Health Care Coverage and Financing in Minnesota:

Public Sector Programs

March 1999

Health Economics Program
Health Policy and Systems Compliance Division
Minnesota Department of Health

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Minnesota Department of Health
121 East Seventh Place
St. Paul, MN 55105

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

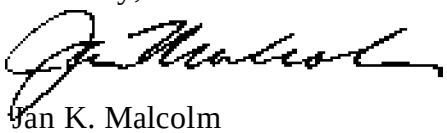
Dear Colleague:

I am pleased to provide you with a copy of *Health Care Coverage and Financing in Minnesota: Public Sector Programs.* One in four Minnesota residents relies on a public program as a primary source of health insurance coverage. These programs provide a valuable safety net for individuals who might otherwise have no health insurance coverage due to health conditions, income, or age.

This report compiles and analyzes information from a variety of sources to provide an overview of the many different public health insurance programs that are available to Minnesota residents. In addition to describing the purposes and eligibility requirements of each program, it highlights important trends in enrollment and financing. This report also partially fulfills the market study requirement under Minn. Stat. §144.70.

I hope you find this report to be a valuable source of information and a useful reference. The report was prepared by Julie Sonier of MDH's Health Economics Program. Questions regarding this report can be directed to the Health Economics Program at (651) 282-6367.

Sincerely,



Jan K. Malcolm
Commissioner

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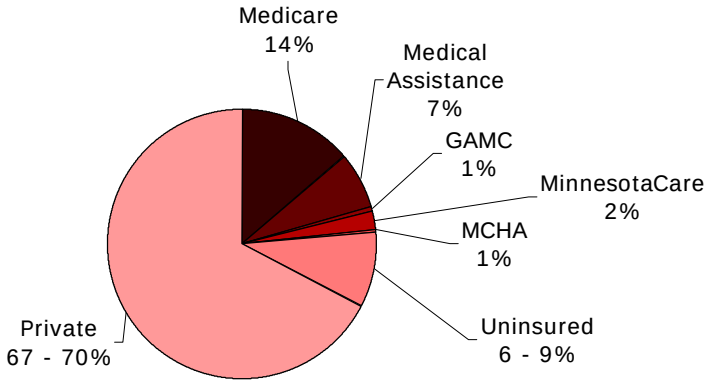
Introduction

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 1997. The distribution of insurance coverage for Minnesota residents is illustrated in Figure 1.

Figure 1
Distribution of Minnesota Population
by Primary Source of Insurance Coverage
1997



This report provides an overview of the public sector's current 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 24% of the population relies on public programs as a primary source of coverage, these programs account for 40% 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 Health Insurance Programs in Minnesota

Program Name	Time Period	Minnesota Enrollment[a,b]	% of Population[a]	Minnesota Spending ($ millions)	Sources of funding
Medicare	FFY 1997	639,293	13.6%	$2,460	Federal payroll tax; federal general revenues; enrollee premiums
Medical Assistance (MA, Medicaid)	SFY 1998	384,083	8.1%	$2,918	Federal, state, county
MinnesotaCare	SFY 1998	97,864	2.1%	$108	State (Health Care Access Fund) and federal, enrollee premiums
General Assistance Medical Care (GAMC)	SFY 1998	31,113	0.7%	$119	State (formerly state and county)
Minnesota Comprehensive Health Association (MCHA)	CY 1997	26,314	0.6%	$91	Enrollee premiums, assessment on health plan companies, state (1998 and 1999)

[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, 1997; MA, MinnesotaCare, and GAMC average monthly enrollment for state fiscal year 1998; MCHA enrollment as of December 31, 1997.

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 1999, the Part B premium is $45.50 per month.) Nearly all Medicare enrollees who are eligible for Part A also choose to enroll in Part B coverage.

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. Nationally, about two-thirds (64%) of Medicare enrollees purchase additional private insurance coverage and/or receive it from employers as a retirement benefit. Some low-income Medicare enrollees obtain additional coverage through Medicaid; nationally, about 17% of Medicare enrollees receive some type of assistance through Medicaid. Less than one-fifth (19%) of Medicare enrollees rely solely on Medicare for their health insurance coverage.[1]

Medicare enrollment: In 1997, nearly 640,000 Minnesotans were enrolled in Medicare, representing 13.6% of the state's population. Nationally, over 38 million Americans were enrolled in Medicare, or about 14.4% 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 1997, the federal government spent over $207 billion on Medicare, about $2.5 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 1997, spending per enrollee in Minnesota was an estimated $3,848 compared to an average of $5,388 nationally. Spending per enrollee in Minnesota has been growing more rapidly than the national average for the last decade — in 1997, spending per enrollee in Minnesota was about 71% of the national average, compared to 62% in 1988.

