Health Care Coverage and Financing in Minnesota: Public Sector Programs

January 2003

HEALTH ECONOMICS PROGRAM
HEALTH POLICY AND SYSTEMS COMPLIANCE DIVISION
MINNESOTA DEPARTMENT OF HEALTH

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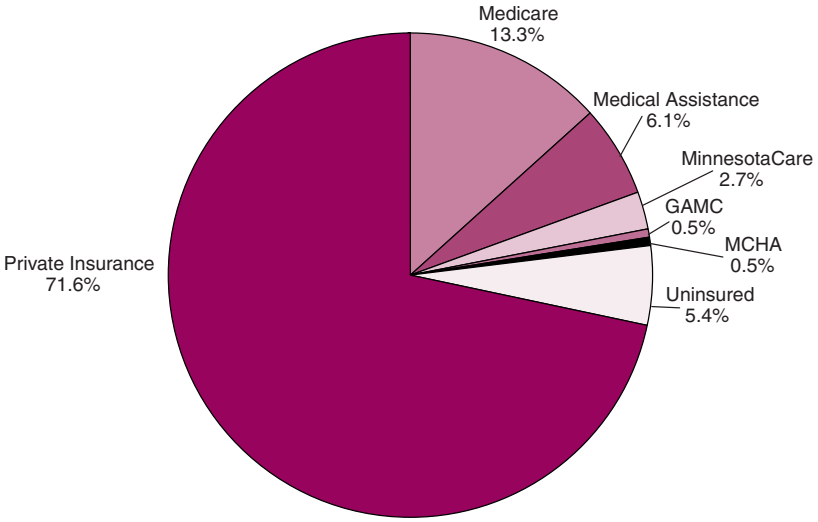
Introduction

Minnesotans obtain their health insurance coverage from a wide variety of sources. While most obtain coverage through private sources (coverage offered through employers or purchased individually), nearly 1 in 4 Minnesota residents relied on a publicly sponsored program as their primary source of health insurance coverage during 2001. The distribution of insurance coverage for Minnesota residents is illustrated in Figure 1.

Figure1

Distribution of Minnesota Population
by Primary Source of Insurance Coverage, 2001



GAMC is General Assistance Medical Care; MCHA is Minnesota Comprehensive Health Association.
Source: Minnesota Department of Health, Health Economics Program

This report provides an updated overview of the public sector's role in providing and financing health care coverage for Minnesota residents. Public health insurance programs are typically targeted toward specific populations: the aged, disabled, low-income, children, and people with "high-risk" health conditions that often preclude them from obtaining private coverage, or prevent them from obtaining it at reasonable cost. Because public programs enroll a higher-risk population, they account for a disproportionate share of health care spending in Minnesota. Although only 23% of the population relies on public programs as a primary source of coverage, these programs account for about two-fifths of total health care spending in the state.

Table 1 provides summary information on the programs that are highlighted in this report, their enrollment, costs, and sources of funding.

Table 1

Overview of Public Sector Insurance Programs in Minnesota

Program Name	Time Period	Minnesota Enrollment[a,b]	% of Population[a]	Minnesota Spending ($ millions)	Sources of Funding
Medicare	FFY 2000	654,405	13.3%	$2,798	Federal payroll tax; federal general revenues; enrollee premiums
Medical Assistance (MA, Medicaid)	SFY 2002	403,675	8.1%	$4,136	Federal, state, county
MinnesotaCare	SFY 2002	137,936	2.8%	$351	State (Health Care Access Fund), federal, enrollee premiums
General Assistance Medical Care (GAMC)	SFY 2002	29,886	0.6%	$182	State
Prescription Drug Program	SFY 2002	4,780	0.1%	$5	State
Minnesota Comprehensive Health Association (MCHA)	CY 2001	27,428	0.6%	$125	Enrollee premiums, assessment on health plan companies, state (state contributed $15 million in 1998, 1999, and 2001)

[a] Enrollment figures in this table represent the total number of people enrolled in the program, disregarding the fact that some people are enrolled in more than one program. Thus, entries in this table should not be added to determine the total number of people or percent of the population covered by public programs. The data in Figure 1 make the adjustment for double coverage in public programs and thus provide a more accurate estimate of the total number of Minnesotans who rely on public sector programs as their primary source of coverage.

[b] Medicare enrollment as of July 1, 2000; MA, MinnesotaCare, GAMC and Prescription Drug Program average monthly enrollment for state fiscal year 2002; MCHA enrollment as of December 31, 2001.

FFY = federal fiscal year; SFY = state fiscal year; CY = calendar year.

Medicare

Medicare is a federal health insurance program that covers persons over age 65 and some disabled persons under 65. Medicare coverage is divided into two parts:

- **Part A**, or **Hospital Insurance**, primarily covers inpatient hospital services, but also pays for some skilled nursing and home health services. Most Americans age 65 and over are automatically eligible to enroll in Part A.

- **Part B**, or **Supplementary Medical Insurance**, pays mainly for physician and outpatient hospital services. Enrollment in Part B is voluntary, and those who choose to participate must pay a monthly premium. (In 2003, the Part B premium is $58.70 per month.) Nearly all Medicare enrollees who are eligible for Part A also choose to enroll in Part B coverage.

Medicare enrollment: In 2001, over 660,000 Minnesotans were enrolled in Medicare, representing 13.3% of the state's population. Nationally, over 40 million Americans were enrolled in Medicare, or about 14.1% of the population. Table 2 presents trends in Medicare enrollment and spending for both Minnesota and the U.S.

Medicare spending: In federal fiscal year 2000, the federal government spent over $214 billion on Medicare, about $2.8 billion of which was paid in benefits for Minnesota residents.

Medicare spending per enrollee in Minnesota is lower than the national average. As shown in Table 2, Medicare spending per enrollee has historically been lower in Minnesota than the national average. In 2000, spending per enrollee in Minnesota was $4,279, which represents 79% of the national average of $5,401.

Table 2

Medicare Enrollment and Spending History

	Enrollment		Expenditures (millions of dollars)		Spending Per Enrollee	
	MN	**US**	**MN**	**US**	**MN**	**US**
1991	596,834	34,870,240	$1,650	$113,942	$2,763	$3,268
1992	606,405	35,579,149	$1,749	$129,179	$2,886	$3,631
1993	615,628	36,305,903	$1,895	$142,934	$3,079	$3,937
1994	623,733	36,935,366	$1,955	$159,345	$3,135	$4,314
1995	630,521	37,535,024	$2,140	$176,884	$3,394	$4,713
1996	635,748	38,064,130	$2,334	$191,176	$3,671	$5,022
1997	639,293	38,444,739	$2,460	$207,123	$3,848	$5,388
1998	643,877	38,824,855	$2,629	$210,102	$4,083	$5,412
1999	648,272	39,140,386	$2,693	$208,624	$4,154	$5,330
2000	654,405	39,619,986	$2,798	$214,868	$4,276	$5,423

- Enrollment data as of July 1 each year. Expenditure data pertain to federal fiscal years. State expenditure data are payments on behalf of Minnesota residents, estimated by MDH Health Economics Program from payments to Minnesota providers. Spending per enrollee calculated as federal fiscal year spending divided by July 1 enrollment.

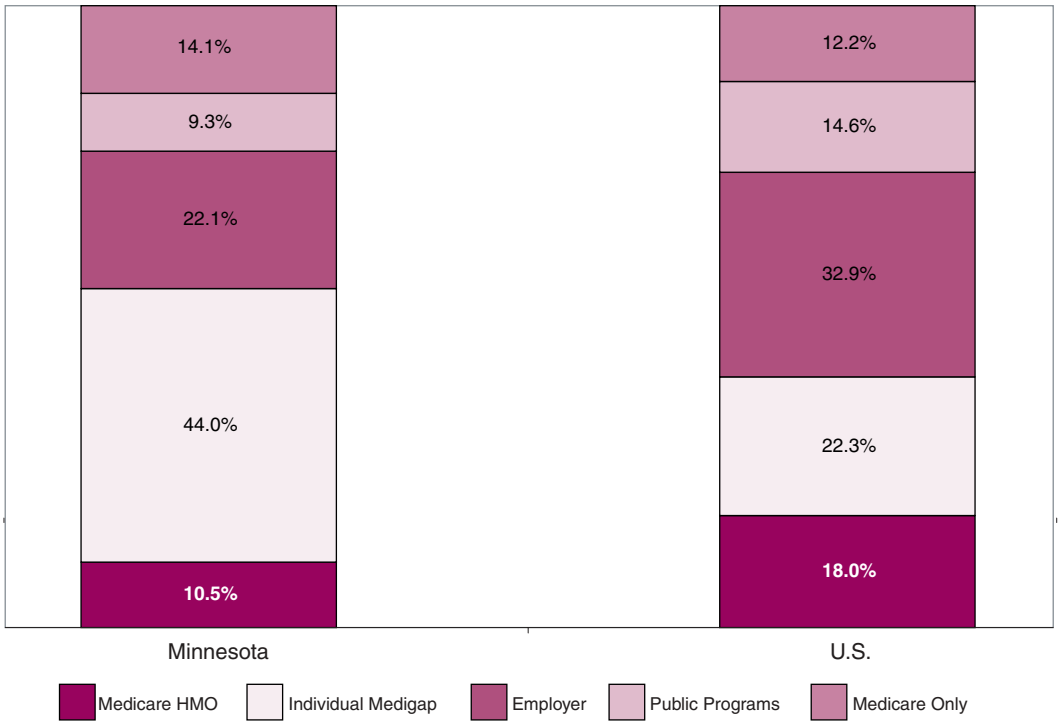
Source: Centers for Medicare and Medicaid Services; MDH Health Economics Program estimates of spending for Minnesota residents and spending per enrollee.

