



**APPROACHING UNIVERSAL COVERAGE:
MINNESOTA'S HEALTH INSURANCE PROGRAMS**

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Mathematica Policy Research, Inc.

FIELD REPORT

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EXECUTIVE SUMMARY

In 2001, Minnesota had the highest rate of health insurance coverage in the United States: 95 percent of the nonelderly population. While a high rate of private insurance coverage is an important reason for Minnesota's success relative to other states, the state also operates five public health insurance programs that collectively cover nearly all adults and children without private coverage. Together, these programs—Medical Assistance, General Assistance Medical Care, MinnesotaCare, the Minnesota Comprehensive Health Association, and the Public Employees Insurance Pool—cover about 11 percent of the state's nonelderly population. In 2000, four of five Minnesotans under age 65 without private coverage participated in a state-sponsored health insurance program.

This study reviews the eligibility rules, covered services, and funding for each of these programs and attempts to identify lessons that other state and federal policymakers might learn from the programs that Minnesota has built to support an unusually high and stable rate of health insurance coverage.

STRUCTURE OF MINNESOTA'S PUBLIC PROGRAMS

Three of Minnesota's five public health insurance programs target low-income children and adults; two target individuals of any income who have difficulty obtaining insurance in the private market (Table ES-1).

Table ES-1. Minnesota's Public Health Insurance Programs

Program	Target Population	Enrollment
General Assistance Medical Care (GAMC)	Low-income adults without children	34,050 ^a
Medical Assistance (MA)	Low-income families, children, pregnant women, elderly, and disabled	409,138 ^a
MinnesotaCare	Low-income families without access to employer-subsidized insurance	153,953 ^a
Minnesota Comprehensive Health Association (MCHA)	Medically Uninsurable	26,000 ^b
Public Employees Insurance Program (PEIP)	Employee groups representing Minnesota's counties, cities, towns, school districts, and other public jurisdictions	3,800 ^c

^a June 2002 enrollment according to Minnesota Department of Human Services website.

^b MCHA website.

^c Department of Employee Relations estimate of 2001 enrollment.

Medical Assistance

Minnesota's Medicaid program, Medical Assistance (MA), targets low-income children and families, the elderly, and the disabled. It is the state's largest public health insurance program, covering 409,000 Minnesotans as of June 2002. MA's income eligibility rules are set at the federal maximum in each eligibility category: 275 percent of the federal poverty level (FPL) for pregnant women and infants, 170 percent of FPL for children ages 2 through 18, and 100 percent of FPL for parents. Minnesota finances MA from the state's General Fund. MA requires no enrollee cost-sharing (such as coinsurance, copayments, or premiums), and it retroactively covers medical bills incurred within three months of the date of application for enrollment.

General Assistance Medical Care

General Assistance Medical Care (GAMC) offers health insurance coverage to members of the state's poorest population who are ineligible for any other state program. As of June 2002, nearly 34,000 Minnesotans were enrolled in GAMC. Low-income individuals become eligible for GAMC when they do not qualify for MA based on pregnancy, age, or disability—although GAMC's income ceiling is lower than that of any other program (approximately 70 percent of FPL for single adults, or about \$5,784 per year). Nearly all GAMC enrollees are adults between the ages of 21 and 65. Like MA, GAMC retroactively covers medical bills for three months prior to the date of application, and most of GAMC's payments are retroactive (for care that otherwise would have been unreimbursed). Minnesota pays the full cost of GAMC medical benefits and administration from the state's General Fund.

MinnesotaCare

MinnesotaCare targets low-income families with children and other adults without children whose incomes, while modest, exceed federal Medicaid standards and who do not have access to employer-subsidized group coverage. Families with children and household income that is less than 275 percent of FPL qualify for MinnesotaCare; adults without children qualify if their household income is less than 175 percent of FPL. MinnesotaCare is more like a conventional private insurance plan than a public program: it requires enrollees to pay premiums, coverage for adults entails some additional cost-sharing, and it does not pay medical bills retroactively. In addition to enrollee premiums, MinnesotaCare receives some federal Medicaid funds (for enrollees who would be eligible for Medicaid), and more than half of the program's costs are funded by a 1.5 percent tax on provider revenues. Minnesota is now taking steps to integrate the efforts of the MA, GAMC, and MinnesotaCare programs by automating eligibility determinations and blending the programs' benefits and financing to make the application and claims processes

as seamless as possible for the populations they serve. Nearly 154,000 Minnesotans were enrolled in MinnesotaCare as of June 2002.

Minnesota Comprehensive Health Association

The nation's largest high-risk pool is the Minnesota Comprehensive Health Association (MCHA). Established in 1976, MCHA offers comprehensive and Medicare supplemental coverage to individuals who have been denied standard coverage or standard premiums in the market because of a past or current health problem. In 1999, 47 percent of enrollees were self-employed. Enrollment in MCHA peaked at more than 35,000 in 1993. It subsequently declined, as Minnesota instituted small-group insurance reforms and employer coverage expanded in a strong economy. Since 1999, as Minnesota's economy has softened, MCHA enrollment has risen steadily. In May 2001, more than 26,000 individuals were enrolled in MCHA. The pool covers its annual operating deficit by assessing the group and individual premiums earned by commercial carriers, HMOs, fraternal organizations, and nonprofit health service corporations in the state. In 2001, the total assessment to support MCHA was \$51.5 million, less than 2 percent of insurers' earned premiums. The state contributed another \$15 million to support MCHA losses.

Public Employees Insurance Program

The modest Public Employees Insurance Program (PEIP) is a small-group purchasing pool for county governments, town governments, and school districts operated by the Minnesota Department of Employee Relations. In 2001, PEIP covered about 3,800 individuals.

THE REMAINING UNINSURED

Minnesota's mix of high rates of private insurance coverage and generous public insurance programs covers about 95 percent of the state population, but some Minnesota residents remain uninsured. Not surprisingly, Minnesota's uninsured population is ethnically, demographically, and economically concentrated. Some racial/ethnic groups, including blacks, Hispanics, and Native Americans, are much more likely to be uninsured than the general population, as are young adults ages 18 to 24, low-income Minnesotans, and residents in the north central and northwestern parts of the state (MDH 2002). About three-quarters of the uninsured in Minnesota are employed (or live in the family of an employed worker), but they are more likely than the overall population to be self-employed or work in a small business.

An estimated two-thirds of uninsured Minnesotans are eligible for health insurance, either through an employer-sponsored plan or a public program. Among the uninsured with access to employer-sponsored insurance, most cited cost as the reason for

not enrolling (MDH 2002). Among the uninsured who are potentially eligible for public programs, 77 percent stated that they would enroll if they learned that they were eligible for a public program.

CONCLUSION

Whether or not Minnesota offers a good model for other states is a complex question. None of Minnesota's programs is unique: every program that Minnesota operates has existed or currently exists in some other state. However, Minnesota is unusual in its overarching commitment to extending health insurance coverage and its practice of seizing opportunities to do so. Like other states, Minnesota struggles to pay for its public programs; it is unusual in that it has proven willing to allocate state funds to support broad eligibility. Minnesota also has benefited from having a number of legislative champions for broader health insurance coverage and from significant longevity among its senior program officials. Minnesota's lesson is simple, although apparently not easy for many states to follow: by starting programs modestly, expanding them as they demonstrate their value, and serving populations in need at all levels of income, states can approach universal coverage.

APPROACHING UNIVERSAL COVERAGE: MINNESOTA'S HEALTH INSURANCE PROGRAMS

I. INTRODUCTION

Minnesota has the highest statewide rate of health insurance coverage in the United States. In 2001, an estimated 95 percent of the population had coverage from either private insurance or a public program, compared with a national rate of about 86 percent in 2000 (MDH 2001; U.S. Census Bureau 2001b). Minnesota's high rate of coverage is due in part to the high rate of private insurance coverage in the state. About 83 percent of Minnesota's nonelderly population had private health insurance in 2000, compared with a national average of 72 percent (U.S. Census Bureau 2001b).

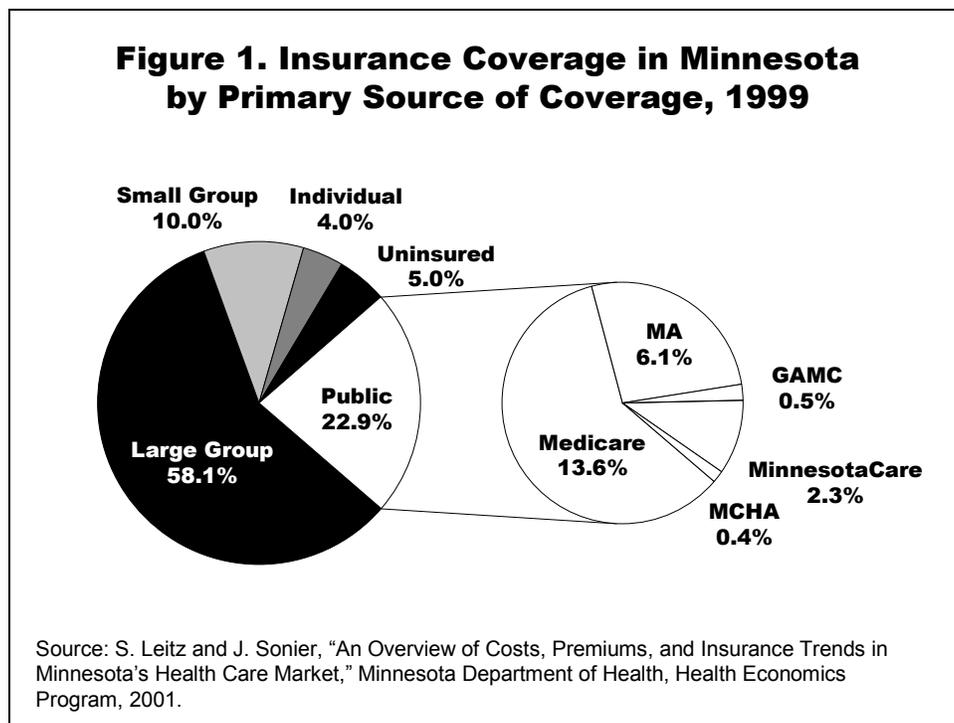
While a high rate of private insurance coverage is an important reason for Minnesota's success relative to other states, Minnesota also operates a series of public health insurance programs that are among the most inclusive in the nation, with broad eligibility and comprehensive benefits. In 2000, five state insurance programs—Medical Assistance, General Assistance Medical Care, MinnesotaCare, the Minnesota Comprehensive Health Association, and the Public Employees Insurance Pool—covered more than 500,000 Minnesotans. Together, these enrollees made up about 78 percent of Minnesota's nonelderly population without private insurance (Leitz and Sonier 2001; DHS 2001a; MCHA 2000).

This study attempts to identify lessons that other state and federal policymakers might learn from the programs that Minnesota has built to support its extraordinarily high and stable rate of health insurance coverage. While some other states have instituted programs that are roughly similar to Minnesota's major public and private programs, in no other state is the combination of these programs as effective in complementing private insurance. The study looks at potential lessons in a number of areas: program eligibility, benefits, and administration. Information about Minnesota's programs was drawn from public documents and from a series of extensive, semistructured interviews conducted in person with program officials and other key informants in the state.