Table 2
Medicare Enrollment and Spending History

	Enrollment		Expenditures (Millions of Dollars)		Spending Per Enrollee	
	MN	US	MN	US	MN	US
1988	573,000	32,980,033	$920	$85,704	$1,606	$2,599
1989	579,000	33,579,449	$1,053	$94,300	$1,819	$2,808
1990	588,000	34,203,383	$1,300	$106,861	$2,211	$3,124
1991	597,000	34,870,240	$1,650	$113,942	$2,763	$3,268
1992	606,000	35,579,149	$1,749	$129,179	$2,886	$3,631
1993	615,627	36,305,903	$1,895	$142,934	$3,079	$3,937
1994	623,633	36,935,366	$1,955	$159,345	$3,135	$4,314
1995	630,523	37,535,024	$2,140	$176,884	$3,394	$4,713
1996	635,747	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

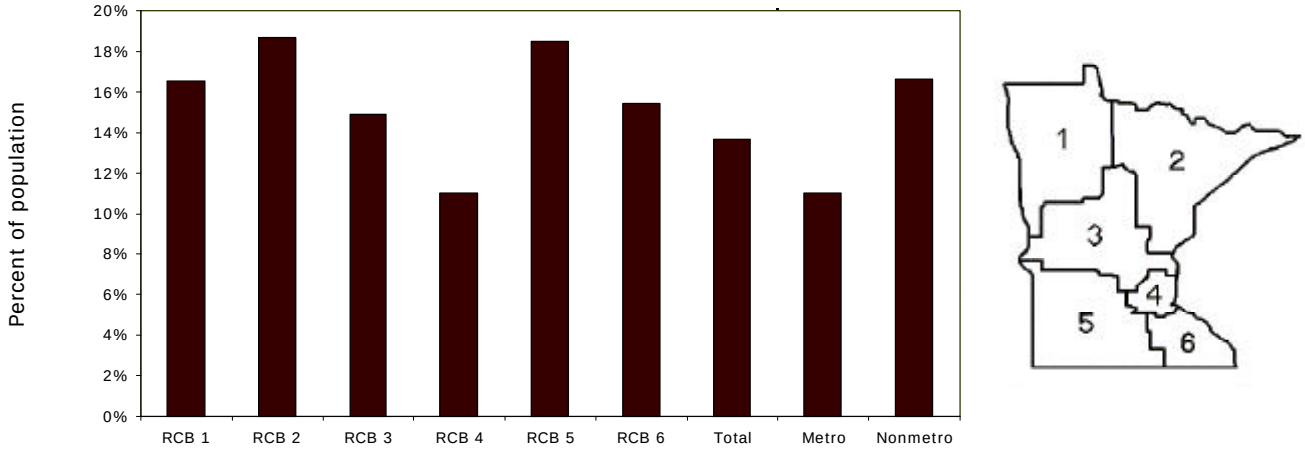
Enrollment data as of July 1 each year. Expenditure data pertain to federal fiscal years. State expenditure data are payments on behalf of Minnesota residents. 1988-90 spending for MN residents from Health Care Financing Administration; 1991-97 estimated by MDH Health Economics Program from payments to Minnesota providers. Spending per enrollee estimated by MDH Health Economics Program as federal fiscal year spending divided by July 1 enrollment.

Source: Health Care Financing Administration, various years; 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.

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 17% in Greater Minnesota. Figure 2 illustrates this difference by region.

Figure 2
Medicare Enrollees as Percent of Population
1997



RCB = Regional Coordinating Board

Source: Health Care Financing Administration, enrollment by county as of June 1997.