Sources of funding: There are different sources of financing for Parts A and B of the Medicare program. Part A is financed primarily through a 2.9% federal payroll tax which is split equally between employers and employees. Part B is funded through a combination of premiums paid by enrollees and the federal government's general revenues; enrollee premiums cover about 25% of the cost of the Part B program.

Most Medicare enrollees obtain additional insurance coverage through the private market or other public programs. Because Medicare requires significant cost-sharing and does not cover most prescription drugs, most Medicare enrollees choose to obtain additional insurance coverage through the private market. Figure 2 compares the sources of supplemental insurance coverage in Minnesota and the U.S. In both Minnesota and the U.S., about three-quarters of Medicare enrollees purchase additional private insurance coverage and/or receive it from employers as a retirement benefit; however, coverage through employers and HMOs is lower in Minnesota than the U.S. Some low-income Medicare enrollees obtain additional coverage through Medicaid (9% in Minnesota compared to 15% nationally). Only 14% of Minnesota Medicare enrollees rely solely on Medicare for their health insurance coverage, compared to 12% nationally.[1]

Figure 2

Sources Of Medicare Supplemental Coverage, Minnesota and U.S.

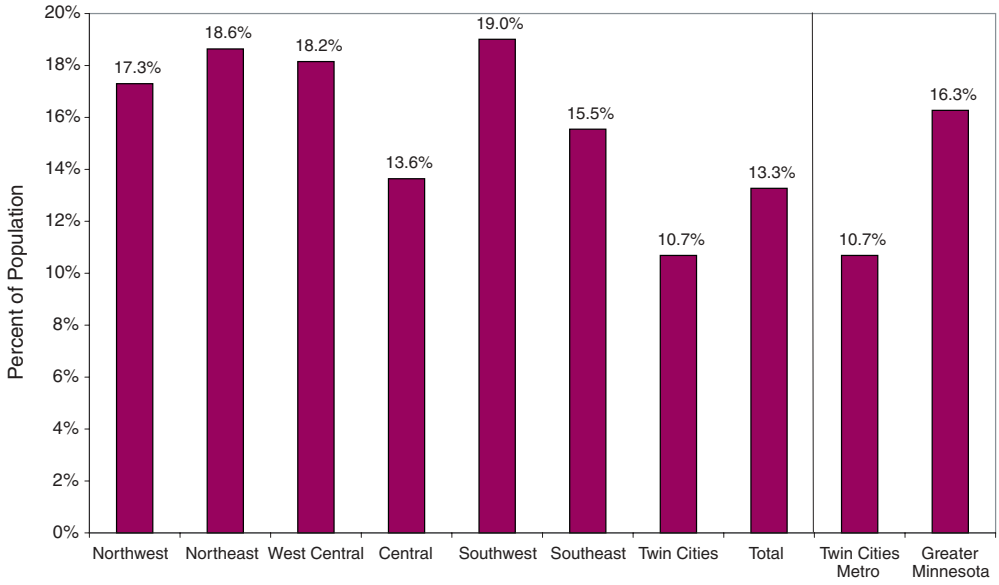


Sources: Minnesota Department of Health, 2001 Minnesota Health Access Survey; Centers for Medicare and Medicaid Services, 2000 Medicare Current Beneficiary Survey. Data pertains to non-institutionalized population only

Medicare enrollment in Minnesota is disproportionately rural. Because the rural areas of Minnesota have a relatively high proportion of elderly residents, enrollment in Medicare as a share of the population is higher in rural areas than it is in the Twin Cities metropolitan area. About 11% of the seven-county metro area population is enrolled in Medicare, compared to 16% in Greater Minnesota. Figure 3 illustrates this difference by region.

Figure 3

Medicare Enrollees as Percent of Population, 2000



Source: Centers for Medicare and Medicaid Services, enrollment by county as of July 1, 2000; U.S. Census Bureau, population by county as of July 1, 2000.

Rural health care providers in Minnesota are more dependent on Medicare revenues than urban providers. The larger proportion of the population that is served by Medicare in Greater Minnesota means that rural health care providers are more heavily dependent on Medicare revenue than their metro area counterparts. For example, rural hospitals in Minnesota relied on Medicare for 36% of their patient revenue in 2000, compared to 30% for urban hospitals. In the Twin Cities, 29% of hospital revenue in 2000 came from Medicare; in other regions of the state, the percentage of hospital revenue from Medicare was substantially higher (ranging from a low of 35% in Central Minnesota to a high of 41% in Southeast Minnesota).[2]

About 13% of Medicare enrollees in Minnesota are enrolled in HMOs.[3] Participation in Medicare HMOs in Minnesota varies widely by region – 25% of Medicare beneficiaries in the Twin Cities metro area are enrolled in HMOs, compared to only about 2% in Greater Minnesota. Part of the reason for this difference is that Medicare payment rates to HMOs are lower in rural areas, which may discourage HMOs from participating under Medicare, and part may be due to more limited availability of any type of HMO coverage in rural areas compared to the Twin Cities.

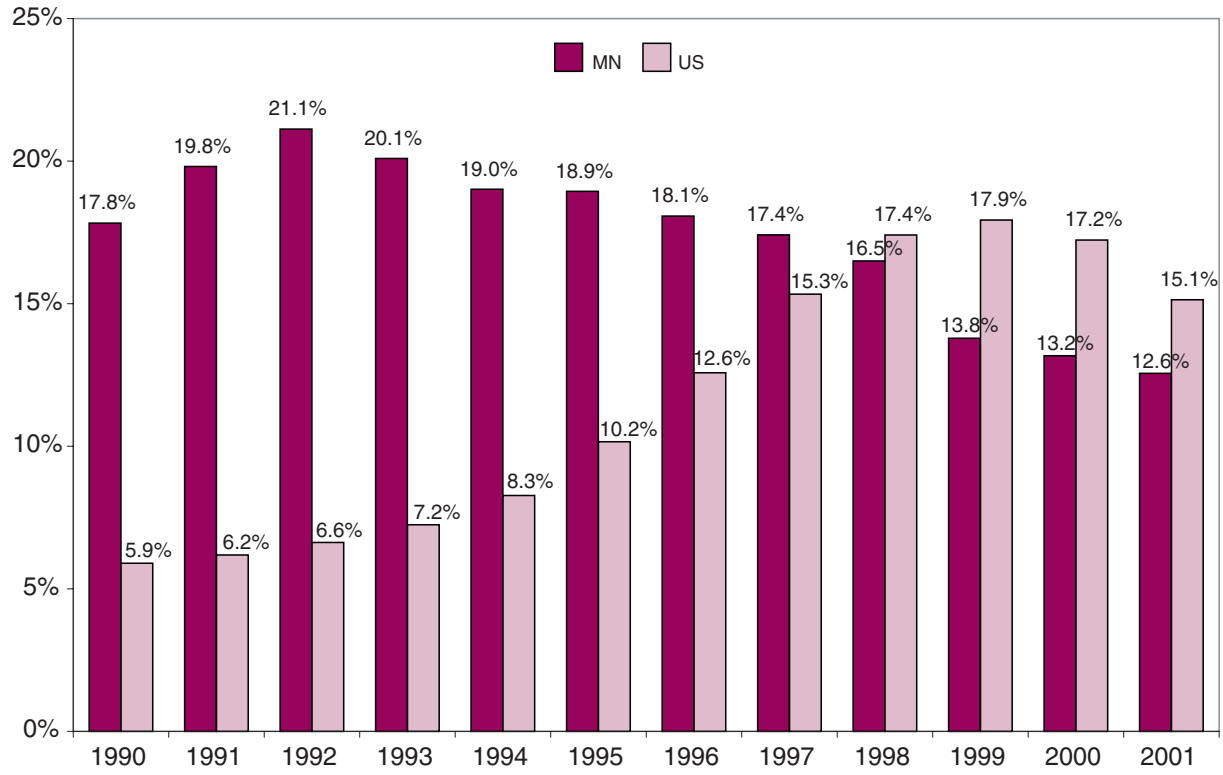
- There are currently 2 types of Medicare HMO arrangements in Minnesota. Under the ***Medicare+Choice*** program, HMOs assume financial risk for the cost of Medicare benefits beyond a pre-specified monthly payment amount (known as the Medicare+Choice or AAPCC rate) that varies by county. These plans must provide all Part A and Part B services that are covered under traditional Medicare. Under a ***cost contract***, a health plan receives payments from the federal government to provide Medicare Part B services to enrollees but does not bear any financial risk.