II. STRUCTURE OF MINNESOTA'S PUBLIC PROGRAMS

Minnesota operates five public health insurance programs, which collectively cover about 22.9 percent of the state's total population and about 11 percent of the population under age 65 (Figure 1 and Table 1). Three of these programs target low-income children and adults:

- Medical Assistance (MA) targets children and families, the elderly, and the disabled. Each of these subpopulations is eligible for federal Medicaid funds. Although Minnesota’s broad eligibility for MA has meant that very few children are eligible for the State Children’s Health Insurance Program (CHIP) within federal limits, Minnesota enrolls its few CHIP-eligible children in MA.¹
- General Assistance Medical Care (GAMC) is primarily for adults without children and is wholly funded by the state. Some GAMC enrollees also receive General Assistance payments, but most do not. Many GAMC enrollees are disabled and waiting for federal Supplemental Security Income (SSI) benefits to begin.
- MinnesotaCare targets children and families with income that, while modest, exceeds federal Medicaid standards. To be eligible, children and adults cannot have access to employer-subsidized group coverage. As of 2002, Minnesota will enroll adults eligible for CHIP in MinnesotaCare.



¹ Federal regulations require that the states use CHIP funds to pay only for populations made eligible by enactment of the program. Because MA and MinnesotaCare already covered children in households with income up to 275 percent of FPL, these children were not eligible for Minnesota’s CHIP program. To secure interim federal CHIP funding, Minnesota expanded eligibility for infants (ages 0–2) to 280 percent of FPL.

Table 1. Enrollment in Minnesota's Health Care Programs by Age

Age of Enrollee	NUMBER OF ENROLLEES			PERCENT OF ENROLLMENT		
	MA	GAMC	MinnesotaCare	MA	GAMC	MinnesotaCare
0–2 years old	53,066	100	6,442	13.9%	0.4%	4.7%
3–18 years old	143,559	995	53,618	37.7%	3.8%	39.3%
19–20 years old	11,842	45	6,241	3.1%	0.2%	4.6%
21–64 years old	123,656	25,293	69,876	32.4%	95.4%	51.2%
65+ years old	49,083	92	266	12.9%	0.3%	0.2%
Total	381,206	26,525	136,443	100.0%	100.0%	100.0%

Note: Enrollment data are as of June 2001, most recent date for which detailed enrollment data are available.
Source: Information from the Minnesota Department of Human Services, 2001.

Two additional, publicly sponsored private insurance programs target people of any income who have difficulty obtaining private insurance in either of two particular circumstances:

- Minnesota Comprehensive Health Association (MCHA) is Minnesota's high-risk pool for those denied coverage in the private, individual (nongroup) health insurance market.
- Public Employees Insurance Program (PEIP) provides group health coverage to county, municipal, and school-district employees.

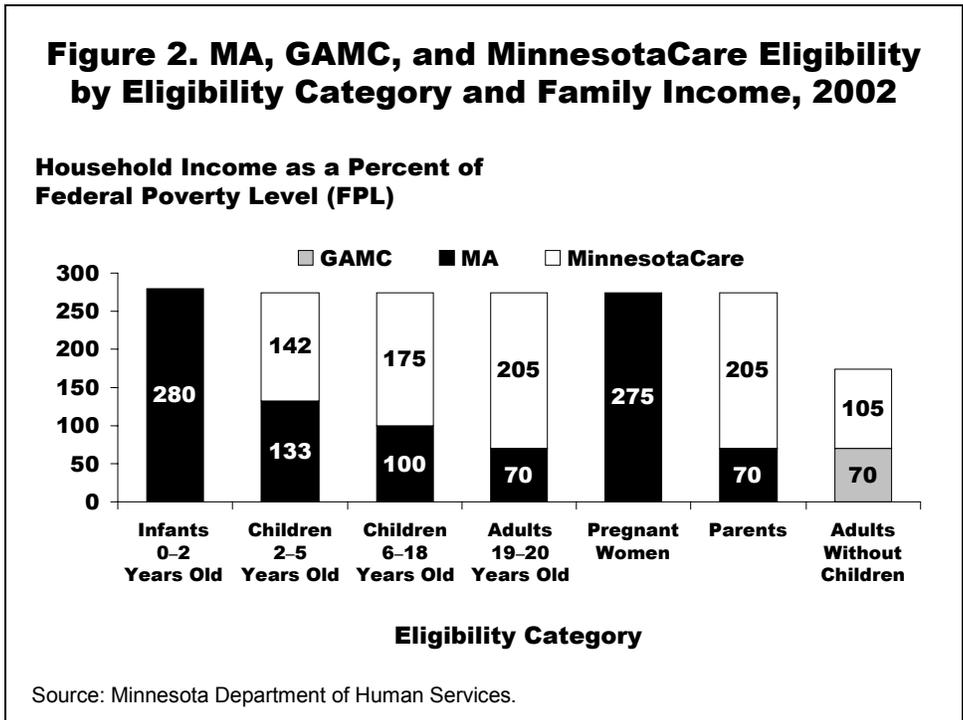
The following sections review eligibility rules, covered services, and funding for each of these programs. These program characteristics and other facts about Minnesota's public programs are summarized in the Appendix (as are the state's publicly sponsored private programs, described below). The study then examines program administration, focusing on the state's efforts to coordinate eligibility determination and managed care contracting among the three programs that serve low-income populations.

III. MINNESOTA'S INCOME-RELATED PUBLIC HEALTH INSURANCE PROGRAMS

Minnesota's three income-related programs in general complement one another. However, because there is a degree of overlap in eligibility requirements, certain individuals who are eligible for one program may also be eligible for another. The programs' different eligibility standards, benefit configurations, sources of funding, and administrative structures are described below.

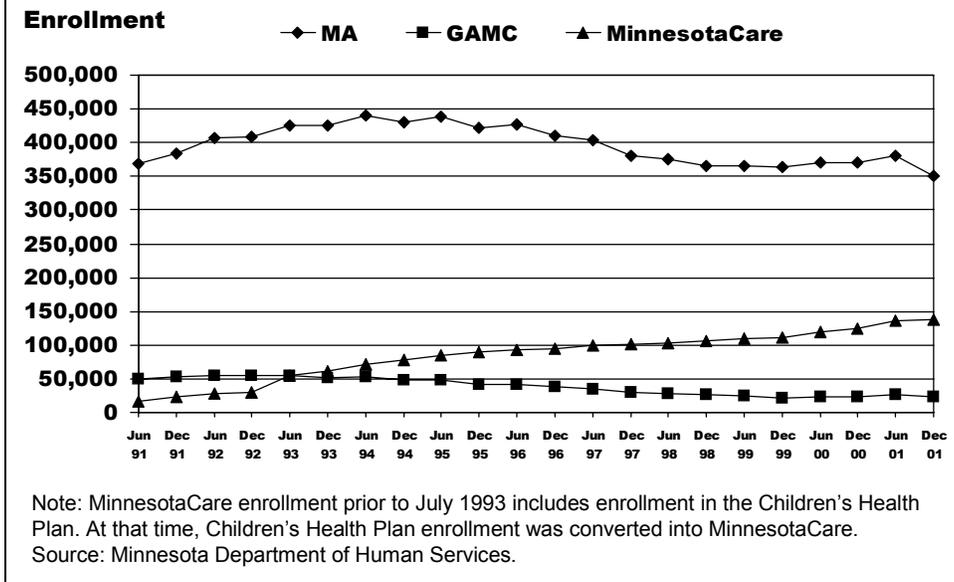
A. ELIGIBILITY AND ENROLLMENT

Eligibility for MA, GAMC, or MinnesotaCare is determined by the characteristics of the applicant’s family as well as the family’s income and assets. Among the nonelderly population, MA is available principally to families with children, but it is also available to the disabled population. GAMC is available to extremely low-income adults without children. MinnesotaCare serves the higher-income population, but with different provisions for families with children and adults without children. Eligibility categories and the qualifying income level in each category are depicted in Figure 2.



As with similar programs in every state, both MA and GAMC enrollment declined over the last decade as a result of welfare reform and high rates of employment. However, MinnesotaCare enrollment grew steadily. Thus, total enrollment across all three programs was slightly higher in December 2001 than in January 1991 (Figure 3).

Figure 3. Enrollment in Minnesota's Public Health Insurance Programs, 1991-2001



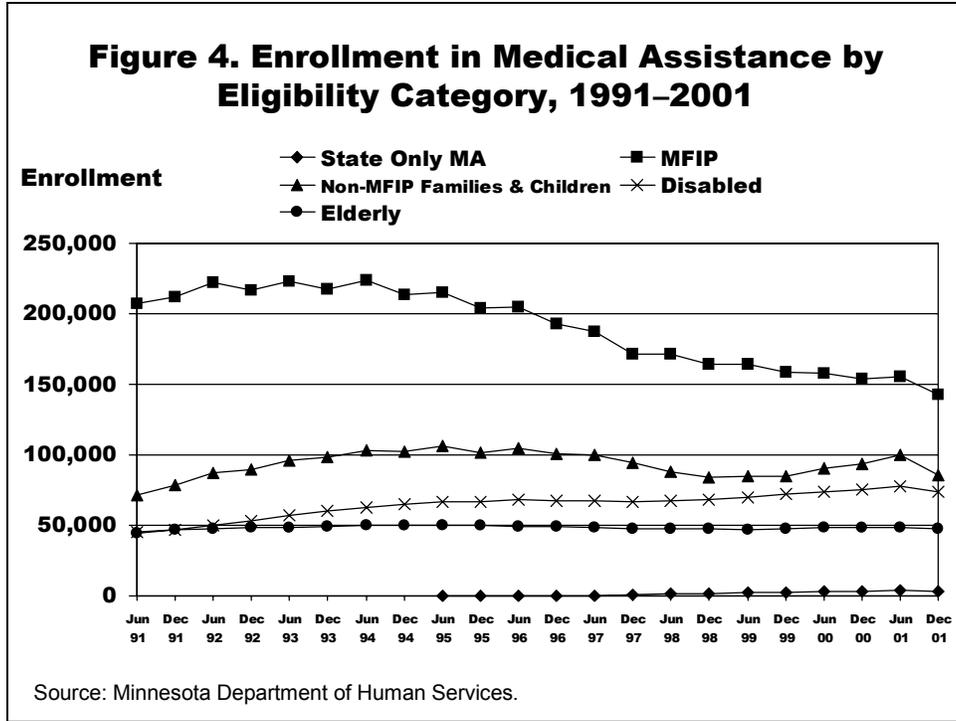
MA

MA, Minnesota's Medicaid program, is the state's largest public health insurance program. As of October 2001, nearly 354,000 children and adults were enrolled in MA (DHS 2001b). MA defines eligibility for Medicaid based on federal "categorical" eligibility criteria as well as family income and assets.

Categorical eligibility. The categories of Minnesota residents eligible for MA are (1) children, (2) pregnant women, (3) parents, (4) people unable to work due to disability, and (5) people age 65 or older. About two-thirds of MA enrollees are children and their parents; one-third of enrollees are elderly or disabled (DHS 2001c).