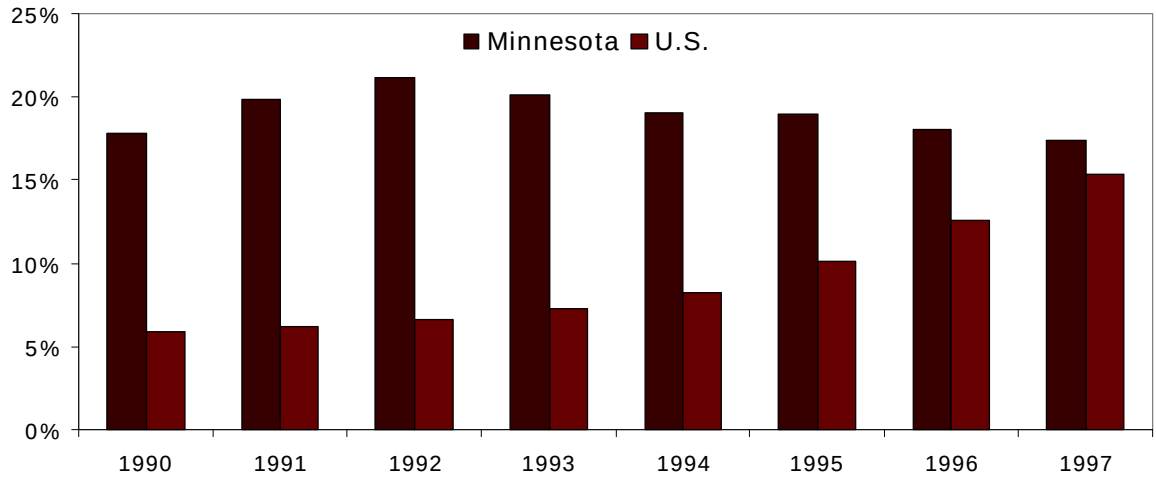
Rural health care providers in Minnesota are more dependent on Medicare revenues. The larger proportion of the population that is served by Medicare in Greater Minnesota means that rural health care providers are more heavily dependent on Medicare revenue than their metro area counterparts. For example, rural hospitals in Minnesota relied on Medicare for 43% of their revenue in 1996, while urban hospitals received about 33% of their revenue from Medicare.

About 17% of Medicare enrollees in Minnesota are enrolled in HMOs.[2] Participation in Medicare HMOs in Minnesota varies widely by region — about one-third of Medicare beneficiaries in the metro area are enrolled in HMOs, compared to only about 5% in Greater Minnesota. Part of the reason for this difference may be that HMO payment rates for Medicare are lower in rural areas, and part may be due to the lower HMO presence in rural areas in general.

- There are currently 2 types of Medicare HMO arrangements in Minnesota. Under a ***risk contract*** with the federal government, HMOs assume financial risk for the cost of Medicare benefits beyond a pre-specified monthly payment amount (called Medicare + Choice rates, formerly called average adjusted per capita cost, or AAPCC, rates) that varies by county. Risk plans must provide all Part A and Part B services that are covered under traditional Medicare. Under a ***health care prepayment plan (HCPP)*** arrangement, the HMO receives payments from the federal government to provide Medicare Part B services to enrollees but does not bear any financial risk.

- Virtually all (98%) of the risk HMO enrollment in Minnesota is in the seven-county metro area, where the AAPCC rates tend to be higher than they are for the rest of the state. In addition, two-thirds of the HCPP enrollment is in the metro area.[3]

Figure 3
Medicare Managed Care as Percent of Enrollment



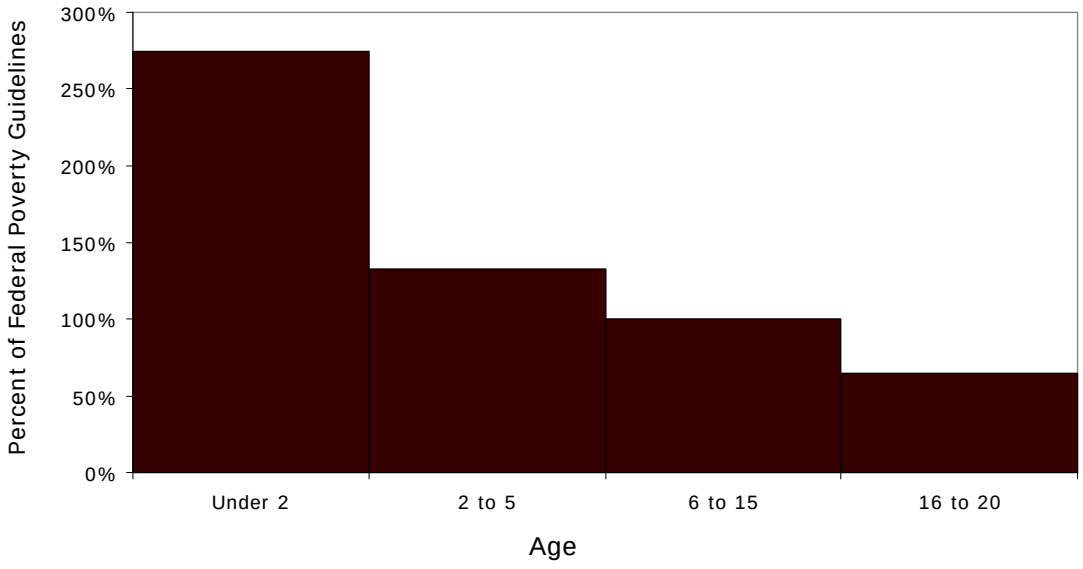
Source: Health Care Financing Administration — Medicare Managed Care Contract Reports for December of each year and total enrollment as of July 1 each year.