- Virtually all (97%) of the Medicare+Choice enrollment in Minnesota is in the seven-county Twin Cities metro area, where the capitation rates are higher than the rest of the state. In addition, 75% of the cost contract enrollment is in the Twin Cities metro area.[4]

Medicare managed care enrollment is declining in both Minnesota and the U.S. Historically, Minnesota has had a higher rate of participation in Medicare HMOs than the national average. However, enrollment in Medicare HMO products in Minnesota peaked at 21% in 1992 and has declined steadily since then, falling to 13% in 2001. In contrast, Medicare HMO enrollment grew rapidly at the national level through the 1990s, but has since declined. Figure 4 illustrates the trend in Medicare managed care enrollment as a share of total enrollment for both Minnesota and the U.S.

Figure 4

Medicare Managed Care as Percent of Enrollment



Source: Centers for Medicare and Medicaid Services, Medicare Managed Care Contract Reports for December of each year and total enrollment as of July 1 each year.

- One major reason for declining Medicare HMO enrollment has been the decision by many health plans to withdraw from the program. From 1999 through 2002, HMO withdrawals and service area reductions affected coverage for 2.2 million Medicare beneficiaries.[5] In Minnesota, only two HMOs, Group Health and UCare, currently participate in the Medicare+Choice market; Medica and Blue Plus withdrew from the market in 2001 and 1999, respectively.

Coverage for prescription drugs has become a key policy issue for Medicare. In Minnesota, half (50%) of Medicare beneficiaries do not have any insurance that pays for the cost of prescription drugs, compared to 38% nationally.[6] There are a variety of proposals currently under consideration that would add a prescription drug benefit to Medicare. Minnesota, like many states, has created its own program that pays for prescription drug costs for very low-income Medicare beneficiaries; this program is described later in this report. The Health Economics Program's December 2002 report, "Medicare Supplemental Coverage in Minnesota," provides more detailed information on prescription drug coverage of Medicare beneficiaries.

Medical Assistance

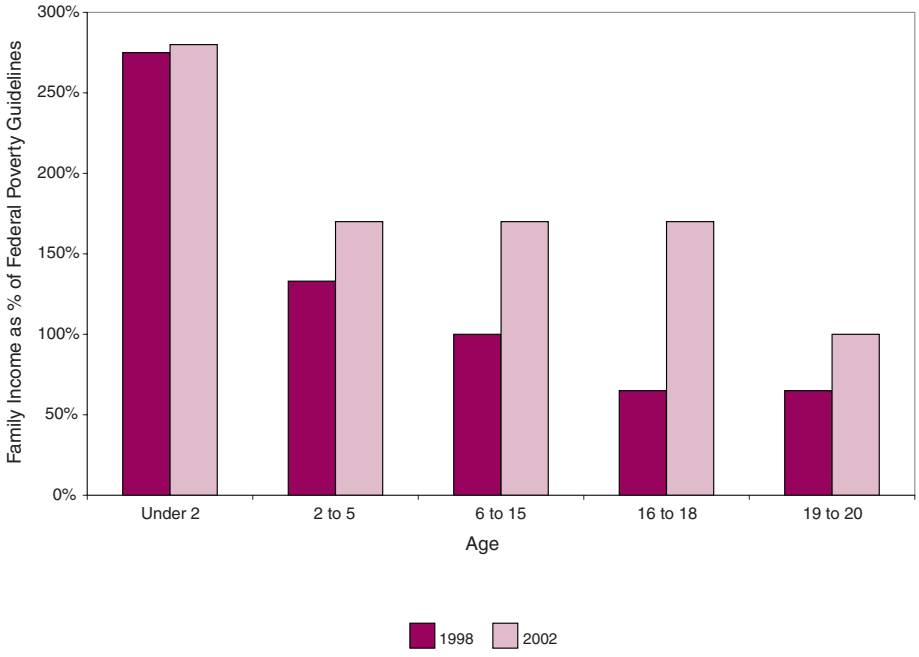
Medical Assistance is a state/federal program that serves lower income, disabled, and elderly Minnesotans. Medical Assistance (MA) is Minnesota's name for the Medicaid program.

Who can enroll in MA? Eligibility for MA is based on age and income level. For example, under current eligibility rules children ages 2 to 18 may be covered if their family incomes are below 170% of poverty while young adults ages 19 and 20 may be covered with incomes only up to 100% of poverty. Several expansions of Medicaid eligibility have been enacted in Minnesota since the mid-1980s. Figure 5 shows how the MA eligibility criteria for children changed between 1998 and 2002, by age and income level.

Because states provide health coverage through a variety of Medicaid, SCHIP (State Children's Health Insurance Program) and other programs that each have their own eligibility rules, it is difficult to compare states directly in terms of their eligibility standards for publicly funded health insurance coverage. Compared to most other states, however, Minnesota's programs for covering low-income children and families are more comprehensive in terms of who is eligible to enroll.[7]

Figure 5

MA Eligibility for Children in Minnesota



Source: Minnesota Department of Human Services.

Sources of funding: 50% of the total cost of the MA program in state fiscal year 2002 was paid for by the federal government, with the remaining 50% paid by the state and counties. The federal reimbursement rate for Medicaid varies by state and depends on each state's per capita income relative to the national average.

- For federal fiscal year 2003, the federal share of Medicaid spending by state ranges from a low of 50% to a high of about 77%.
- The federal government's share of Minnesota's MA spending has been declining for several years. For federal fiscal year 2003, the federal match rate for Minnesota is 50%.

Enrollment: MA covered about 404,000 Minnesotans in an average month in state fiscal year 2002, or about 8.1% of the population. Nationally, about 36.6 million people were enrolled in Medicaid in 2001, or about 12.9% of the population.[8] Table 3 shows the trend in MA enrollment and spending in Minnesota over the last 10 years.

- For some enrollees, particularly the elderly, MA serves as a secondary source of coverage. In 2001, about 21% of Minnesota's MA enrollees were also enrolled in Medicare. Excluding those who have Medicare coverage, MA was the primary source of health insurance coverage for about 303,000 Minnesotans in calendar year 2001, or about 6.1% of the population.

Table 3

Medical Assistance Enrollment and Spending History

State FY	Avg. Monthly Enrollment	Spending ($ millions)	Avg. Monthly Spending per Enrollee	Growth in: Enrollment	Growth in: Total Spending	Growth in: Spending Per Enrollee
1991	338,443	$1,638	$403.44	11.3%	15.2%	3.5%
1992	373,075	1,923	429.49	10.2%	17.4%	6.5%
1993	412,306	2,119	428.38	10.5%	10.2%	-0.3%
1994	428,187	2,418	470.61	3.9%	14.1%	9.9%
1995	433,441	2,592	498.37	1.2%	7.2%	5.9%
1996	428,467	2,805	545.50	-1.1%	8.2%	9.5%
1997	414,585	2,797	562.23	-3.2%	-0.3%	3.1%
1998	387,891	2,917	626.74	-6.4%	4.3%	11.5%
1999	370,054	2,997	674.98	-4.6%	2.7%	7.7%
2000	367,727	3,233	732.66	-0.6%	7.9%	8.5%
2001	378,884	3,582	787.84	3.0%	10.8%	7.5%
2002	403,675	4,136	853.88	6.5%	15.5%	8.4%

Source: Minnesota Department of Human Services, November 2002 forecast.

