cost-sharing, and benefits offered in the small group and individual health insurance markets in the state. SPG funds were used to conduct this survey in 2003. The title of this survey project conducted in 2003 was "Study of Insurance Coverage Adequacy." Given the fact that employer based coverage has declined in the state and that a majority of the uninsured work for small employers, it is important to collect updated information on trends in this market in order to develop solutions designed to maintain and or increase health insurance coverage for people employed by small employers.

Similar to the 2003 survey, the Health Economics Program at the Minnesota Department of Health will survey health plan companies with a 2004 earned premium of $5 million or more in Minnesota's small group or individual health insurance market. The survey will collect data on enrollment, premiums, cost-sharing including deductibles, coinsurance, and copayments, benefits covered, and maximum out-of-pocket levels on all plans in force in these markets. Our focus on the small group and individual markets is related to historic concerns about the concentration of uninsured Minnesotans working for small employers, the adequacy of coverage in these markets

and practical issues surrounding the collection of data. Plans operating in the small group and individual markets in Minnesota are regulated in various ways, and health plan companies must seek approval for all variations in the benefits they offer. As a result, the number of plans offered in these markets is more limited than in the large group market, where benefit sets may be negotiated with individual employers.

The anticipated result of this survey is that updated information on small employer and individual market trends will help to explain the decrease in private coverage and lead to solutions designed to increase the number of Minnesotans with private health insurance coverage. Results from this survey will allow the state to analyze changes in premiums, cost-sharing, and benefits and explain how these changes are impacting the level of enrollment in private coverage.

This survey will be conducted by the Health Economics Program at the Minnesota Department of Health. The budget for this project requests one half-time staff to be supported with Limited Competition Planning Grant funds with in-kind support from staff in the Health Economics Program. This survey will start in January 2006, and it is expected that the survey will be completed by June 2006 and that results will be reported by August 2006. The timeline for specific tasks is detailed in the project matrix. The results of this survey, along with a discussion of policy options, will be included in the report to the Department.

Study of Uncompensated Care Funding Sources: The 2004 Minnesota Health Access Survey found that the uninsurance rate in Minnesota increased significantly from 2001 to 2004. Given the recent increase in the number of uninsured Minnesotans, it is important to understand the impact of this increase on uncompensated care and look at innovative ways for using uncompensated care funding to provide more cost effective care to the uninsured. The purpose of this project is to analyze the funding streams that pay for uncompensated care provided to the uninsured and examine options for redirecting uncompensated care funding for coverage purposes.

Researchers in the Health Economics Program at the Minnesota Department of Health will follow a research design similar to that used by Jack Hadley and John Holahan[2], who recently estimated that 85 percent of spending for uncompensated care comes from public sources (mainly federal and state). In a similar vein, this proposed study will trace the sources of funding for uncompensated care in Minnesota, using similar methodology to that employed by Hadley and Holahan.

Having identified public sources and existing mechanisms of funding uncompensated care, Minnesota will develop options for redirecting funding that currently pays for uncompensated care to potentially pay for care and/or provide coverage to a larger number of people that results in better health outcomes. There is ample evidence documenting the importance of health insurance coverage for accessing health care services in a timely manner and for obtaining high quality health care services, yet we continue to invest significant financial resources to support

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[2]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.

providers in their provision of uncompensated care to the uninsured. Research that Minnesota has done with funds from previous SPG grants will be a critical input to this study. Updated information from the 2004 Minnesota Health Access Survey on the uninsured and the characteristics of the uninsured will be used to project future uncompensated care levels in Minnesota in the absence of a policy change.

The anticipated result of this study will be a set of options that can be used to redirect the funding streams that currently go to pay for uncompensated care to activities that promote health insurance coverage and better health outcomes for a larger number of people. The results of this study can be used to begin discussion among state and local governments and health care safety net providers on how the funds that currently pay for uncompensated care could be more efficiently used to cover more people and potentially produce better health outcomes. In addition, the results are likely to be of relevance to ongoing efforts to reduce uninsurance in other states.

The Health Economics Program at the Minnesota Department of Health will conduct this project. The budget for this project requests one half-time staff to be supported with Limited Competition Planning Grant funds with in-kind support from staff in the Health Economics Program. This project will be completed within the first six months of the grant period and results will be reported shortly thereafter. The timeline for specific tasks is detailed in the project matrix. The results of this survey, along with a discussion of policy options, will be included in the report to the Department.