With the extension of federal Medicaid eligibility to pregnant women and children from families with higher incomes and later with welfare reform, MA has enrolled populations ineligible for cash assistance—historically the main point of entry into MA—for more than a decade. Throughout the 1990s, the population enrolled in MA but not in the state's Temporary Assistance for Needy Families Program, the Minnesota Family Investment Program (MFIP), grew steadily. This population included many two-parent families. In June 2001, MA enrolled about 94,000 adults and children who were not

enrolled in MFIP—40 percent of total enrollment (Figure 4). In general, single adults without children remain ineligible for MA, as do many noncitizens.²



Income eligibility. MA’s eligibility rules are set at the maximum recognized in federal law for each of the program’s eligibility categories. Children and pregnant women qualify for MA benefits at higher levels of income (up to 275 percent of the federal poverty level) than applicants in other eligibility categories. In July 2002, MA income limits rose to 170 percent of FPL for children ages 2 through 18 and to 100 percent of FPL for parents. Minnesota estimates that, by 2005, these higher limits will bring into the program an additional 20,000 children, including 12,000 uninsured children, and an additional 4,000 parents (DHS 2001d).

Minnesota is one of 38 “Medicaid spend-down” states; that is, states in which categorically eligible individuals may deduct personal health care expenditures from family income to determine eligibility for MA. All MA enrollees must requalify every six months.

² The Personal Responsibility Work and Reconciliation Act of 1996 (P.L. 104-193) instituted a federal five-year ban on Medicaid eligibility for legal resident aliens and other qualified aliens who arrived in the United States after August 1, 1996. There are some exceptions for refugees and aliens granted asylum.

GAMC

GAMC provides coverage to members of the state's poorest population who are ineligible for any other state program. As of June 2002, GAMC enrollment was 34,050 (DHS 2001b).

Categorical eligibility. Low-income individuals become eligible for GAMC when they do not fit the eligibility categories of Minnesota's Medicaid program (MA), even though they would qualify for MA on the basis of income alone. GAMC enrollees are primarily low-income adults without dependent children. More than 95 percent of GAMC enrollees are adults between the ages of 21 and 64. GAMC also covers low-income immigrants or noncitizens and some residents of adult foster care or mental illness facilities.

Enrollment in GAMC declined steadily during the 1990s, reflecting both welfare reform and the transfer of many GAMC enrollees into MinnesotaCare. As of October 2001, about 26 percent of GAMC enrollees were also enrolled in the state's General Assistance cash welfare program; 71 percent received only GAMC coverage (DHS 2001b). The remaining 3 percent were residents of institutions for mental diseases.

More than MA or MinnesotaCare, GAMC is a transitional program; enrollees are encouraged to make the transition to either MA or MinnesotaCare as early as possible. As a result, approximately 40 percent of GAMC enrollees participate in the program for six months or less (Table 2).³

Table 2. Duration of Enrollment in Minnesota Health Care Programs for June 2001 Enrollees

	MA				GAMC			MinnesotaCare	
	MFIP ^a Families and Children	Non-MFIP Families and Children	Elderly	Disabled	General Assistance	GAMC Only	Residents of Institutions for Mental Diseases	Families with Children	Adults
0–6 months	14.2%	30.8%	6.8%	10.2%	35.9%	48.9%	8.3%	16.4%	20.7%
7–12 months	12.4%	17.4%	5.4%	8.2%	17.2%	17.2%	5.9%	11.9%	13.7%
13–24 months	17.9%	19.7%	10.5%	14.3%	17.5%	14.0%	8.2%	17.1%	20.0%
25–36 months	11.9%	8.6%	17.3%	9.7%	8.1%	5.7%	7.3%	11.7%	12.5%
37–48 months	7.8%	4.6%	5.8%	7.1%	4.7%	3.0%	5.8%	7.9%	8.2%
49+ months	35.9%	19.0%	64.3%	50.4%	16.7%	11.3%	64.5%	35.0%	24.9%

^a Minnesota Family Investment Program (MFIP) is the state's low-income cash assistance program.

Note: Data are June 2001 program enrollees' length of stay in current episode of enrollment. Breaks in enrollment of 1 or 2 months are disregarded. A break of 3 months or more is considered a separate episode.

Source: Information from the Minnesota Department of Human Services, 2001.

³ This figure excludes residents of institutions for mental diseases, who constitute a small proportion of GAMC enrollment.

Income eligibility. GAMC has the lowest income limits of any of the state's insurance programs. To qualify for GAMC, single adults must have income less than \$5,784 per year, or about 70 percent of FPL.⁴ Also, eligible individuals may not have household assets that exceed \$1,000 in value.⁵ Childless adults with income equal to at least 75 percent of FPL are routinely referred to Minnesota's health care assistance program for higher-income adults, MinnesotaCare. Individuals with income higher than the GAMC limits may "spend down" to GAMC eligibility if their medical bills exceed the difference between their income and the program's limits.

GAMC enrolls individuals for 12-month periods, but enrollees must requalify at six-month intervals during the first year. In subsequent years, individuals must requalify annually, at the time of enrollment.

MinnesotaCare

MinnesotaCare covers low-income families and individuals without access to employer-subsidized group coverage. In FY2000, enrollment in MinnesotaCare averaged about 109,000 adults and children per month (DHS 2001a). Since its inception in 1992, MinnesotaCare enrollment has increased steadily as more groups have become eligible to enroll and the popularity of the program has grown.

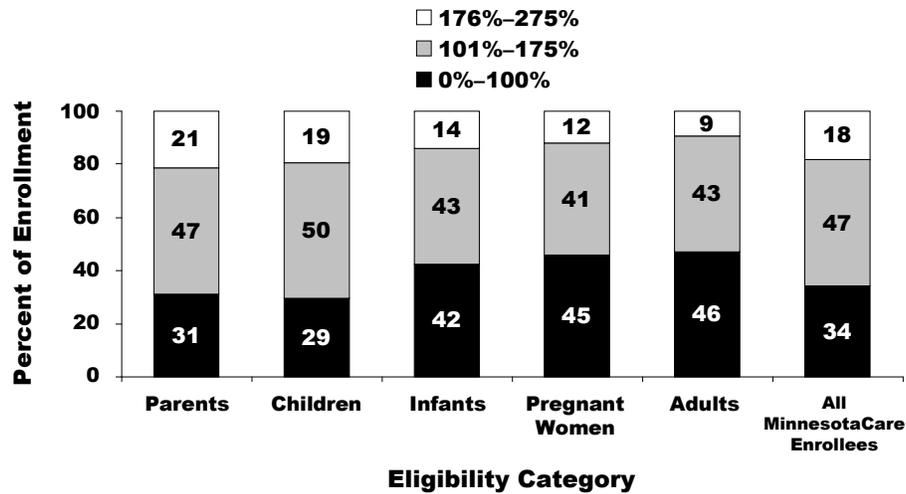
Categorical eligibility. Families with children as well as adults without children may enroll in MinnesotaCare (the latter by amendment to the program in 1994). As a result of the overlapping eligibility standards of MinnesotaCare and MA, some MinnesotaCare enrollees are also eligible for MA, and they incur out-of-pocket expenses that they would not incur in MA.

Income eligibility. Qualifying income for MinnesotaCare varies by category of eligibility. Families with children qualify if their income is less than 275 percent of FPL; adults without children qualify if their income is less than 175 percent of FPL. Reflecting the lower income limits applied to adults without children, these enrollees generally are poorer than enrolled families with children (Figure 5). In October 2001, 34 percent of all MinnesotaCare enrollees were in families with income below the poverty level.

⁴ Qualifying income for GAMC is frozen at 133.3 percent of 1996 qualifying income for Aid to Families with Dependent Children (AFDC)—a federal/state cash assistance program that was replaced in 1996 by the Temporary Assistance for Needy Families (TANF) Program. Minnesota's TANF program is the Minnesota Family Investment Program (MFIP).

⁵ Selected personal assets (such as the family's home and car) are exempted from the calculation of assets.

Figure 5. MinnesotaCare Enrollees by Income and Eligibility Category, October 2001



Source: Minnesota Department of Human Services.

Access to employer-subsidized coverage. Minnesota defines employer-subsidized coverage as an employer-sponsored plan in which the employer pays at least 50 percent of the insurance premium. To qualify for MinnesotaCare, adult applicants must have been uninsured for at least four months and without access to employer-subsidized group coverage for 18 months. For children, MinnesotaCare’s access rules are more inclusive:

- Children in families with an income of less than 150 percent of FPL are eligible for MinnesotaCare if they are uninsured or underinsured, regardless of access to employer-subsidized coverage.⁶
- Children in families with an income of between 150 and 275 percent of FPL qualify for MinnesotaCare only if they have been uninsured for at least four months and have no current access to employer-subsidized coverage.

Both provisions—the level of employer contribution to health insurance and waiting periods to qualify for MinnesotaCare—were intended to discourage crowd-out, or the substitution of public coverage for private insurance that is either more costly to the individual or offers narrower benefits than the public coverage would. However, the specifics of these provisions are arbitrary. Program officials have no estimates of the extent

⁶ An individual is considered underinsured if he or she has coverage that does not include at least basic hospital and medical/surgical care (DHS 2001c).

to which crowd-out exists or how many uninsured adults are ineligible for MinnesotaCare due to its crowd-out provisions.⁷ There is some concern that the 50-percent standard that defines employer-sponsored coverage is a barrier to enrollment—that many workers who otherwise would qualify for MinnesotaCare are unable to pay as much as half of the cost of private group coverage. In addition, workers who lose health insurance because their employer dropped group coverage or went out of business must wait 18 months before they become eligible for MinnesotaCare.

B. BENEFITS

Each of Minnesota’s public insurance programs covers basic hospital and medical care, as well as other major categories of medical expense, including prescription drugs. However, the programs differ in their coverage of some specific benefits and in their cost-sharing provisions.

MA

MA covers the comprehensive core set of benefits that all state Medicaid programs must cover in order to qualify for federal funding. These include inpatient and outpatient hospital care, ambulatory care, laboratory services, and X-ray services. In addition, MA covers a broad array of “optional” services, including prescription drugs, mental health care, alcohol and drug treatment, dental care, vision and hearing care, home health care, hospice care, personal care, private-duty nursing, chiropractic services, and transportation services.⁸

MA requires no enrollee cost-sharing (such as coinsurance, copayments, or deductibles) and will retroactively cover medical bills incurred within three months of the date of application for enrollment.

GAMC

GAMC offers the same coverage as MA, with the exception of some specific service categories: prenatal and maternity care, nursing home care, home health care, personal care assistance, or hospice care. In general, low-income people in need of these services (pregnant women, the elderly, or the disabled) would qualify for MA. Like MA, GAMC requires no premiums or cost-sharing. Also like MA, GAMC covers medical bills incurred within three months of the date of application for enrollment.

⁷ One state official said that “the four-month block-out period was picked out of the air to reduce crowd-out, but there doesn’t seem to be a lot of crowd-out” (MN interviews 2001).

⁸ A comprehensive listing of Medicaid’s required and optional service categories is posted at www.cms.hhs.gov/medicaid/mservice.asp.