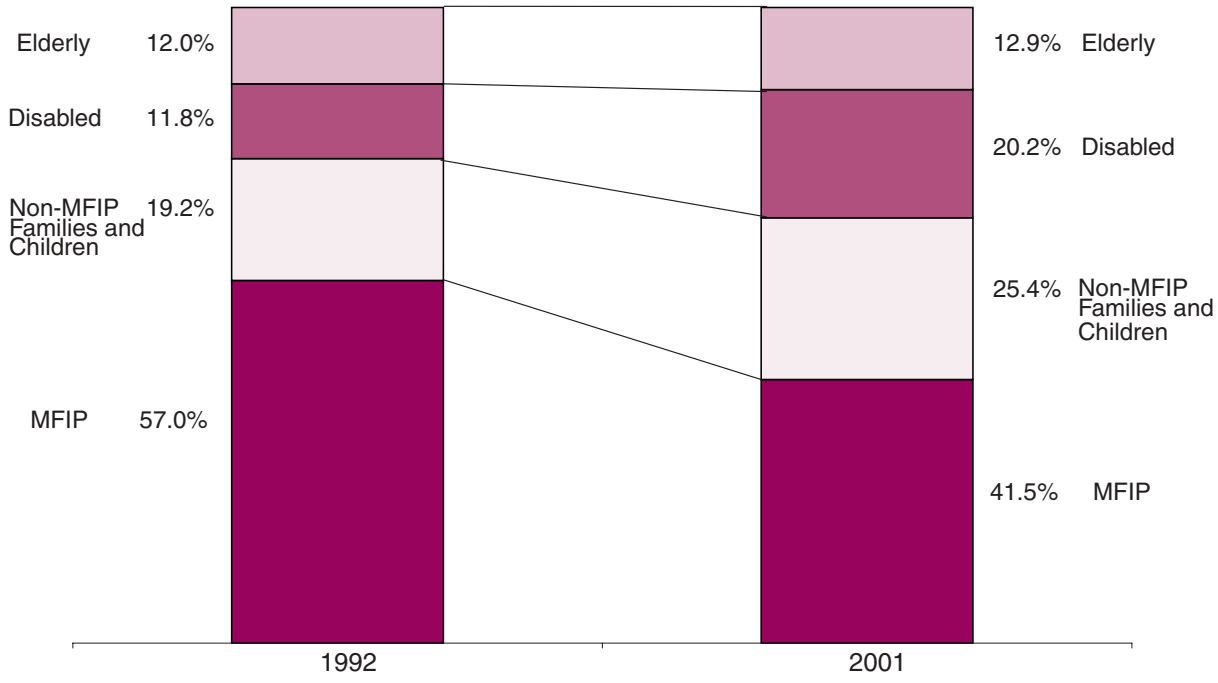
Note: FY 2001 includes 11 monthly payments to HMOs, due to a shift in the timing of payments. As a result, the calculated growth in total spending and spending per enrollee is lower in 2001 and higher in 2002 than would otherwise have been the case.

After declining each year since 1995, MA enrollment began to grow again in 2001. Most of the decrease in enrollment that occurred between 1995 and 2000 was due to the declining number of welfare recipients enrolled in MA. After growing slightly in 2001, MA average monthly enrollment grew sharply in 2002, from about 379,000 enrollees to nearly 404,000. The increase in enrollment that began in 2001 is likely due primarily to the economic recession.

Welfare recipients account for a declining share of MA enrollment. Figure 6 shows the distribution of Minnesota's MA enrollees by eligibility category in 1992 and 2001. In 1992, recipients of cash assistance under the MFIP program (formerly known as Aid to Families with Dependent Children, or AFDC) accounted for nearly three-fifths (57%) of MA enrollment; by 2001, this category had fallen to just 42% of enrollment. The number of MFIP recipients enrolled in MA decreased from about 213,000 in 1992 to 175,000 in 2001, a decline of roughly 25%. Meanwhile, other parts of the MA program grew — most notably, the disabled and blind enrollment increased by 72% (from 44,000 to 67,000) and the number of other children and parents enrolled in MA increased by one-third (32%) between 1992 and 2001, growing from about 72,000 to over 94,000. Much of the increase in the "other children and parents" enrollment category is due to expansions of child eligibility that occurred during this period.

Figure 6

Changes in MA Enrollment by Eligibility Category, 1992 to 2001

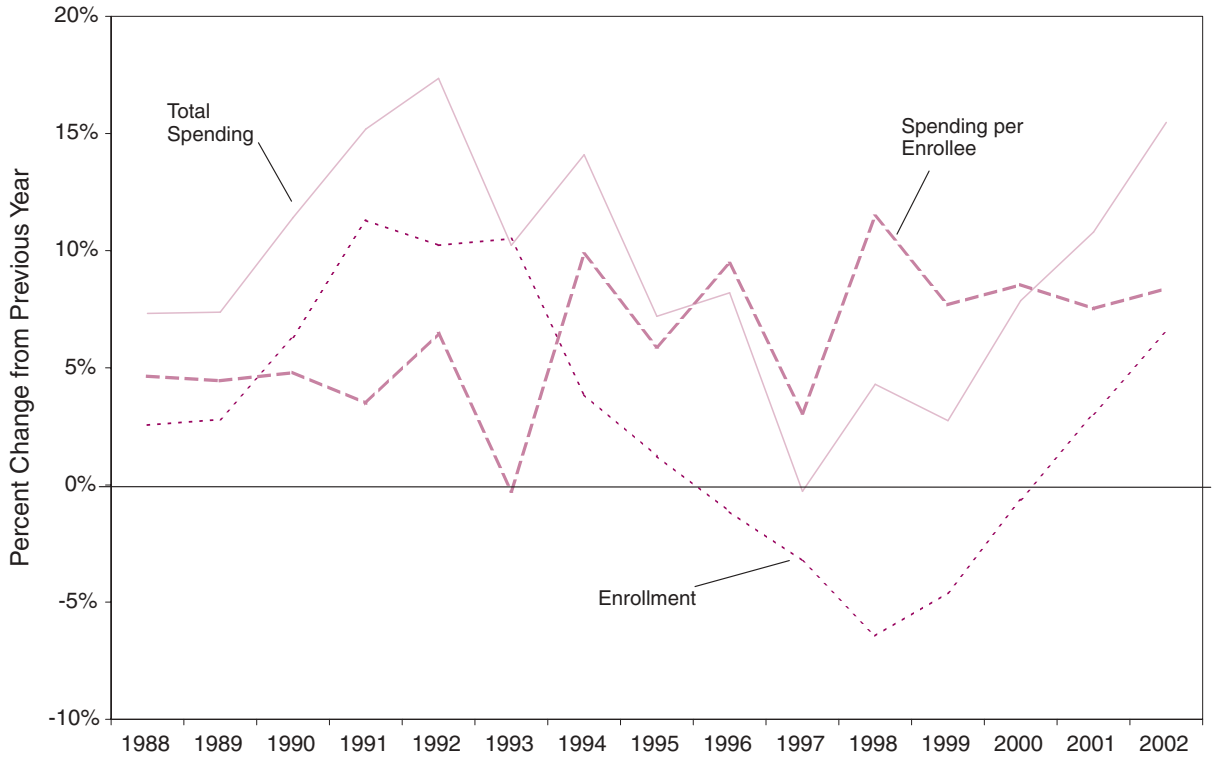


Source: Minnesota Department of Human Services.

Despite declining enrollment during the late 1990s, total MA spending grew in every year except 1997. The change in total spending is affected by both changes in enrollment and changes in spending per enrollee. Figure 7 illustrates the trends in MA enrollment, spending per enrollee, and total spending. As shown in the figure, increases in spending per enrollee had a stronger effect on total spending than declines in enrollment during the late 1990s. In 2002, the 15% increase in total MA spending was driven by strong growth in both enrollment and spending per enrollee.

Figure 7

MA Enrollment and Spending Growth



Source: Minnesota Department of Human Services. See note to Table 3.