Report to the Department: The report on the activities of Minnesota's Limited Competition Planning Grant will include a description of the results of the studies undertaken with grant funding and how they have informed the development of solutions designed to maintain and increase private coverage and restructure uncompensated care funding to more effectively provide health care to the uninsured. The final report will be completed within thirty days after the end of the one-year project period and will adhere to the reporting requirements, format, and timeframe established by the Project Officer. Minnesota will also attend and participate in quarterly meetings by providing updates on the status and findings of State Planning Grant funded projects. Minnesota will assist in the preparation of consolidated national reports describing the process and outcomes of the State Planning Grant. Separate from the report to the Secretary, Minnesota is committed to providing, in a timely manner, any additional information that the Secretary, HRSA, or the organization preparing a summary report on behalf of HRSA may require. Minnesota is also committed to serving as a resource to other States.

B. Project Management Plan:

Action Step	Timetable	Responsible Organization	Anticipated Results	Evaluation/ Measurement/ Quality Control
Project 1: Mail Survey of Employers				
Action Step 1: Develop and finalize mail employer survey tool based on prior telephone employer survey tools.	9-05 to 11-05	MDH Staff	Development of a four page survey that is easy to understand yet contains all pertinent questions.	The mail employer survey tool is simple and easy to understand yet still contains questions of interest that can be compared to prior telephone employer surveys.
Action Step 2: Pilot test mail employer survey tool and revise based on feedback.	11-05 to 1-06	MDH Staff	Mail employer survey tool is revised based on results from the pilot test.	Employers report that the survey tool is easy to follow and understand. Employers are able to answer the questions in the survey tool correctly.
Action Step 3: Purchase stratified random sample of employers from Dun & Bradstreet.	12-05 to 1-06	MDH Staff	Sample is representative of Minnesota employers and includes oversampling by employer size and geographic region.	Sample size of approximately 3000 or more. Get distribution of all Minnesota employers by size and region to use to weight the oversampled stratified sample to represent all Minnesota employers and employees.
Action Step 4: Mail employer survey and follow up to increase response rate.	1-06 to 6-06	MDH Staff	Survey data is representative of all Minnesota employers and will provide desired information on employer-based coverage.	Achieve at least a 40% response rate and get the desired number of completed surveys.
Action Step 5: Scan, clean, and enter responses in data base.	1-06 to 7-06	MDH Staff	The scanning technology and cleaning processes create a dataset that is usable for analysis.	The level of missing data is minimal, skip patterns were generally followed, the range of responses matches expectations, and the responses are consistent.
Action Step 6: Analyze data and disseminate results.	7-06 to 9-06	MDH Staff	The results from the survey provide information that is useful to policy makers.	Policy makers use the survey results to inform policy decisions.
Project 2: Small Employer and Individual Market Survey				
Action Step 1: Develop and finalize survey tool using prior survey tool.	9-05 to 11-05	MDH Staff	Creation of survey tool capable of collecting benefits information for a wide variety of insurance products in a standardized format.	The survey tool is broad enough to collect information on the benefit design of a wide variety of products while standardizing responses so that the information can be consolidated and compared.
Action Step 2: Pre-test survey tool with several insurance companies.	11-05 to 1-06	MDH Staff	Survey tool is revised to reflect feedback.	Insurance companies report that the survey tool is easy to understand and that the information requested is available with minimal effort.

Action Step	Timetable	Responsible Organization	Anticipated Results	Evaluation/ Measurement/ Quality Control
Action Step 3: E-mail survey to large insurance companies and follow-up until all surveys are completed.	1-06 to 4-06	MDH Staff	Survey data includes all large companies selling products in the small group and individual markets and represents more than 90% of enrollment in these markets respectively.	Achieve a 100% response rate.
Action Step 4: Crosscheck data with other sources to check for accuracy and follow-up on inconsistencies or reporting errors.	5-06 to 6-06	MDH Staff	The data is clean and ready to analyze.	The level of missing data is minimal and responses are consistent with exiting data and expectations.
Action Step 5: Analyze data and disseminate results.	7-06 to 8-06	MDH Staff	The results from the survey provide information that is useful to policy makers.	Policy makers use the survey results to inform policy decisions.
Project 3: Study of Uncompensated Care Funding Sources				
Action Step 1: Literature review.	9-05 to 11-05	MDH Staff	Prepare a summary of literature on uncompensated care and national-level analysis of funding streams for uncompensated care.	Summary is clear, complete, and accurate.
Action Step 2: Determine applicability of national analysis to MN.	10-05 to 12-05	MDH Staff	Study how national-level analysis is applicable to Minnesota marketplace and data; determine whether methodology needs to be adapted due to differences in data at the state vs national level.	Differences in state and national level data are enumerated; strengths and weaknesses of different data sources are identified; proposed adaptations to national are appropriate for producing reliable results.
Action Step 3: Develop and refine MN-specific estimates.	12-05 to 3-06	MDH Staff	Develop and refine MN-specific estimates of uncompensated care and sources of funding.	Estimates are prepared using reliable data and widely accepted methods; differences between state and national estimates are documented and explained.
Action Step 4: Develop options for making more efficient use of uncompensated care funds.	3-06 to 5-06	MDH Staff	Study the opportunities and barriers to redirecting funding for uncompensated care to activities that are more cost-effective.	Options developed are based on study results; advantages and disadvantages of each are clearly defined.
Prepare Report to the Department				
Action Step 1: Prepare and deliver report to the Department.	9-06 to 10-06	MDH Staff	Report completed within thirty days after the end of the project period. Report will adhere to the established reporting requirements. The report will include a description of the results of the research conducted under the grant as well as a description of policy options and next steps.	