MinnesotaCare

For children under age 21 and pregnant women, MinnesotaCare offers benefits that are identical to those in MA.⁹ For other eligible adults, MinnesotaCare covers all MA benefits except personal care, case management, nursing home care, and dental care other than preventive services. For enrolled parents with income above 175 percent of FPL and all adults without children, MinnesotaCare's hospital benefit is capped at \$10,000 per year. Adults whose hospital care exceeds the \$10,000 annual limit may "spend down" to become eligible for MA or GAMC. MinnesotaCare does not pay medical bills incurred before the date of enrollment.

In contrast to MA and GAMC, MinnesotaCare requires enrollees to pay premiums. Enrollees with family income below 150 percent of FPL pay the minimum premium, which is currently \$4 per enrollee per month. Enrollees with family income above 150 percent of FPL pay premiums that are adjusted for family size and capped at 8.8 percent of family income (Interview 2001). In FY2000, the average MinnesotaCare enrollee paid \$22 per month (DHS 2001e).¹⁰

Adults enrolled in MinnesotaCare must pay some cost-sharing. The amount of cost-sharing varies by family income and whether or not there are children in the family. Parents with income above 275 percent of FPL and all adults without children pay 10 percent of the cost of hospital care, capped at \$1,000 per individual and \$3,000 per family. All adults (except pregnant women) must pay \$3 per prescription.

C. PROGRAM EXPENDITURES AND FUNDING

Minnesota's income-related health insurance programs are financed with substantial state funds, matched in part by federal funding for Medicaid and CHIP. Minnesota has expanded program eligibility to the limits that qualify for federal matching funds. Approximately half of the state's expenditures for children and parents qualify for federal matching.

MA

In FY2000, MA payments for covered services totaled nearly \$3.3 billion. Like other state Medicaid programs, MA spends far more for the one-third of enrollees who are elderly, blind, or disabled than for parents or children enrolled in the program—in 1999, nearly \$1,700 per capita was spent for the elderly, blind, or disabled compared with just \$220 for

⁹ When first enacted, MinnesotaCare covered only outpatient services. In 1993, benefits were expanded to include inpatient services, and they subsequently have been expanded further.

¹⁰ MinnesotaCare drops enrollees who fail to pay premiums but reinstates enrollees retroactively if they pay all outstanding premiums within 20 days of the cancellation date. MinnesotaCare does not drop pregnant women or infants for nonpayment of premiums; these enrollees can avoid being charged for unpaid premiums by enrolling in MA.

enrolled parents and children. In 2001, spending for the elderly, blind, or disabled accounted for about 78 percent of the program's total medical costs (DHS 2001c).

As the state's Medicaid program, MA is financed from the state's General Fund with federal matching. Historically, federal matching funds have covered about 51.5 percent of medical outlays, but in October 2001, the federal matching rate dropped to 50 percent (the federal minimum). In 2000, Minnesota paid \$1.4 billion of MA's total medical outlays of \$3.3 billion (DHS 2001a). Each county funds its own administrative role.

Because Minnesota historically has extended MA eligibility to the limits of federal Medicaid matching, it has had difficulty qualifying for CHIP funds.¹¹ Minnesota obtained an initial federal waiver to use CHIP funds to cover a small expansion of its MA population—infants to age 2 from families with total incomes of between 275 and 280 percent of FPL—in order to claim and retain its initial three-year federal CHIP appropriation.¹²

GAMC

In FY2000, GAMC paid \$126 million for enrollees' medical care. Since welfare reform in 1996, total GAMC medical payments have declined from a peak level of \$164 million paid in 1993. However, medical payments per enrollee have more than doubled—from \$249 per enrollee in 1993 to \$520 in December 2000 (DHS 2001a). GAMC's total projected medical payments in FY2001 reached \$136 million—an 8 percent increase over FY2000 (DHS 2001a). Most of this increase reflects anticipated further growth in medical payments per enrollee; total enrollment as projected rose only slightly.

Most of GAMC's payments are retroactive, for care that otherwise would have gone unreimbursed. Thus, one program official described GAMC as a "safety net program for the providers," directly reducing uncompensated care in the state (Interview 2001).

Because GAMC includes only adults ineligible for MA, program expenditures do not draw either Medicaid or CHIP federal matching funds. Minnesota's General Fund pays the full cost of GAMC medical benefits and state administration, while each county pays its own cost for program administration.

¹¹ Federal rules require that CHIP funds pay only for populations made eligible by the enactment of CHIP. CHIP offers a higher federal matching rate than Medicaid, covering two-thirds of medical expenditures, compared with a federal Medicaid matching rate of 50 percent in Minnesota.

¹² Under a separate federal waiver effective in 2002, parents with family income between 100 and 200 percent of FPL who are enrolled in MinnesotaCare will also qualify for federal CHIP matching funds. Minnesota expects to receive \$9 million in federal CHIP funds in 2002, rising to \$15 million by 2005 (DHS 2001d). In 2002, these funds will cover approximately 27,000 parents who qualify for MinnesotaCare. Minnesota also will use some of its federal CHIP funds to implement health improvement initiatives in the state.

MinnesotaCare

MinnesotaCare's medical payments totaled \$196.3 million in FY2000—\$70 million more than GAMC, but far less than MA. MinnesotaCare paid much less than either GAMC or MA per enrollee—about \$150 per month (DHS 2001a).

MinnesotaCare is financed from the state's Health Care Access Fund (HCAF), which in turn is funded by a tax on providers. The provider tax has been set at 1.5 percent of providers' gross revenues since 1998. Through Medicaid waivers, Minnesota has obtained federal Medicaid matching funds for children and parents enrolled in MinnesotaCare who would qualify for MA.¹³ In FY2000, enrollee premiums paid 14.4 percent of MinnesotaCare's expenditures for medical care, federal matching funds paid nearly 26 percent, and the state paid 60 percent (DHS 2001a).

D. PROGRAM ADMINISTRATION

Minnesota's Department of Human Services (DHS) oversees all three income-related programs. However, Minnesota's counties directly administer MA and GAMC eligibility determination, and 38 of Minnesota's 80 counties are also enrollment sites for MinnesotaCare. Because DHS oversees all of the programs, there is considerable coordination among the programs, although they are not fully integrated.

In this section, two aspects of program administration for GAMC, MA, and MinnesotaCare are considered: how eligibility determinations are made and how managed care contracting is done. Both aspects of program administration have important implications for enrollees who may move between public programs as their family and income circumstances change.

Eligibility Determination

Like many other states, Minnesota recently simplified its eligibility determination process to encourage enrollment. GAMC, MA, and MinnesotaCare all now rely on the same application form—the Minnesota Health Care Program Application. Shortened from 24 to four pages, the application is available electronically on the DHS website, from county social service agencies, and from most health care providers in the state. The major safety net hospitals and community clinics typically also have caseworkers on-site to help enroll patients who may be eligible for any of these programs. The Health Care Program Application is available in English and eight other languages. Since Minnesota shortened

¹³ Since July 1995, MinnesotaCare has used a Medicaid Section 1115 waiver to obtain the federal Medicaid match for children and pregnant women in MinnesotaCare. In 2000, Minnesota received another waiver to obtain federal Medicaid matching funds for parents and relative caretakers enrolled in MinnesotaCare (DHS 2001d).

the application, the statewide processing center for MinnesotaCare has received 3,000 to 4,000 applications per month, compared with about 1,000 per month previously (Interview 2001).

Applicants may either mail the Health Care Program Application to the state or submit it to their county social service agency. Because the counties determine eligibility for GAMC and MA, applicants who wish to be considered for these programs must submit or mail their application to their county social service agency. In counties that also determine eligibility for MinnesotaCare, applicants who wish to be considered for all three programs are also encouraged to apply through their county social service agency.

Applicants who want to be considered for MinnesotaCare only (or who live in a county that does not conduct MinnesotaCare eligibility determinations) must send their applications to the state processing center for an eligibility determination. The state may cross-refer an individual to the county for a determination of MA or GAMC eligibility if the applicant appears to be eligible and has checked a box on the application form indicating that they are comfortable with their application being sent to the county for review.

A system with multiple points of entry offers some advantages to applicants, but it can also pose problems if controls are not in place to ensure uniform standards for eligibility determination and cross-referral. Neither the state nor any of the counties have automated eligibility systems. All determinations are performed by caseworkers, assisted by an online MDHS Health Care Programs manual. County caseworkers are described as “knowing as much as can be expected about eligibility” for the programs (Interview 2001). However, there is inevitable variation among counties in the efficiency with which they make eligibility determinations and cross-referrals among programs. Even at the state level, the higher caseload that followed simplification of the application is believed to have impeded the state processing center in making cross-referrals.

The stigma associated with enrollment in welfare programs has impeded the state’s success in referring low-income applicants to MA or GAMC, especially in rural communities. Despite MinnesotaCare’s premium and cost-sharing requirements, state officials believe that some applicants prefer to enroll in a program through a state office, rather than at a local social service agency where the community might learn of the applicant’s request for assistance. Historically, rural counties have had more difficulty enrolling eligible individuals in MA or GAMC, both because enrollment required personally visiting the local welfare office and because some county boards reviewed applications in person. These practices have disappeared, but state officials—observing that

rural enrollment in the state-administered MinnesotaCare program remains disproportionately high—believe that many rural residents are still wary of county-administered public assistance and prefer the anonymity of a state program (Interview 2001). Residents of rural counties compose nearly 46 percent of MinnesotaCare enrollment, but only 30 percent of the state’s population (Table 3).

Table 3. Enrollment in Minnesota Health Care Programs by Urban/Rural Residence

	NUMBER OF ENROLLEES		PERCENT OF ENROLLEES	
	MSA ^a	Non-MSA	MSA	Non-MSA
Total Population	3,463,360	14,561	70.4%	29.6%
MA	256,215	124,991	67.2%	32.8%
GAMC	19,230	7,295	72.5%	27.5%
MinnesotaCare	73,918	62,630	54.1%	45.8%

^a Minneapolis, St. Paul, Rochester, and Duluth, Minnesota.

Source: U.S. Census, 2000 Census; Minnesota Department of Human Services.

Managed Care Contracting

DHS contracts with HMOs to deliver care to enrollees in each of the state’s three public health insurance programs. State law requires all HMOs to contract with all three programs in good faith. Thus, any HMO with a significant presence in a county must bid to be part of the programs’ managed care network.

All MinnesotaCare enrollees must participate in an HMO. However, with respect to MA and GAMC, the counties choose whether or not to participate in Minnesota’s managed care program, the Prepaid Medical Assistance Program (PMAP). All but about 20 rural counties do so.¹⁴ With some significant exceptions, all MA and GAMC enrollees in PMAP counties are required to participate in an HMO.¹⁵ In FY2000, 43 percent of MA enrollees and 52 percent of GAMC enrollees were enrolled in managed care (DHS 2001e).

With the advice of the counties in which HMO contracts are awarded, DHS contracts with HMOs to provide care to MinnesotaCare and PMAP enrollees. HMOs that contract with MinnesotaCare are also PMAP providers for MA and GAMC enrollees

¹⁴ Counties that do not participate in PMAP may participate in Minnesota’s county-based purchasing program. DHS pays these counties a capitation amount per MA or GAMC enrollee; the county may then either assume full financial risk for serving enrollees or assign it to a third party.