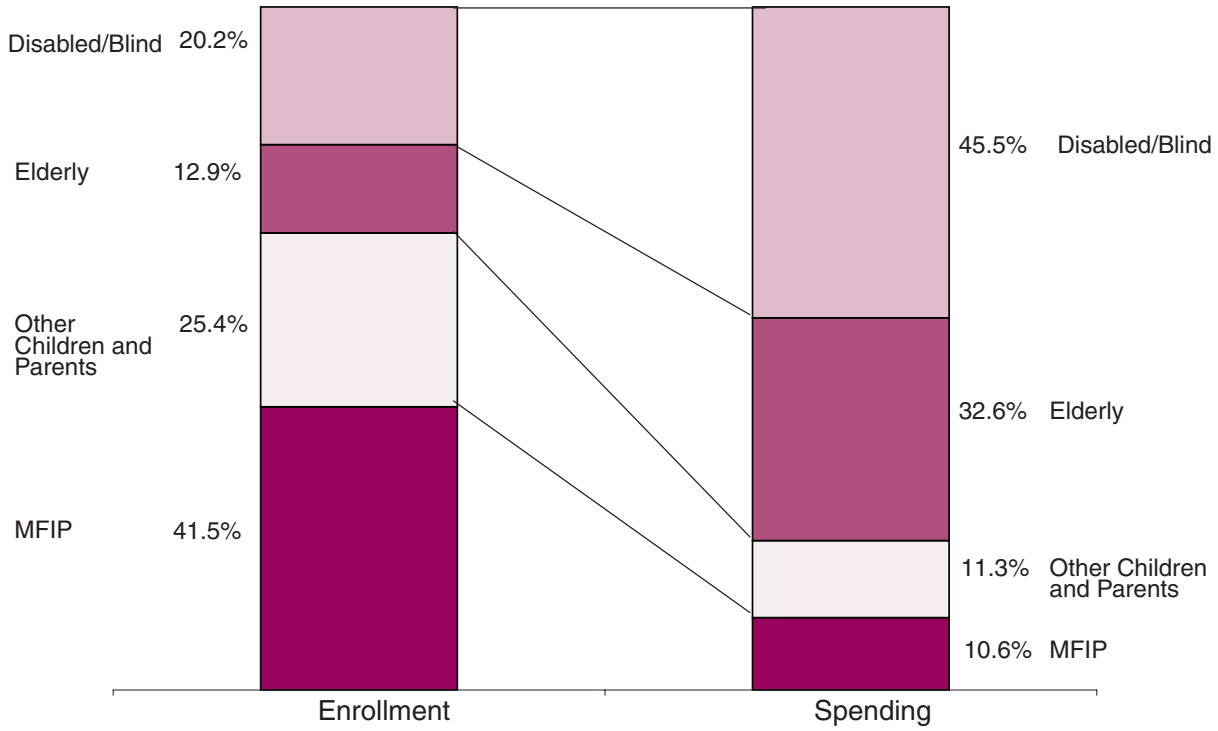
Although the elderly, blind and disabled account for a relatively small share of MA enrollment, together they account for a majority of MA spending. Because most of the enrollment declines in the mid- to late 1990s were among populations that typically are least expensive to serve, declining enrollment had little impact on spending per enrollee or overall spending.

- In Minnesota, elderly, blind and disabled enrollees made up about 33% of total MA enrollment in 2001, but accounted for about 78% of spending. Figure 8 illustrates the differences between the shares of enrollment and spending by enrollment category.

- Average costs vary dramatically by enrollment category — in fiscal year 2001, Minnesota's average cost per enrollee was about $2,391 for MFIP recipients, $4,154 for other children and families, $21,135 for disabled or blind enrollees, and $23,620 for elderly enrollees.[9] National spending patterns by category of Medicaid enrollment are similar.[10]

Figure 8

MA Spending by Eligibility Category, 2001



Source: Minnesota Department of Human Services, data for fiscal year 2001.

Medicaid accounts for a large share of most state budgets. In Minnesota, Medicaid spending as a share of the state budget was 18.4% in fiscal year 2001, below the national average of 19.6%. However, Medicaid spending in Minnesota grew more rapidly than in most other states during state fiscal year 2001: total Medicaid spending in Minnesota grew by 15.7%, compared to an average of 7.8% nationally.[11]

MinnesotaCare

MinnesotaCare was created in 1992 as a sliding-scale subsidized health insurance program for low- and moderate-income people who do not have access to other health insurance coverage. MinnesotaCare replaced the Children's Health Plan, which was established in 1987 with a more limited set of eligibility requirements and benefits. Since the inception of MinnesotaCare, eligibility and benefits under the program have been expanded several times.

Who can enroll in MinnesotaCare? Currently, families with children are eligible to enroll in MinnesotaCare if their incomes are below 275% of the Federal Poverty Guidelines (for a family of four in 2002, this limit was $49,775). Adults without children are eligible for MinnesotaCare if their incomes are below 175% of the Federal Poverty Guidelines. There are other eligibility standards for MinnesotaCare in addition to the income requirements. With some exceptions, an applicant must have been uninsured for at least 4 months, and must have had no access to employer-subsidized insurance coverage for at least 18 months.

MinnesotaCare was not intended to replace or substitute for private insurance coverage. There are several mechanisms in place that are intended to deter the potential "crowd-out" of private coverage and encourage people to obtain or keep private coverage instead of enrolling in MinnesotaCare. These include: eligibility restrictions (such as the requirement of 4 months without insurance and 18 months without access to employer-subsidized coverage), benefit limitations (a $10,000 limit on inpatient hospital benefits for certain adults), a sliding scale premium structure which requires higher enrollee payments at higher income levels, and an asset test.

Evidence on the extent to which "crowd-out" has occurred in public insurance programs is mixed. Although most studies have found that expansion of public program eligibility results in some substitution of public coverage for private coverage, conclusions about the degree of crowd-out vary depending on the time period studied (because of changes in eligibility requirements and changes in general economic conditions), the population studied (e.g., children or adults), the state or states included in the study, the source of data, and the analytical methods.

One recent national study found that while the percentage of children in low-income working families who had access to employer-based health insurance remained steady between 1997 and 2001, the percentage of those children whose families took up employer coverage declined slightly.[12] During this time period, availability of coverage through SCHIP (State Children's Health Insurance Programs) expanded significantly in many states; however, this was also a period of rapidly rising private health insurance premiums. The study does not distinguish between the effect that rising costs and reduced affordability may have had on private coverage vs. expanded availability of public coverage.

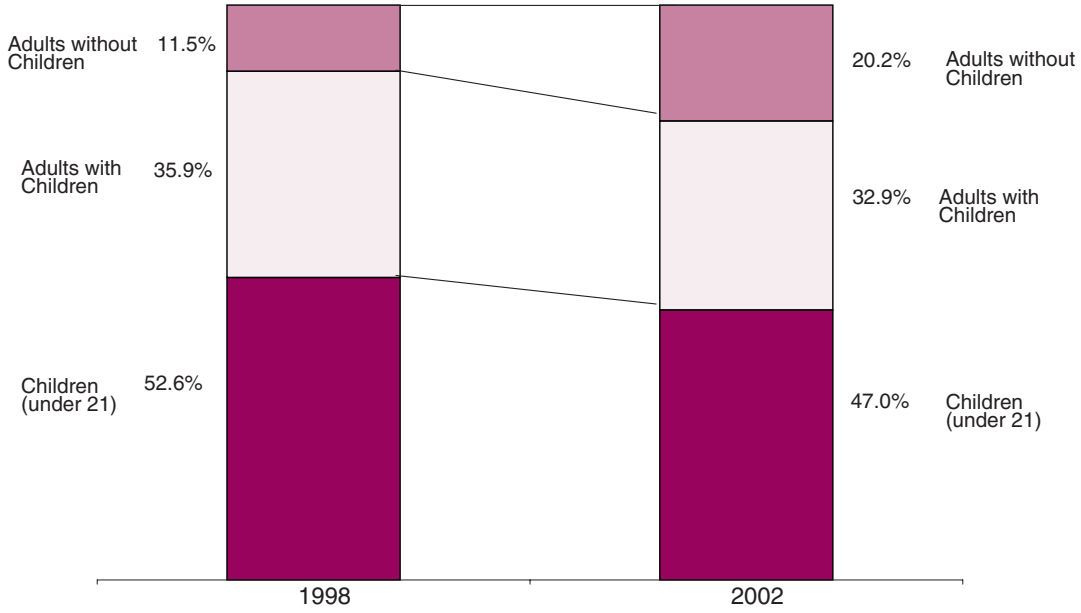
Specific to Minnesota, a study based on data from 1990 and 1995 (before and after the MinnesotaCare program was implemented) concluded that MinnesotaCare did not result in a significant erosion of private insurance coverage.[13] More recent data from another survey show that between 1997 and 1999, the percentage of low-income children in Minnesota with private coverage increased, probably reflecting the strong economy during that period, while the percentage with public coverage declined and the share that were uninsured remained constant.[14] On the other hand, another recent study suggests substantial crowd-out of private coverage among low-income adults enrolled in MinnesotaCare; however, a re-analysis by researchers at the University of Minnesota using the same data source and the same modeling technique has found very little evidence of crowd-out.[15]

About half of MinnesotaCare enrollees are children, and most have family incomes below 200% of poverty. In August 2002, there were just over 154,000 people enrolled in MinnesotaCare, or an estimated 3.1% of the population. Just under half (47%) of the enrollees were children, an additional 33% were parents, and 20% were adults without children. Adults without children are the most rapidly growing enrollment category: since 1998, the share of enrollees who are adults without children has risen from 12% to 20%.

About two-thirds of MinnesotaCare enrollees (68%) have family incomes below 150% of poverty, and almost 90% have family income less than 200% of poverty. Figures 9 and 10 illustrate the family composition and income levels of MinnesotaCare enrollees.