Medical Assistance

Medical Assistance is a state/federal program designed to serve 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 infants may be covered if their family incomes are below 275% of poverty, while children ages 2 to 5 are covered with incomes only up to 133% of poverty. Several expansions of Medicaid eligibility have been enacted in Minnesota since the mid-1980s. Figure 4 shows current eligibility for MA by age and income level for children. Compared to most other states, Minnesota's Medicaid program is relatively generous in terms of both eligibility and benefits.

Figure 4
MA Eligibility for Children in Minnesota



Source: Minnesota Department of Human Services.

Sources of funding: 52.8% of the total cost of the MA program in state fiscal year 1998 was paid for by the federal government, with the remaining 47.2% 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 1998, the federal share of Medicaid spending by state ranged 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 the federal fiscal year that began on October 1, 1998, the federal match rate for Minnesota is 51.5%.

Enrollment: MA covered about 384,000 Minnesotans on average in state fiscal year 1998, or about 8.1% of the population. Nationally, about 32.2 million people on average were enrolled in Medicaid in federal fiscal year (FFY) 1997, or about 12.0% of the population.[5] Table 3 shows the trend in MA enrollment and spending over the last 10 years.

- For some enrollees, particularly the elderly, MA serves as a secondary source of coverage. In 1997, about 19% of MA enrollees were also enrolled in Medicare. Excluding those who have Medicare coverage, we estimate that MA was the primary source of health insurance coverage for about 321,000 Minnesotans in calendar year 1997, or about 6.8% of the population.

MA enrollment has declined for the last 3 years in a row. The number of Minnesotans enrolled in MA grew rapidly during the early 1990s, reaching a peak of over 433,000 on an average monthly basis in 1995. Most of the decrease in enrollment since 1995 is due to the declining number of welfare recipients enrolled in MA. In addition, some people who might otherwise be enrolled in MA are enrolled in MinnesotaCare instead.

Welfare recipients account for a declining share of MA enrollment. Figure 5 shows the distribution of Minnesota's MA enrollees by eligibility category in 1988 and 1998. In 1988, recipients of cash assistance under the AFDC/MFIP programs[6] accounted for nearly two-thirds (64%) of MA enrollment; by 1998, this category had fallen to just 46% of enrollment. The *number* of AFDC/MFIP recipients enrolled in MA was virtually the same in 1988 as in 1998 (roughly 175,000 people). Meanwhile, other parts of the MA program grew rapidly — in particular, the number of other children and parents enrolled in MA more than tripled between 1988 and 1998, growing from 30,000 to over 94,000. Much of the increase in this enrollment category, which is composed mostly of children, is due to expansions of eligibility that occurred during this period.