¹⁵ GAMC or MA enrollees who are disabled, Native Americans on reservations, those eligible as a result of medical spend-down for acute care, or part of selected subpopulations are exempted from mandatory enrollment in managed care. Dual-eligibles (elderly or disabled individuals eligible for both Medicare and MA) may enroll in either PMAP or the Senior Health Options program, a Minnesota waiver program designed to bundle Medicare and Medicaid managed care services.

in the county. DHS awards contracts based on an HMO's ability to serve the population, not on price. DHS pays the HMO a capitation payment based on a set of risk factors and location, and the HMO assumes full risk for covered services. In turn, Minnesota HMOs generally pay providers on a discounted fee-for-service basis (Interview 2001). Minnesota HMOs reported profits from these programs of \$39.3 million in 2000 and \$17 million in 2001 (Baumgarten 2002).

For GAMC, MA, and MinnesotaCare enrollees, the PMAP system reduces the potential that enrollees will be forced to change providers if they change programs. Coordinated contracting also gains the state administrative efficiencies.

E. EMERGING ISSUES

Among the many issues that emerge in any program of the size and scope of those in Minnesota, the state Department of Human Services has identified three as critical to maintaining and improving the state's income-related health insurance programs: access to dental services, automated program enrollment, and improved coordination among the programs to boost retention and eliminate unnecessary lapses in coverage. These are discussed below.

Access to Dental Care

GAMC, MA, and MinnesotaCare all cover dental services.¹⁶ However, enrollee problems in accessing dental care have been documented: disparities in dental service use between Minnesota's publicly and privately insured populations persist, as do regional and racial disparities among public program enrollees (DHS 2001f).¹⁷

Dental providers in Minnesota claim that patients from public programs are more difficult to treat. Specifically, they claim that they have higher "no-show" rates than privately insured patients. Dental providers also complain that the programs' low reimbursement rates often do not cover even overhead costs (DHS 2001f). DHS paid 54 percent of charges in 1999, while private insurance plans paid 80 percent (DHS 2001f). A shortage of providers, especially in rural areas, also contributes to enrollees' lower use of dental care.

Minnesota has undertaken several initiatives to reduce disparities in access to and use of dental care within the state's public health insurance programs. Since 1990, DHS has raised dental payment rates four times (DHS 2001f). The legislature has approved

¹⁶ Adult MinnesotaCare enrollees are covered only for preventive dental care.

¹⁷ In the mid-1990s, only 30 percent of GAMC, MA, and MinnesotaCare enrollees visited a dentist, compared with 70 percent of all Americans with private health insurance (DHS 1999).

grants to community clinics and training sites, forgiveness of dental student loans, higher reimbursement for child preventive care, and greater use of dental hygienists. In its 2001 prepaid contracts, DHS included dental service performance incentives and raised payment rates in rural areas specifically to increase dental access (DHS 2001f).

Automated Enrollment

DHS plans to automate enrollment systems for MA, GAMC, and MinnesotaCare. Automated enrollment would achieve faster eligibility determination, ensure uniformity in the application of eligibility rules, and reduce error in referring applicants between programs. When applicants are found ineligible for one program, such a system would automatically test their eligibility for alternative programs.

DHS has dedicated some of its funding to develop this system, but probably will need additional state or federal funds to accomplish automated enrollment by 2003. Because MinnesotaCare is state-administered, DHS will first automate MinnesotaCare eligibility determination and enrollment and then roll the county-administered GAMC and MA programs into the system over time (Interview 2001).

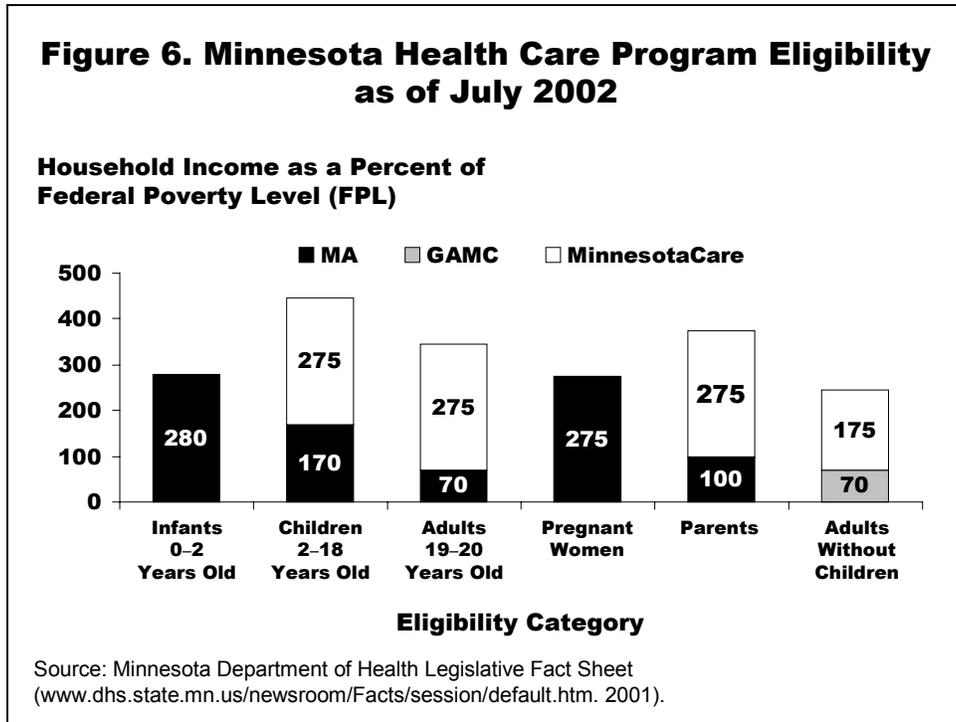
Coordination Among Programs

Compared with most other states, Minnesota's eligibility standards for public health insurance are generous—reaching 275 percent of FPL for families with children and 175 percent for adults without children. Thus, DHS has begun to shift its focus from expanding eligibility to reducing unnecessary lapses in enrollment.

Historically, the division of administrative responsibility for enrollment in the programs—with the state administering MinnesotaCare enrollment and the counties administering GAMC and MA enrollment—has been a major barrier to coordinating the programs. Although MinnesotaCare was intended to accommodate people who would be reluctant to apply for any program at a county welfare office, referring enrollees among programs has been more difficult than DHS originally imagined. The programs' different funding streams (variously, from the General Fund, the federal government, the Health Care Access Fund, and enrollee premiums) require careful accounting for enrollment to ensure that the right revenues pay for the right people (Interview 2001).

As of 2002, Minnesota has begun to simplify its program structure, making MA and MinnesotaCare indistinguishable for many enrollees. For children under 170 percent FPL and for parents under 100 percent FPL, MA and MinnesotaCare eligibility determination will be uniform, and all state funding for these populations will come from

the General Fund (Figure 6). These enrollees pay no premiums—whereas those in MinnesotaCare had been charged premiums (Interview 2001). Also, to encourage continuous coverage, all children who lose eligibility for MA are able to enroll in MinnesotaCare without premiums for one year; for these children, MinnesotaCare requires a \$5 copayment for nonpreventive care.



IV. MINNESOTA’S PUBLICLY SPONSORED PRIVATE HEALTH INSURANCE PROGRAMS

While Minnesota’s income-tested programs are collectively its largest public effort to improve health insurance coverage, the state also operates two publicly sponsored private health insurance programs: an individual health insurance program for residents who are denied coverage in the private market, and a group health insurance program for employees of local government entities. These programs are described below.

A. MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION (MCHA)

MCHA is the nation’s largest state-based high-risk pool. Established in 1976, MCHA offers individual health insurance policies and Medicare supplemental products to Minnesota residents who are denied standard coverage or standard premiums in the individual health insurance market because of a past or current health problem. In June

2000, nearly 26,000 people were enrolled in MCHA—equal to about 6 percent of the state’s individually insured population (Achman and Chollet 2001).

Eligibility and Enrollment Trends

To be eligible for MCHA coverage, individuals must offer proof that they were denied an individual (nongroup) health insurance policy within six months of applying to the program.¹⁸ Applicants with various specified medical conditions (such as HIV/AIDS, leukemia, multiple sclerosis, and hemophilia) are presumed eligible to enroll in MCHA, and do not need to present proof of having been denied private coverage. In 1999, 47 percent of MCHA’s enrollees were self-employed and 18 percent were unemployed (MCHA 2001). The average MCHA enrollee (excluding Medicare-eligible enrollees) was 50 years old (MCHA 2000).

MCHA enrollment peaked at more than 35,000 in 1993, but subsequently declined to less than 25,000 in 1998. MCHA administrators attributed the program’s declining enrollment both to Minnesota’s insurance reforms and the growth of employer group coverage in a strong economy.¹⁹ Since 1999, as Minnesota’s economy has softened, MCHA enrollment has risen steadily. In 2001, MCHA enrolled nearly 27,000 Minnesotans. Unlike some other states’ high-risk pools, MCHA has never capped enrollment in order to contain program costs.

Benefits

MCHA offers fee-for-service indemnity coverage. Point-of-service preferred provider organization coverage is optional. Enrollees may choose plans with a \$500, \$1,000, or \$2,000 deductible. Coinsurance on covered services in all plans is 20 percent. Annual out-of-pocket costs are capped at \$3,000 per person and lifetime benefits are capped at \$2.8 million. MCHA coverage excludes services relating to a preexisting condition for six months, with a 90-day look-back period before enrollment.²⁰

Compared with other state high-risk pools, MCHA coverage is very comprehensive (for example, it provides unlimited coverage for mental health and substance abuse treatment), although it is less comprehensive than Minnesota’s means-

¹⁸ Individuals eligible for Medicare also may buy Medicare supplemental coverage from MCHA if they are denied Medigap coverage in the private market.

¹⁹ In 1992, Minnesota enacted a series of insurance market reforms requiring small-group insurers to guarantee issue, prohibiting individual (nongroup) insurers from issuing riders to restrict coverage, and prohibiting high-risk “carve outs” in insured groups (MCHA 2000). To comply with the federal Health Insurance Portability and Accountability Act (HIPAA), Minnesota also enacted guaranteed renewal of individual policies.

²⁰ A look-back period is defined as the number of months prior to enrollment during which an individual had a diagnosed condition or symptoms of a condition.

tested public health insurance programs. While MCHA historically has not covered preventive services, it now covers selected preventive services such as flu shots and smoking cessation classes. MCHA does not cover either dental or vision care.

Funding

MCHA sets premiums to reflect the enrollee's age and choice of deductible; premiums are not adjusted for either gender or health status. Minnesota statute requires that MCHA set premiums between 101 and 125 percent of the weighted average of commercial rates for a comparable policy (MCHA 2000). Minnesota's statewide health care costs historically have been low relative to the national average, making MCHA premiums very moderate compared with either average market premiums or high-risk pool premiums in other states. In 1999, the average annual premium per MCHA enrollee was \$2,042.²¹

Because MCHA's premiums are constrained by law, it is not surprising that the program's medical costs exceed premium revenues. In 1999, MCHA paid out in medical claims nearly twice as much as it received in premiums (\$102 million versus \$52 million) (MCHA 2000). However, as MCHA enrollment has declined, its costs and operating deficit per member per month have risen.