Figure 9

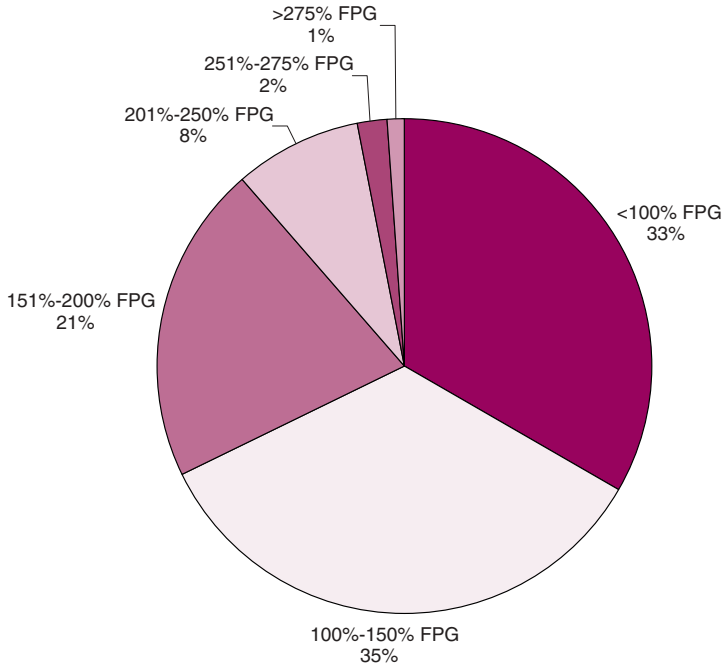
MinnesotaCare Enrollment by Eligibility Category



Enrollment as of December 1998 and August 2002. Source: Minnesota Department of Human Services.

Figure 10

MinnesotaCare Enrollment by Income Category
(Income as Percent of Federal Poverty Guidelines)



Source: Minnesota Department of Human Services, data for June 2002.

MinnesotaCare enrollment and spending leveled off during the late 1990s, but have since begun to grow quickly again. Table 4 shows historical enrollment and spending information for MinnesotaCare. Program enrollment and spending grew rapidly during the mid-1990s as the program became more widely known and as eligibility was expanded to new population groups and higher income levels. In the late 1990s, enrollment was roughly stable at about 100,000 people. In 2001 and 2002, average monthly enrollment grew by 12 to 13 percent per year; the economic recession is likely a primary contributor to the recent enrollment growth. Total program spending increased by 46% in 2002, driven by a 13% increase in average enrollment and a 30% increase in spending per enrollee.

Table 4

MinnesotaCare Enrollment and Spending History

State FY	Avg. Monthly Enrollment	Total Spending ($ millions)	Avg. Monthly Spending per Enrollee	Growth in: Enrollment	Growth in: Total Spending	Growth in: Spending Per Enrollee
1992*	22,896	$7.7	$28.18	--	--	--
1993*	35,217	12.8	30.31	53.8%	65.5%	7.6%
1994	62,232	33.2	44.52	76.7%	159.6%	46.9%
1995	77,417	56.2	60.50	24.4%	69.0%	35.9%
1996	88,276	79.6	75.19	14.0%	41.7%	24.3%
1997	93,136	98.1	87.80	5.5%	23.2%	16.8%
1998	97,854	108.4	92.36	5.1%	10.5%	5.2%
1999	106,552	164.5	128.63	8.9%	51.7%	39.3%
2000	108,999	187.1	143.05	2.3%	13.8%	11.2%
2001	122,204	240.0	163.65	12.1%	28.3%	14.4%
2002	137,936	350.8	211.96	12.9%	46.2%	29.5%

Source: Minnesota Department of Human Services, November 2002 forecast.

*Includes Children's Health Plan.

Note: FY 2001 includes 11 monthly payments to HMOs, due to a shift in the timing of payments. As a result, the calculated growth in total spending and spending per enrollee is lower in 2001 and higher in 2002 than would otherwise have been the case.

Sources of funding: In fiscal year 2002, total spending for MinnesotaCare was $351 million. Since July 1995, Minnesota has received some federal funds for the MinnesotaCare program under a Medicaid waiver. Federal matching payments are received for pregnant women, parents, and children enrolled in MinnesotaCare. In 2001, the state began receiving enhanced federal matching payments through the State Children's Health Insurance Program (SCHIP) to cover parents with incomes between 100% and 200% of the poverty level enrolled in MinnesotaCare. The remaining costs are financed through the Health Care Access Fund (HCAF). The HCAF's primary sources of revenue are a 1.5% tax on all health care providers[16] and premiums paid by MinnesotaCare enrollees.

Over time, an increasing share of the MinnesotaCare program has been paid for with federal funds. Table 5 shows historical spending information for MinnesotaCare by funding source. For fiscal year 2002, the federal contribution covered about 34% of the cost, premium payments by enrollees covered an additional 11%, and the remaining 55% was paid by the state through other HCAF revenues. Figure 11 shows the sources of revenue for the HCAF in state fiscal years 1998 and 2002 as shown in the figure, the federal share has increased from about 7% of the total to 35% during this time period, and the provider tax as a share of total HCAF resources declined from 83% to 57%.

Table 5

MinnesotaCare Funding Sources

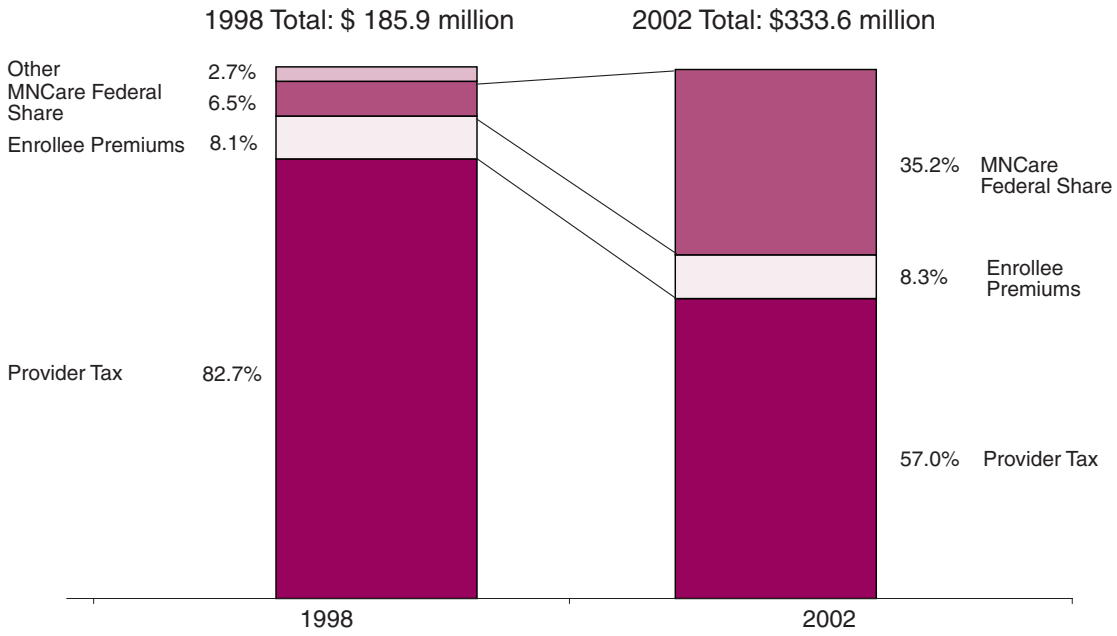
State FY	Total Spending ($000s)	Source of Funding:			Share of Funding:		
		State	Federal	Enrollee Premiums	State	Federal	Enrollee Premiums
1992*	$7,742	$6,988	$0	$754	90%	0%	10%
1993*	12,809	10,328	0	2,481	81%	0%	19%
1994	33,249	22,841	0	10,408	69%	0%	31%
1995	56,204	41,606	0	14,598	74%	0%	26%
1996	79,648	46,990	15,235	17,424	59%	19%	22%
1997	98,127	65,398	12,423	20,306	67%	13%	21%
1998	108,448	73,121	13,776	21,551	67%	13%	20%
1999	164,473	99,542	38,153	26,778	61%	23%	16%
2000	187,104	104,863	49,386	32,855	56%	26%	18%
2001	239,978	140,004	62,178	37,796	58%	26%	16%
2002	350,838	194,600	117,549	38,688	55%	34%	11%

Source: Minnesota Department of Human Services, November 2002 forecast.

*Includes Children's Health Plan.

Figure 11

Health Care Access Fund Sources of Revenue



Source: Minnesota Department of Finance, data for fiscal years 1998 and 2002. Includes federal matching funds.