C. Governance:

Organizational Structure: The research conducted under the Limited Competition Planning Grant will have an organizational structure that has the appropriate authority to provide adequate oversight of the project. The administrative and research staff for the project will be located in the Health Economics Program (HEP), which is the primary program at the Minnesota Department of Health that conducts research and applied policy analysis to monitor changes in the health care marketplace. HEP has also been the responsible entity for prior work conducted using SPG funds. The main responsibilities of HEP are to understand factors influencing health care cost, quality, and access and to provide technical assistance in the development of state health care policy on these issues. HEP is recognized for its expertise in these areas by the Governor, Legislature, other policy makers, and stakeholders in the health care market including health care providers, health care plans, and consumers as purchasers of these services.

The results from all three of these projects will be reported by the Health Economics Program at the Minnesota Department of Health to the Governor, Legislators, the Health Cabinet, and the public in general. Researchers in the Health Economics Program will work with Dr. Jonathan Gruber of MIT to incorporate the results from these three research projects and the feedback on these results from policymakers into the refinement of the microsimulation model designed to assess the cost effectiveness of various coverage options.

Project Personnel: Personnel who were actively involved in earlier waves of activities funded under the State Planning Grants Program will be the primary project staff and will be providing in-kind support to the project. Scott Leitz, the Director of the Health Economics Program and Julie Sonier, the Assistant Director for Policy Analysis at the Health Economics Program will oversee and direct the funded activities, each with 5 percent of their time. April Todd-Malmlov and Stefan Gildemeister, both Senior Research Economists in the Health Economics Program, will provide in-kind support with 20 percent of their time each. Elizabeth Callahan Lukanen, a Senior Research Analyst in the Health Economics Program, will also provide in-kind support with 20 percent of her time.

Minnesota's Limited Competition Planning Grant proposal requests funding for two new full-time Senior Research Analyst positions and one full-time Management Analyst position. The Management Analyst and one of the Senior Research Analysts will work on the mail employer survey. The other Senior Research Analyst will be responsible for the small employer and individual market survey and the study of uncompensated care funding sources.

6. Grant Monitoring and Report

Monitoring: The State of Minnesota will implement a variety of processes designed to evaluate and monitor progress toward meeting the project goals and completing tasks. These processes have been used in earlier State Planning Grant efforts and have proven effective to ensure the timely and successful completion of project components. One staff person will be designated to ensure progress on each of the three projects. The State Planning Grant project team, which includes staff who have been continuously involved in State Planning Grant activities since Minnesota's initial SPG award in 2000, will meet bi-weekly with the Director of the Health

Economics Program and the Assistant Director to discuss progress on individual project components, necessary interventions, and how the project results can be incorporated into the ongoing policy making process. Should problems occur that result in delays, the State Planning Grant team can assemble quickly to develop responses addressing the delays. The state's ability and interest in making available significant in-kind efforts in the form of project oversight and staff support reflects Minnesota's commitment to performing tasks on time. When needed, such in-kind staff support can assist in bringing delayed projects in line with the anticipated timeline.

Report to the Department: The report on the activities of Minnesota's continuation grant will include a description of the results of the studies undertaken with the grant funding, and how they have informed the development of coverage options. This final report will be completed within thirty days after the end of the one-year project period and will adhere to the reporting requirements, format, and timeframe established by the Project Officer. Minnesota will also attend and participate in quarterly meetings by providing updates on the status and findings of State Planning Grant funded projects. Minnesota will assist in the preparation of consolidated national reports describing the process and outcomes of the State Planning Grant. Separate from the report to the Secretary, Minnesota is committed to providing, in a timely manner, any additional information that the Secretary, HRSA, or the organization preparing a summary report on behalf of HRSA may require. Minnesota is also committed to serving as a resource to other States.