MCHA covers its annual operating deficit by assessing all group and individual premiums earned by commercial carriers, HMOs, fraternal organizations, and nonprofit health service plan corporations in the state. In 1999, the total assessment to support MCHA was \$41.6 million—about 1.24 percent of insurers' earned premiums (MCHA 2000). Historically, Minnesota allowed insurers to offset this assessment against their state income tax liability; thus, in effect, the state funded MCHA's deficits from the General Fund. However, this tax offset was repealed in 1997 (MCHA 2000).

The federal Employee Retirement Income Security Act (ERISA) prohibits states from taxing self-insured plans directly. Thus, as the number of self-insured plans in Minnesota has grown in recent years, MCHA's funding base has eroded.²² Responding to insurers' concerns that the state's ongoing exemption of self-insured plans places them at a competitive disadvantage, the legislature has appropriated additional funds to cover

²¹ Estimated as total annual premium income divided by December 1999 enrollment (MCHA 2000). In 2001, MCHA's monthly premium for a 50-year-old male was \$249 for the \$500 deductible plan, \$209 for the \$1,000 deductible plan, and \$187 for the \$2,000 deductible plan (DOC 2001).

²² Recognizing ERISA's exemption of self-insured plans, some states levy their high-risk pool assessment on covered lives—including stop-loss lives, as well as fully insured lives (Butler 2000). Minnesota does not do this, but instead follows the more conventional path of assessing insurer's premiums, which de facto assesses primarily insured group coverage and largely bypasses self-insured plans. MCHA's assessment is applied to only \$134 million of stop-loss business, accounting for about 4 percent of total assessment revenues (Interview 2001).

MCHA's growing operating deficits without raising the assessment on health insurers. In both 1998 and 1999, MCHA was given \$15 million from the state's Health Care Access Fund; in 2001, it was given \$15 million from the Workers Compensation Assigned-Risk Plan.

Program Administration

MCHA is organized as a nonprofit corporation within the health insurance industry. Commercial insurers, HMOs, and fraternal organizations are required to participate in MCHA and some self-insured employer plans participate voluntarily. MCHA is regulated by the Minnesota Department of Commerce and governed by a nine-member Board of Directors. Five of MCHA's board members are selected by its industry members and approved by the Commerce Commissioner. The Commerce Commissioner also chooses four board members from the public; at least two must be MCHA enrollees. With a majority of MCHA's board members selected from the insurance industry, the industry's interests generally dominate (Interview 2001).

MCHA contracts with an insurer (since 1983, Blue Cross Blue Shield of Minnesota) to perform administrative functions, including collecting premiums, confirming eligibility, handling customer service, and paying claims.

Emerging Issues

In recent years, the legislature has asked MCHA to consider a number of changes. These requests have been in part a response to insurers' concerns about supporting MCHA's operating deficits, but they also reflect some reluctance on the part of the legislature to continue subsidizing MCHA from other state funds.

Eligibility review. Because its premiums are higher than premiums for comparable coverage in the private market, MCHA historically has assumed that enrollees who renew coverage continue to be uninsurable elsewhere. In 2001, the legislature urged MCHA to consider measures that would encourage enrollees to explore private insurance options, and MCHA considered sending notifications to enrollees who had not filed claims in the past year that they might be insurable in the private market (Interview 2001). However, because such enrollees are relatively low-cost to the program, their exit would cause MCHA's medical costs per enrollee to rise. Thus, its total operating deficit would decline much more slowly than its enrollment.

Most enrollees who leave MCHA do so when they become eligible for Medicare, not because they obtain private insurance (Interview 2001). To the extent that enrollees

obtain private insurance, MCHA officials believe that it is typically group coverage and the result of a change in their employment status or that of their spouse (Interview 2001). MCHA officials believe that many of the program's enrollees have modest family incomes and note that some MCHA enrollees are actually eligible for one of the state's income-related insurance programs. Neither MCHA nor DHS have information about the extent to which enrollees leave MCHA to enroll in any of the state's income-related health insurance programs, but officials from both agencies believe that the numbers are probably low.²³

Managed care. Also in 2000, the legislature requested that MCHA study the potential for offering a managed care product. MCHA currently has disease management programs for some enrollees, and it reviews all hospital stays over three days.²⁴ MCHA officials speculate that high-risk enrollees are likely to have little interest in enrolling in managed care, especially if it would entail changing providers. Moreover, most MCHA enrollees live outside the Minneapolis/St. Paul metropolitan area and may not have convenient access to a managed care plan.

Alternative models to ensure access to health insurance. As stipulated in its 2001–02 budget, the Department of Health was obligated to investigate an alternative model of individual health insurance in Minnesota—restructuring the state's role to become, in effect, the manager of a health insurance purchasing pool for all individuals not enrolled in either a group plan or public program. While no details of the restructuring have been developed, such a concept would likely entail the partial or total retirement of the MCHA in favor of a statewide system of risk-adjusted, guaranteed-issue private insurance. The Department of Health is obligated to report to the legislature on the feasibility of this approach in 2002.

B. MINNESOTA'S SMALL-GROUP EMPLOYEE PROGRAMS

Minnesota has a history of attempting to improve small-group health insurance affordability and coverage. One early program, the Minnesota Employers Insurance Program (MEIP), was a purchasing pool for small employers. Created in 1992, MEIP was intended to encourage small employers to offer health insurance by reducing their costs and increasing employee choice. MEIP hoped to reduce average costs by spreading administrative costs over a larger insured population and by increasing the ability of participating employers to negotiate with health plans. MEIP also offered participating employees a greater choice of health plans (DOER 1998).

²³ One official noted that “MinnesotaCare hasn't budgeted for the chronically ill” (Interview 2001). MinnesotaCare's average costs might rise substantially if it enrolled a significant number of MCHA lives.

²⁴ MCHA administers a diabetes disease management program, as well as a coronary disease management program for enrollees with coronary artery disease or congestive heart failure (CFA 2002).

Enrollment in MEIP reached a high of 356 employers, accounting for 6,500 covered employees and dependents. However, following Minnesota's insurance market reforms (effective in 1993), the number of lives covered in the small-group market rose from approximately 300,000 in 1994 to more than 400,000 in 1996 (DOER 1998). Actively competing within an extensively reformed market, MEIP lost overall enrollment but retained its relatively high-cost groups. Forced to raise its rates, MEIP worsened its problems of adverse selection, became financially unstable, and was closed in 1997.

A second small-group employee program—for employees of local government entities—continues to operate. Managed by the Minnesota Department of Employee Relations, the Public Employees Insurance Program (PEIP) is a small-group purchasing pool for county and town governments and school districts. In 2001, PEIP enrolled about 3,800 lives (DOER 2001).

PEIP enrollees have a choice of HMOs, which vary by the employers' location in the state. PEIP also offers a point-of-service option and an indemnity plan for enrollees living in areas where no managed care plan is available. Benefit packages for PEIP enrollees look similar to those of any employer-sponsored insurance product.

Premium rates in PEIP depend on the plan chosen, the size of the specific employer group, and the experience of that group. In 2000, premiums ranged from \$220 to \$311 for single coverage, and \$558 to \$815 for family coverage (DOER 2000).

In contrast to MEIP, the PEIP program has been able to remain stable despite low enrollment numbers. PEIP's relative success may come from small public entities feeling more strongly bound to a state government pool than the small private employers did, making them less likely to defect to the private insurance market. In addition, many of the small public employers that are part of the program are located in rural Minnesota, where there may be less competition for small-group business than in the Minneapolis/St. Paul metropolitan area (DOER 2000).

V. MINNESOTA'S REMAINING UNINSURED

Minnesota's mix of a high rate of private insurance coverage and generous public insurance programs covers about 95 percent of the state population, but some Minnesota residents remain uninsured. Not surprisingly, Minnesota's uninsured population is ethnically, demographically, and economically concentrated, with some population groups much more likely to be uninsured than the general population. Specifically, Minnesota's ethnic minorities—black, Hispanic, and Native American populations—are much more

likely to be uninsured than the population average (MDH 2002). In 2001, 15.6 percent of blacks, 17.4 percent of Hispanics, and 16.2 percent of Native Americans were uninsured, compared with just 5.4 percent of the total population. Young adults ages 18 to 24, low-income Minnesotans, and residents in the north central and northwestern parts of the state were also more likely to be uninsured than the general population.

About three-quarters of Minnesota's uninsured population are employed (or are children in families of employed workers), typically in full-time permanent jobs (MDH 2002). However, they are more likely than the overall population to be self-employed or to work in a small business. Nearly 60 percent of the uninsured are in families of workers in firms with fewer than 50 employees. Only one-third of the total population belongs to families with workers in firms with fewer than 50 employees.

The Minnesota Department of Health estimates that two-thirds of uninsured Minnesotans are eligible for health insurance, either through an employer-sponsored plan or a public program (MDH 2002). Uninsured children are the most likely to be eligible but not enrolled in a private or public insurance plan: about 91 percent of uninsured children have access either to employer coverage through a parent (34 percent) or to a public insurance program (76 percent).²⁵ Among adults, an estimated 43 percent have access to employer-sponsored coverage but are not enrolled, and another 20 percent are eligible for public health insurance but not enrolled. In response to a population survey, most uninsured workers with access to employer coverage cited cost as the reason for not enrolling. Among the uninsured who are probably eligible but not enrolled in one of Minnesota's public programs, 77 percent stated they would enroll if they knew that they were eligible (MDH 2002).

The large number of uninsured who may be eligible for public insurance and willing to enroll indicates that further efforts by the state to improve the take-up rates for available public insurance could significantly decrease the number remaining without health insurance in Minnesota. If all eligible children and adults enrolled in available public coverage, Minnesota's rate of uninsured would decline to an estimated 2.7 percent of the nonelderly population.²⁶

²⁵ Percentages add up to more than 100 due to overlap between eligibility for employer coverage and income eligibility for public programs.

²⁶ These are author's calculations based on data from the Minnesota Department of Health's Minnesota Health Access Survey (2002).

VI. CONCLUSIONS

While Minnesota's high rate of employer-based coverage is an important factor in the state's overall high rate of health insurance coverage, Minnesota has also been aggressive in crafting public programs to serve Minnesotans without employer-subsidized coverage who have low or moderate income or are uninsurable because of health status. Collectively, Minnesota's five health insurance programs have succeeded in covering the substantial majority of these populations. In 2000, four of five Minnesotans under age 65 without private insurance participated in one of the state's health insurance programs.

Minnesota's public programs—Medical Assistance, General Assistance Medical Care, and MinnesotaCare—are an amalgam of efforts to insure low- and middle-income Minnesotans without group coverage. The benefit designs and eligibility rules of these programs strongly reflect the federal Medicaid and CHIP programs' historical development and rules.

Minnesota is now working to make its programs more coherent and seamless for the populations they serve. These efforts include automation of eligibility determination, referrals among programs, and fully coordinating the programs' benefits and financing for the lowest-income populations. Minnesota hopes that simplifying the application process and coordinating financing for a larger block of enrollees will encourage more eligible people to enroll and remain in the program, with fewer having to reapply because of minor changes in their economic circumstances.