General Assistance Medical Care

General Assistance Medical Care, or **GAMC**, is a state program similar to Medical Assistance (MA) for certain categories of low-income people that do not qualify for MA, typically working-age adults without children.

Who can enroll in GAMC? Low-income people who are not otherwise eligible for MA may enroll in GAMC if their incomes are below 75% of Federal Poverty Guidelines. Other eligibility requirements such as residency and asset tests also apply.

GAMC enrollment in 2002 was about half what it was 10 years earlier. Table 6 provides historical enrollment and spending information for the GAMC program. In state fiscal year 2002, the monthly average enrollment for GAMC was about 30,000, or about 0.6% of the population. Enrollment declined each year between 1992 and 2000, but began rising again in 2001. In 2002, average monthly enrollment increased by about 22% and total program spending grew by 35%.

Table 6

GAMC Enrollment and Spending History

State FY	Avg. Monthly Enrollment	Spending ($ millions)	Avg. Monthly Spending per Enrollee	Growth in: Enrollment	Growth in: Total Spending	Growth in: Spending per Enrollee
1991	48,929	$124.0	$211.22	14.3%	15.3%	0.9%
1992	55,292	161.3	243.10	13.0%	30.1%	15.1%
1993	54,963	163.9	248.57	-0.6%	1.6%	2.3%
1994	53,796	161.1	249.57	-2.1%	-1.7%	0.4%
1995	53,173	150.6	236.06	-1.2%	-6.5%	-5.4%
1996	43,533	152.8	292.46	-18.1%	1.4%	23.9%
1997	38,428	145.0	314.34	-11.7%	-5.1%	7.5%
1998	31,113	120.8	323.59	-19.0%	-16.7%	2.9%
1999	26,794	132.3	411.49	-13.9%	9.5%	27.2%
2000	23,347	127.7	455.96	-12.9%	-3.4%	10.8%
2001	24,592	134.7	456.53	5.3%	5.5%	0.1%
2002	29,886	182.2	508.09	21.5%	35.3%	11.3%

Source: Minnesota Department of Human Services, November 2002 forecast.

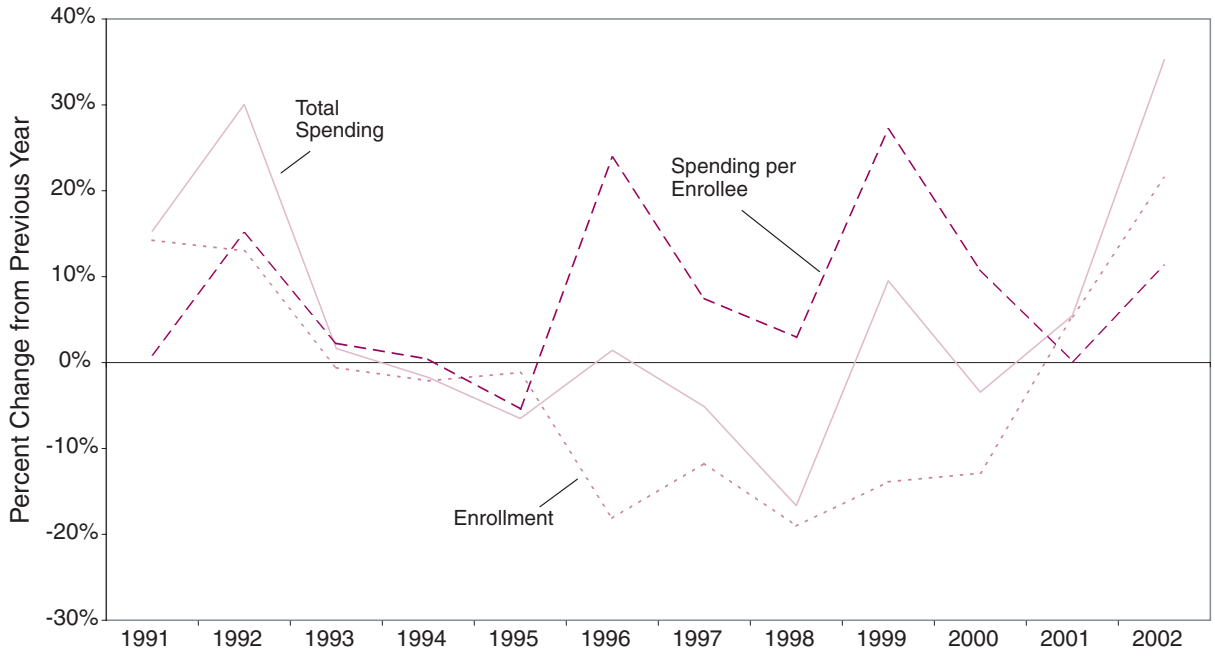
Note: FY 2001 includes 11 monthly payments to HMOs, due to a shift in the timing of payments. As a result, the calculated growth in total spending and spending per enrollee is lower in 2001 and higher in 2002 than would otherwise have been the case.

Although total spending for GAMC declined for much of the 1990s, spending per enrollee continued to rise. Total spending for the GAMC program declined from a high of about $164 million in 1993 to $128 million in 2000, rising to $182 million in 2002. However, average monthly spending per enrollee in 2002 was more than double its level of a decade earlier (not adjusted for inflation). This increase in average spending per enrollee is likely explained in part by the fact that the population remaining on GAMC is more vulnerable and less healthy than the population that moved off of GAMC during the strong economic growth of the mid- to late 1990s. Figure 12 illustrates the changes in GAMC enrollment, spending per enrollee, and total spending during the 1990s. For most of the period from 1995 through 2001, declining enrollment was offset by increases in spending per enrollee, resulting in relatively stable overall program spending. In 2002, strong growth in both enrollment (22%) and spending per enrollee (11%) combined to produce a total spending increase of 35%.

Sources of funding: The state pays for 100% of the cost of the GAMC program. Prior to state fiscal year 1998, the state paid for 90% of the cost, with counties responsible for the remaining 10%.

Figure 12

GAMC Enrollment and Spending Growth



Source: Minnesota Department of Human Services.

Prescription Drug Program

Minnesota's **Prescription Drug Program** is the state's newest program that provides public insurance coverage. Started in 1999, the program provides prescription drug benefits for low-income Medicare enrollees who do not have other drug coverage. Overall, nearly half (49.9%) of Minnesota's Medicare enrollees lack insurance that pays for prescription drugs.[17]

Who can enroll in the Prescription Drug Program? Currently, Medicare enrollees (both elderly and disabled) with income at or below 120% of Federal Poverty Guidelines are eligible to enroll in the Prescription Drug Program. An expansion of the income limit for elderly Medicare beneficiaries from 120% to 135% of poverty that had been planned for January 1, 2002 was delayed due to projections that program spending would exceed the amount that had been appropriated by the Legislature. That expansion is currently scheduled for July 1, 2003. Eligibility for the program was expanded to people who qualify for Medicare due to a disability in July 2002.

Applicants must have been without prescription drug coverage for at least 4 months, and must have assets below a certain level ($10,000 for single enrollees and $18,000 for married couples). Enrollees in the Prescription Drug Program must also be enrolled in or applying for Medical Assistance programs that provide assistance with Medicare premiums and cost sharing (Qualified Medicare Beneficiary, or QMB, and Service Limited Medicare Beneficiary, or SLMB).

What are the benefits? The program pays the entire cost for most prescription drugs after enrollees pay the first $35 per month.

Although the program is small, it grew rapidly during its first few years of operation. Table 7 shows the trend in enrollment, spending, and spending per enrollee since the Prescription Drug Program began in 1999. As shown in the table, average monthly spending per enrollee in 2002 was nearly $1,100, indicating that the population enrolled in the program has very high prescription drug usage.

Table 7

Prescription Drug Program Enrollment and Spending History

State FY	Avg. Monthly Enrollment	Spending ($ millions)	Avg. Monthly Spending per Enrollee	Growth in: Enrollment	Growth in: Total Spending	Growth in: Spending per Enrollee
1999	796*	$0.4	$506.18			
2000	2,687	2.2	832.65	237.6%	455.3%	64.5%
2001	5,554	4.7	852.57	106.7%	111.6%	2.4%
2002	4,780	5.1	1,073.83	-13.9%	8.4%	26.0%

Source: Minnesota Department of Human Services, November 2002 forecast. Spending figures represent state costs net of rebates.

*Six months average

Sources of funding: The state pays for 100% of the cost of the Prescription Drug Program. The program is paid for out of the state's general fund.

Minnesota Comprehensive Health Association

Established in 1976, the **Minnesota Comprehensive Health Association**, or **MCHA**, is a high-risk pool for individuals who are unable to purchase private health insurance at standard market rates or without restrictive clauses because of pre-existing conditions. Many other states have similar programs, although MCHA is the nation's largest high-risk pool.