In addition to setting eligibility standards for public coverage well above those of many states, Minnesota also sponsors two private insurance programs that are unusual in their scope and design. It is one of 30 states with a high-risk pool for individuals who are denied private health insurance, and its high-risk pool is by far the largest in the nation relative to the size of its individually insured population (6 percent). While the legislature has instructed MCHA to investigate ways to moderate the net cost of enrollee premiums, there is no evidence that Minnesota's commitment to statewide access to comprehensive and affordable coverage has dissipated. Minnesota has also experimented with operating small-group health insurance pools. One of these, for employees of county and municipal governments and school districts, has thrived.

Whether or not Minnesota offers a useful model for other states is a complex question. Minnesota benefits from high market penetration of not-for-profit managed care and, as a result, has a history of relatively low health care costs. These lower health care costs have, in turn, promoted relatively high rates of employer-based coverage, as well as

individually purchased coverage. While many other states do not share this history, some do, and yet still have much lower rates of coverage overall.

Minnesota's strength seems to lie in its enduring public commitment to extending health insurance coverage to everyone and its habit of seizing opportunities to do so. Minnesota has systematically gone about developing an array of public programs to fill coverage gaps, establishing a greater variety of programs, broader eligibility standards, and more extensive program benefits than those in other states. None of Minnesota's public programs is unique; to the contrary, every program that Minnesota operates has existed or exists now in some form in some other state.

Minnesota's primary lesson is simple, although, judging from the experience of many other states, it is not easy to follow: by starting programs modestly, expanding them as they demonstrate their value, and serving populations in need at all levels of income, states can approach universal coverage. Minnesota has taken a long view in building this strategy—expanding MA eligibility to federal eligibility limits to maximize federal funding; mounting MinnesotaCare as a program to cover only ambulatory care for families with children and then expanding it to become more like a conventional insurance plan; and supporting the nation's largest high-risk pool with open enrollment and benefit levels that are consistent with standard private coverage. By building a sequence of health insurance programs that serve populations at all income levels, Minnesota has also established a broad public constituency for maintaining and improving these programs.

Minnesota has benefited from having a number of legislative champions for broader health insurance coverage and from significant longevity among its senior program officials, some of whom have held positions in several agencies and are extremely knowledgeable about the programs, agency relationships, and legislative process. These factors apparently have helped to build a cache of knowledge about health care financing and public health in state government that, in turn, infuses the political language of the state. Responding to questioning about why Minnesota has been willing to build and maintain these programs when most other states have not, one public official commented, "Minnesotans thought it was a function of government to provide health care for everyone" (Interview 2001).

Like other states, Minnesota struggles to pay for its public programs, but again it is unusual in its commitment to do so. A recent study ranked Minnesota as 14th in the nation in fiscal capacity (the economic ability to support government programs) in 1997,

but fourth in overall fiscal effort (Trenholm and Kung 2000).²⁷ Minnesota allocated a relatively small proportion of its general revenues to its Medicaid program (23 percent of state tax revenues, 44th in the nation in 1997), but (by this study's estimates) it spent about 1 percent of the state's gross domestic product for its public health insurance programs and its high-risk pool combined. By instituting MinnesotaCare before the federal CHIP program was enacted, Minnesota proved that it was "willing to go after problems with just state money." In the words of one state official, "If the state waits for the federal government, we'll wait forever" (Interview 2001).

In short, many other states could probably achieve Minnesota's high rate of insurance coverage given a similar, sustained level of public commitment to achieving that goal. Minnesota's willingness to establish programs with broad eligibility and comprehensive benefits and also its extremely high level of fiscal effort to support these programs appear to explain much of its success in approaching universal coverage.

Finally, the structure and extent of Minnesota's state-based health insurance programs also affect private health insurance in the state. Despite Minnesota's unusually high rate of private coverage, various interest groups in Minnesota are concerned about the rising cost of private insurance and view a possible solution as having more insurers selling coverage in the state.

While Minnesota's efforts to deregulate private insurance met with some legislative success in 2002, the state has strong fiscal and programmatic interests in maintaining a stable private insurance market. By extending eligibility for public insurance programs to the majority of those uninsured, Minnesota has virtually eliminated the "no-man's-land" of uninsured individuals and families that typically lies between public insurance programs and the private insurance market. Minnesota's array of state-based insurance programs closely complements the private insurance market, and changes in private insurance regulation can directly affect program enrollment. Thus, to the extent that changes in private insurance regulation ultimately destabilize the private insurance market, they are likely to burden Minnesota's state-based insurance programs. Historically, this relationship has encouraged regulatory stability and supported a level of public discussion about health insurance that is unusual in many states.

²⁷ Trenholm and Kung (2000) measured fiscal capacity as personal income per capita and fiscal effort as aggregate state tax revenues per dollar of aggregate personal income. Higher fiscal effort may result from higher tax rates, a larger tax base per capita, or both.

APPENDIX

Table A-1. Minnesota’s Public Insurance Programs

Program	Target Population	Income Eligibility	Funding
General Assistance Medical Care (GAMC)	Low-income adults without children	Income less than 133⅓% of 1996 AFDC level, with a \$1,000 per household asset test	State pays from general revenue, counties bear administrative costs
Medical Assistance (MA)	Low-income families, children, pregnant women, elderly, and disabled	Pregnant women < 275% FPL Infants 0-2 < 280% FPL Children 2-5 < 133% FPL Children 6-18 < 100% FPL Adults w/ children < 133⅓% of '96 AFDC Elderly & disabled < 100% FPL Working disabled < 200% FPL	Federal government pays 51.48%, ^a the state pays rest of medical payments from general revenue, counties bear administrative costs
MinnesotaCare	Low-income families without access to employer-subsidized insurance	Families w/children < 275% FPL Adults w/out children < 175% FPL	Enrollee premiums, provider tax and some federal matching payments for individuals who would be eligible for Medicaid
Minnesota Comprehensive Health Association (MCHA)	Medically Uninsurable	Must provide proof of rejection from a health insurer due to a pre-existing medical condition, be HIPAA eligible, or be diagnosed with one on a list of medical conditions	Enrollee premiums and assessment on all health insurers in the state.
Public Employees Insurance Program (PEIP)	Employee groups representing Minnesota’s counties, cities, towns, school districts and other public jurisdictions	Must be an employee, or dependent of an employee, of an employer group participating in PEIP	Self-supported through enrollee premiums

^a State receives the higher federal CHIP matching rate for infants 0–2 in families with income between 275% and 280% of FPL.

^b For calendar year 1999.

^c Enrollment as of December 1999.

^d Average monthly payment is estimated as total claims paid in 1999 divided by 12, per December 1999 enrollment.

Table A-1. Minnesota's Public Insurance Programs (continued)

Program	FY2000 Total Medical Payments	FY2000 Average Monthly Enrollment	FY2000 Average Monthly Payment Per Eligible	Other Notes
General Assistance Medical Care (GAMC)	\$127 million	23,295	\$453.08	GAMC acts as an important payment source for safety net providers. The legislature is trying to move enrollees into MinnesotaCare.
Medical Assistance (MA)	\$3.3 billion	363,605	\$746.04	In July 2002, income eligibility will be raised to 170% FPL for children 2-18 and 100% FPL for adults with children.
MinnesotaCare	\$196.3 million	109,096	\$149.96	Premiums will be eliminated for children with income < 170% FPL, state will begin receiving federal CHIP matching rate for adults 100-200% FPL.
Minnesota Comprehensive Health Association (MCHA)	\$101.6 million ^b	25,433 ^c	\$322.87 ^d	The state is studying the possibility of creating an individual insurance market purchasing pool.
Public Employees Insurance Program (PEIP)	N/A	3,800	N/A	PEIP is overseen by the Minnesota Department of Employee Relations (DOER).

^a State receives the higher federal CHIP matching rate for infants 0-2 in families with income between 275% and 280% of FPL.

^b For calendar year 1999.

^c Enrollment as of December 1999.

^d Average monthly payment is estimated as total claims paid in 1999 divided by 12, per December 1999 enrollment.

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#597 *Assessing State Strategies for Health Coverage Expansion: Profiles of Arkansas, Michigan, New Mexico, New York, Utah, and Vermont* (January 2003, Web publication). Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, Economic and Social Research Institute. The authors discuss, in detail, initiatives undertaken to maximize health insurance coverage in Arkansas, Michigan, New Mexico, New York, Utah, and Vermont. Available at www.cmwf.org.

#596 *Expanding Health Insurance Coverage: Creative State Solutions for Challenging Times* (January 2003). Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, Economic and Social Research Institute. The authors summarize lessons from 10 states that have innovative strategies in place for health insurance expansion or have a history of successful coverage expansion. The report concludes with recommendations for federal action that could help states maintain any gains in coverage made and possibly extend coverage to currently uninsured populations.

#585 *Small But Significant Steps to Help the Uninsured* (January 2003). Jeanne M. Lambrew and Arthur Garson, Jr. A number of low-cost policies could ensure health coverage for at least some Americans who currently lack access to affordable insurance, this report finds. Included among the dozen proposals outlined is one that would make COBRA continuation coverage available to all workers who lose their job, including employees of small businesses that are not currently eligible under federal rules.

#589 *Health Insurance Tax Credits: Will They Work for Women?* (December 2002). Sara R. Collins, Stephanie B. Berkson, and Deirdre A. Downey, The Commonwealth Fund. This analysis of premium and benefit quotes for individual health plans offered in 25 cities finds that tax credits at the level of those in recent proposals would not be enough to make health insurance affordable to women with low incomes.

#586 *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families* (December 2002). Leighton Ku and Donna Cohen Ross, Center on Budget and Policy Priorities. This report examines why many low-income adults lose their health coverage, what the effects of losing coverage are, and which strategies can help people retain their insurance.

#587 *Assessing State Strategies for Health Coverage Expansion: Summary of Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* (November 2002). Sharon Silow-Carroll, Emily K.

Waldman, Jack A. Meyer, Claudia Williams, Kimberley Fox, and Joel C. Cantor. These summaries of case studies look at four states' unique as well as shared experiences and draw lessons for other states. (See pub. #565 for the full case studies.)

#577 *Toward Comprehensive Health Coverage for All: Summaries of 20 State Planning Grants from the U.S. Health Resources and Services Administration* (November 2002, Web publication). Heather Sacks, Todd Kutyla, and Sharon Silow-Carroll, Economic and Social Research Institute. In 2000, the DHHS' Health Resources and Services Administration awarded grants to 20 states to create comprehensive coverage plans for all citizens. These summaries report on the progress of states' coverage expansion efforts, detailing the history of reform, data on uninsured populations, actions taken, and goals for future efforts. Available at www.cmwf.org.

#565 *Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* (November 2002). Sharon Silow-Carroll, Emily K. Waldman, Jack A. Meyer, Claudia Williams, Kimberley Fox, and Joel C. Cantor. These case studies provide an in-depth account of four states' efforts to expand health coverage, detailing their relative strengths and weaknesses and highlighting what appear to be the key factors for success.

#574 *Employer Health Coverage in the Empire State: An Uncertain Future* (August 2002). According to this report, the combination of a weak economy, higher unemployment, and rising health care costs is placing pressure on New York State employers to eliminate or scale back health benefits for workers, their dependents, and retirees.

#559 *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care* (August 2002). Based on a Commonwealth Fund survey of health insurance in the workplace, this report finds that two of five workers experienced increases in their premiums or cost-sharing, or both, during 2001. Although public support for job-based health insurance remains strong, many workers are not confident that employers will continue to offer coverage to them down the road. Workers are even more uncertain about their ability to get good health care in the future.

#509 *Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity* (June 2002). Mark Merlis. This report examines trends in out-of-pocket spending, the components of that spending, and the characteristics of families with high out-of-pocket costs.

#557 *Eliminating Racial/Ethnic Disparities in Health Care: Can Health Plans Generate Reports?* (May/June 2002). David R. Nerenz, Vence L. Bonham, Robbya Green-Weir, Christine Joseph, and Margaret Gunter. *Health Affairs*, vol. 21, no. 3. The absence of data on race and ethnicity in health plan and provider databases is a significant barrier in the creation and use of quality-of-care reports for patients of minority groups. In this article, however, the authors show that health plans are able to collect and analyze quality of care data by race/ethnicity.

#556 *Do Enrollees in 'Look-Alike' Medicaid and SCHIP Programs Really Look Alike?* (May/June 2002). Jennifer N. Edwards, Janet Bronstein, and David B. Rein. *Health Affairs*, vol. 21, no. 3. In their analysis of Georgia's similar-looking Medicaid and SCHIP programs, the authors present three possible explanations for the differences in access to care between the two populations: Medicaid families are less familiar with and supportive of systems requiring use of an assigned primary care physician, the families face more nonprogram barriers to using care, and physicians have different responses to the two programs.

#527 *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets* (May 2002). Jon R. Gabel, Kelley Dhont, and Jeremy Pickreign, Health Research and Educational Trust. This report identifies solutions that might make

tax credits and the individual insurance market work, including raising the amount of the tax credits; adjusting the credit according to age, sex, and health status; and combining tax credits with new access to health coverage through existing public or private group insurance programs.

#518 *Bare-Bones Health Plans: Are They Worth the Money?* (May 2002). Sherry Glied, Cathi Callahan, James Mays, and Jennifer N. Edwards. This issue brief finds that a less-expensive health insurance product would leave low-income adults at risk for high out-of-pocket costs that could exceed their annual income.

#507 *Lessons from a Small Business Health Insurance Demonstration Project* (February 2002). Stephen N. Rosenberg, PricewaterhouseCoopers LLP. This report finds that the recently concluded pilot project, the Small Business Health Insurance Demonstration, launched by New York City in 1997, was successful in providing a comprehensive, low-cost insurance option for firms with two to 50 workers. But poor implementation and marketing, plus flaws in product design, prevented the program from catching on among small businesses.

#528 *The APHSA Medicaid HEDIS Database Project* (December 2001). Lee Partridge, American Public Human Services Association. This study (available on the Fund's website only) assesses how well managed care plans serve Medicaid beneficiaries, and finds that while these plans often provide good care to young children, their quality scores on most other measures lag behind plans serving the commercially insured.

#512 *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk* (December 2001). Lisa Duchon, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman. This report, based on The Commonwealth Fund 2001 Health Insurance Survey, finds that in the past year one of four Americans ages 19 to 64, some 38 million adults, was uninsured for all or part of the time. Lapses in coverage often restrict people's access to medical care, cause problems in paying medical bills, and even make it difficult to afford basic living costs such as food and rent.

#513 *Maintaining Health Insurance During a Recession: Likely COBRA Eligibility* (December 2001). Michelle M. Doty and Cathy Schoen. This issue brief, based on The Commonwealth Fund 2001 Health Insurance Survey, examines the potential as well as limits of COBRA eligibility as a strategy for protecting workforce access to affordable health care benefits.

#514 *Experiences of Working-Age Adults in the Individual Insurance Market* (December 2001). Lisa Duchon and Cathy Schoen. This issue brief, based on The Commonwealth Fund 2001 Health Insurance Survey, describes the difficulties faced by those without access to group health coverage in obtaining adequate, affordable individual health insurance.

#478 *Universal Coverage in the United States: Lessons from Experience of the 20th Century* (December 2001). Karen Davis. This issue brief, adapted from an article in the March 2001 *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, traces how the current U.S. health care system came to be, how various proposals for universal health coverage gained and lost political support, and what the pros and cons are of existing alternatives for expanding coverage.

#511 *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance* (November 2001). Jeanne M. Lambrew, George Washington University. This report documents the link between loss of health insurance and unemployment, estimating that 37 percent of unemployed people are uninsured—nearly three times as high as the uninsured rate for all Americans (14%). The jobless uninsured are at great financial risk should they become ill or injured.

#485 *Implementing New York's Family Health Plus Program: Lessons from Other States* (November 2001). Rima Cohen and Taida Wolfe, Greater New York Hospital Association. Gleaned from research into the ways 13 other states with public health insurance systems similar to New York's have addressed these matters, this report examines key design and implementation issues in the Family Health Plus (FHP) program and how Medicaid and the Child Health Plus program could affect or be affected by FHP.

#484 *Healthy New York: Making Insurance More Affordable for Low-Income Workers* (November 2001). Katherine Swartz, Harvard School of Public Health. According to the author, Healthy New York—a new health insurance program for workers in small firms and low-income adults who lack access to group health coverage—has so far been able to offer premiums that are substantially less than those charged in the private individual insurance market.

#475 *Business Initiatives to Expand Health Coverage for Workers in Small Firms* (October 2001). Jack A. Meyer and Lise S. Rybowski. This report weighs the problems and prospects of purchasing coalitions formed by larger businesses to help small firms expand access to health insurance. The authors say that private sector solutions alone are unlikely to solve the long-term problem, and the public sector will need to step in to make health insurance more affordable to small businesses.

#502 *Gaps in Health Coverage Among Working-Age Americans and the Consequences* (August 2001). Catherine Hoffman, Cathy Schoen, Diane Rowland, and Karen Davis. *Journal of Health Care for the Poor and Underserved*, vol. 12, no. 3. In this article, the authors examine health coverage and access to care among working-age adults using the Kaiser/Commonwealth 1997 National Survey of Health Insurance, and report that having even a temporary gap in health coverage made a significant difference in access to care for working-age adults.

#493 *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (August 2001). Jeanne M. Lambrew, George Washington University. In this report, the author concludes that building on insurance options that currently exist—such as employer-sponsored insurance, the Children's Health Insurance Program (CHIP), and Medicaid—represents the most targeted and potentially effective approach for increasing access to affordable coverage for the nation's 15 million uninsured women.

#472 *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (August 2001). Lori Achman and Deborah Chollet, Mathematica Policy Research, Inc. The authors argue that high premiums, deductibles, and copayments make high-risk pools unaffordable for people with serious medical conditions, and suggest that by lifting the tax exemption granted to self-insured plans, states could provide their high-risk pools with some much-needed financing.

#464 *Health Insurance: A Family Affair—A National Profile and State-by-State Analysis of Uninsured Parents and Their Children* (May 2001). Jeanne M. Lambrew, George Washington University. This report suggests that expanding Medicaid and State Children's Health Insurance Program (CHIP) coverage to parents as well as children may not only decrease the number of uninsured Americans but may be the best way to cover more uninsured children.

#445 *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (February 2001). Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, Economic and Social Research Institute. As with publication **#424** (see below), this report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, but looks more closely at programs in six of the states discussed in the earlier report.

#439 *Patterns of Insurance Coverage Within Families with Children* (January/February 2001). Karla L. Hanson. *Health Affairs*, vol. 20, no. 1. Using the 1996 Medical Expenditure Panel Survey, this article examines patterns of health insurance within families with children, determining that 3.2 million families are uninsured and another 4.5 million families are only partially insured.

#415 *Challenges and Options for Increasing the Number of Americans with Health Insurance* (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This overview paper summarizes the 10 option papers written as part of the series *Strategies to Expand Health Insurance for Working Americans*.

#476 *“Second-Generation” Medicaid Managed Care: Can It Deliver?* (Winter 2000). Marsha Gold and Jessica Mittler, Mathematica Policy Research, Inc. *Health Care Financing Review*, vol. 22, no. 2. This study of Medicaid managed care programs in seven states finds that the programs require state policymakers to make difficult tradeoffs among the competing goals of improving Medicaid access, providing care for the uninsured, and serving those with special needs who are dependent on state-funded programs. Available online only at www.cmwf.org.

#422 *Buying into Public Coverage: Expanding Access by Permitting Families to Use Tax Credits to Buy into Medicaid or CHIP Programs* (December 2000). Alan Weil, The Urban Institute. Medicaid and CHIP offer administrative structures and plan arrangements with the capacity to enroll individuals and families. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes permitting, but not requiring, tax-credit recipients to use their credits to buy into Medicaid or CHIP. Available online only at www.cmwf.org.

#419 *Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs* (December 2000). Sara Rosenbaum, Phyllis C. Borzi, and Vernon Smith. Public programs such as CHIP and Medicaid offer the possibility of economies of scale for group coverage for small employers as well as individuals. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes allowing the self-employed and those in small businesses to buy coverage through these public plans, and providing premium assistance to make it easier for them to do so. Available online only at www.cmwf.org.

#424 *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

#411 *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supersedes state laws that relate to private-sector, employer-sponsored plans.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wynn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

#385 *State Experiences with Cost-Sharing Mechanisms in Children's Health Insurance Expansions* (May 2000). Mary Jo O'Brien et al. This report examines the effect of cost-sharing on participation in the State Child Health Insurance Program (CHIP).

#384 *State Experiences with Access Issues Under Children's Health Insurance Expansions* (May 2000). Mary Jo O'Brien et al. This report explores how the design and administration of state incremental insurance expansions affect access to health insurance coverage and, ultimately, access to all health care services.

#380 *Educating Medicaid Beneficiaries About Managed Care: Approaches in 13 Cities* (May 2000). Sue A. Kaplan, Jessica Green, Chris Molnar, Abby Bernstein, and Susan Ghanbarpour. In this report, the authors document the approaches used and challenges faced in Medicaid managed care educational efforts in 13 cities across the country.

#366 *National Medicaid HEDIS Database/Benchmark Project: Pilot-Year Experience and Benchmark Results* (February 2000). Lee Partridge and Carrie Ingalls Szlyk, American Public Human Services Association. This report summarizes the first year of a project to create national summaries of state Medicaid HEDIS data and national Medicaid quality benchmarks against which each state can measure its program's performance.

#368 *Managed Care in Three States: Experiences of Low-Income African Americans and Hispanics* (Fall 1999). Wilhelmina A. Leigh, Marsha Lillie-Blanton, Rose Marie Martinez, and Karen Scott Collins. *Inquiry*, vol. 36, no. 3. This article examines the experiences of low-income Hispanics, African Americans, and whites enrolled in managed care plans in Florida, Tennessee, and Texas and compares them to their racial/ethnic counterparts enrolled in fee-for-service plans.

#260 *State-Subsidized Health Insurance Programs for Low Income Residents: Program Structure, Administration, and Costs* (April 1998) Laura Summer, Alpha Center. In an effort to determine states' success in covering uninsured populations, the author interviewed public insurance officials in 12 states and reviewed their programs' administrative structures, use of managed care, eligibility rules, and application and enrollment processes.