Who can enroll in MCHA? Generally, people who have been refused insurance coverage, offered coverage at a higher than standard premium, or offered coverage with a requirement of an exclusionary rider or preexisting condition limitation may enroll in MCHA. In addition, people being treated for certain health conditions are automatically eligible to enroll (with a physician's certification of their condition).

MCHA enrollment declined through most of the 1990s, but began to rise again in 1999. After rising rapidly in the late 1980s and early 1990s, MCHA's enrollment peaked at about 35,000 in 1993. At the end of 2001, about 27,000 people were enrolled in MCHA, or an estimated 0.6% of the population. Table 8 presents historical enrollment and spending information for MCHA.

- Since about 15% of MCHA's enrollment is in Medicare Supplement products, the actual number of Minnesotans relying on MCHA as their primary source of coverage in 2001 was about 23,000, or 0.5% of the population.

Table 8

MCHA Enrollment and Spending History

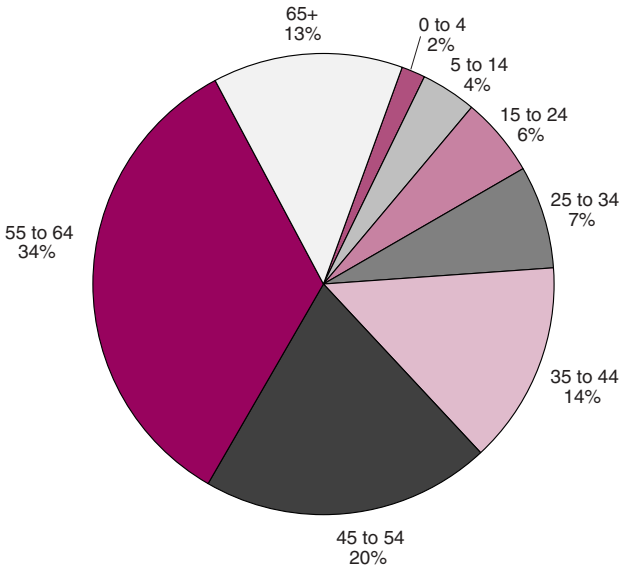
	Enrollment	Spending ($ millions)	Avg. Monthly Spending per Enrollee	Growth in: Enrollment	Growth in: Total Spending	Growth in: Spending per Enrollee
1991	29,902	$60.3	$182.03	18.3%	21.8%	-2.7%
1992	33,805	76.7	200.74	13.1%	27.3%	10.3%
1993	35,296	87.0	209.77	4.4%	13.3%	4.5%
1994	33,477	92.5	224.22	-5.2%	6.4%	6.9%
1995	30,470	94.6	246.58	-9.0%	2.3%	10.0%
1996	27,552	87.7	251.94	-9.6%	-7.3%	2.2%
1997	26,314	90.9	281.22	-4.5%	3.6%	11.6%
1998	24,954	90.5	294.06	-5.2%	-0.5%	4.6%
1999	25,433	101.6	336.04	1.9%	12.3%	14.3%
2000	25,938	112.1	363.66	2.0%	10.3%	8.2%
2001	27,428	124.6	389.27	5.7%	11.2%	7.0%

Source: Minnesota Comprehensive Health Association. Enrollment as of December 31 each year.
Avg. monthly claims per enrollee based on estimated average monthly enrollment.

Enrollment in MCHA is concentrated among middle-aged and near-elderly adults. These are the individuals most likely to be denied coverage in the private market. In 1999, one-third (34%) of MCHA enrollees were between the ages of 55 and 64, and an additional 20% were ages 45 to 54. Figure 13 shows the age distribution of MCHA enrollees.

Figure 13

MCHA Enrollment by Age Group 1999



Source: Minnesota Comprehensive Health Association, 1999/2000 Annual Report.

Premiums paid by MCHA enrollees cover only a little more than half of claims. Enrollees pay premiums which may be set at up to 125% of the average individual premium in Minnesota. To cover costs in excess of premium revenues, MCHA is authorized to make an annual assessment on all health plan companies that do business in Minnesota. Table 9 presents information on MCHA's claims, premiums, and losses over time. In 2001, premium revenues of $65.1 million covered 52% of MCHA's $124.6 million in claims. MCHA's overall operating loss for 2001 was $66.5 million.

Table 9

MCHA Premiums and Losses

In millions of dollars:

	Claims	Premiums	Losses	Premiums as % of Claims
1991	$60.3	$35.5	$28.5	58.9%
1992	76.7	43.6	37.7	56.8%
1993	87.0	51.5	40.6	59.3%
1994	92.5	54.2	44.4	58.6%
1995	94.6	52.4	48.8	55.3%
1996	87.7	48.9	42.9	55.8%
1997	90.9	47.5	47.7	52.2%
1998	90.5	47.7	47.4	52.8%
1999	101.6	51.9	56.6	51.1%
2000	112.1	58.8	58.6	52.4%
2001	124.6	65.1	66.5	52.2%

Source: Minnesota Comprehensive Health Association.

Growth in self-insurance has eroded the share of the private market that shares responsibility for covering MCHA's losses. Since the 1980s, growth in the number of employers choosing to self-insure rather than transfer the risk for health care claims to a health plan company resulted in MCHA's losses being spread over a smaller share of the private health insurance market.[18]

The Minnesota legislature has periodically appropriated funds to assist in covering MCHA's losses. MCHA received $15 million in state funds in 1998, 1999, and 2001. In addition, MCHA received $70 million in September 2002 from the Blue Cross Blue Shield of Minnesota tobacco settlement to offset 2003 losses. However, the money must be held in an escrow fund due to ongoing litigation about the use of tobacco settlement money; this litigation is not expected to be resolved before 2004.

Endnotes

[1] For more information on Medicare supplemental insurance, see "Medicare Supplemental Coverage in Minnesota", Minnesota Department of Health, Health Economics Program, December 2002.

[2] Source: Minnesota Department of Health, Health Care Cost Information System (HCCIS).

[3] Based on Centers for Medicare and Medicaid Services data for managed care enrollment as of December 1, 2001 and total enrollment as of July 1, 2001.

[4] Data from HMO annual reports to the Minnesota Department of Commerce.

[5] The Henry J. Kaiser Family Foundation, "Medicare + Choice," June 2002.

[6] "Medicare Supplemental Coverage in Minnesota," Minnesota Department of Health, Health Economics Program, December 2002.

[7] Kaiser Commission on Medicaid and the Uninsured, "Enrolling Children and Families in Health Coverage: The Promise of Doing More," June 2002.

[8] National Medicaid enrollment data from The Kaiser Commission on Medicaid and the Uninsured, "Medicaid Enrollment in 50 States: December 2001 Data Update," October 2002; population estimate as of July 2001 from U.S. Bureau of the Census.

[9] Minnesota Department of Human Services.

[10] Urban Institute estimates, published in Kaiser Commission on Medicaid and the Uninsured, "Medicaid Enrollment and Spending Trends," April 2001.

[11] National Association of State Budget Officers, "2000 State Expenditure Report," Summer 2001.

[12] Center for Studying Health System Change, "Working Families' Health Insurance coverage, 1997-2001," Tracking Report, Results from the Community Tracking Study, No. 4, August 2002.

[13] Kathleen Thiede Call, et al., "Who Is Still Uninsured in Minnesota? Lessons from State Reform Efforts," Journal of the American Medical Association 278(14), October 8, 1997, p. 1191-1195.

[14] Data from Urban Institute's National Survey of America's Families.

[15] Richard Kronick and Todd Gilmer, "Insuring Low-Income Adults: Does Public Coverage Crowd Out Private?", Health Affairs, January/February 2002; Gestur Davidson, Noreen Arnold, Lynn A. Blewett, and Michael Davern, "A Re-Analysis of the Empirical Evidence Concerning Crowd-Out in MinnesotaCare: Part I," University of Minnesota, State Health Access Data Assistance Center, December 2002.

[16] Prior to 1998, the provider tax was 2%. The tax was reduced to 1.5% starting in fiscal year 1998 and under current law will go back up to 2% in January 2004.

[17] "Medicare Supplemental Coverage in Minnesota," Minnesota Department of Health, Health Economics Program, December 2002.

[18] Self-insured companies are exempt from state regulation under the federal Employee Retirement Income Security Act (ERISA) of 1974. Employers may choose to self-fund their health insurance plans for a variety of reasons, such as the ability to establish uniform benefits for employees located in different states, freedom from state mandates, and exemption from state taxes and assessments. For more information about self-funding, see "Questions and Answers on Self-Funding of Health Care Benefits," Health Economics Program Issue Brief 2000-03, Minnesota Department of Health, May 2000.

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