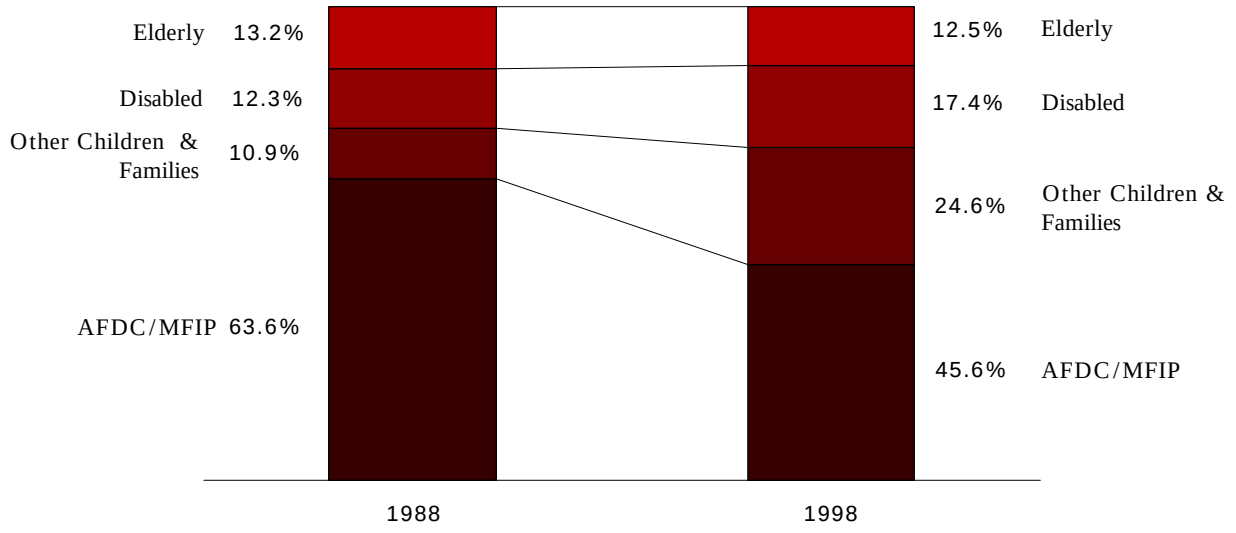
Table 3

Medical Assistance Enrollment and Spending History

State FY	Avg. Monthly Enrollment	Spending ($ millions)	Avg. Monthly Spending Per Enrollee	Growth In:	
				Total Spending	Spending Per Enrollee
1988	278,261	$1,189	$356.11	7.3%	4.6%
1989	286,046	$1,277	$371.96	7.4%	4.5%
1990	304,098	$1,422	$389.81	11.4%	4.8%
1991	338,443	$1,638	$403.44	15.2%	3.5%
1992	373,075	$1,923	$429.49	17.4%	6.5%
1993	412,306	$2,119	$428.38	10.2%	-0.3%
1994	428,187	$2,419	$470.81	14.1%	9.9%
1995	433,441	$2,592	$498.37	7.2%	5.9%
1996	426,545	$2,805	$547.96	8.2%	10.0%
1997	411,491	$2,797	$566.46	-0.3%	3.4%
1998	384,083	$2,918	$633.01	4.3%	11.7%

Source: Minnesota Department of Human Services.

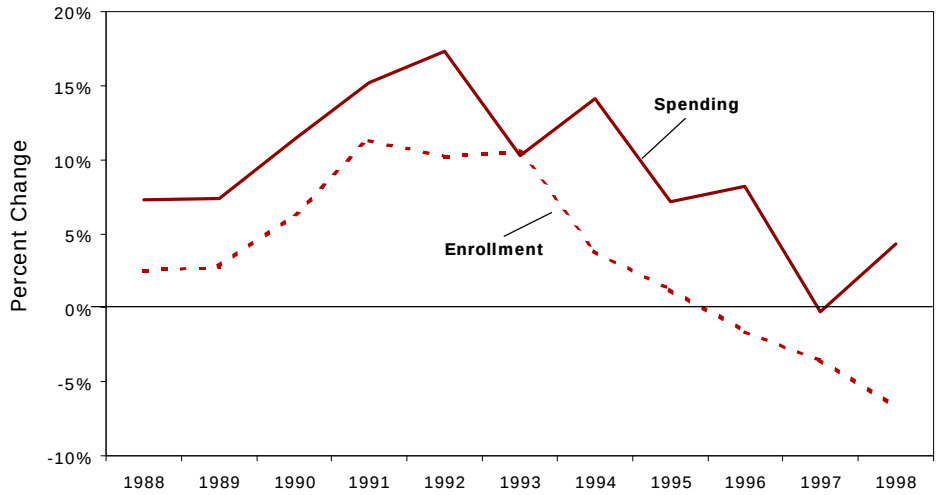
Figure 5
MA Enrollment by Eligibility Category



Source: Minnesota Department of Human Services.

MA spending continues to rise, despite declining enrollment: MA spending in Minnesota for state fiscal year 1998 was about $2.9 billion. Despite the recent declines in MA enrollment, the cost of the program has continued to rise, but at a slower rate than the double-digit annual growth of the early 1990s. Figure 6 illustrates the trends in MA enrollment growth and spending growth.

Figure 6
MA Enrollment and Spending Growth



Source: Minnesota Department of Human Services.

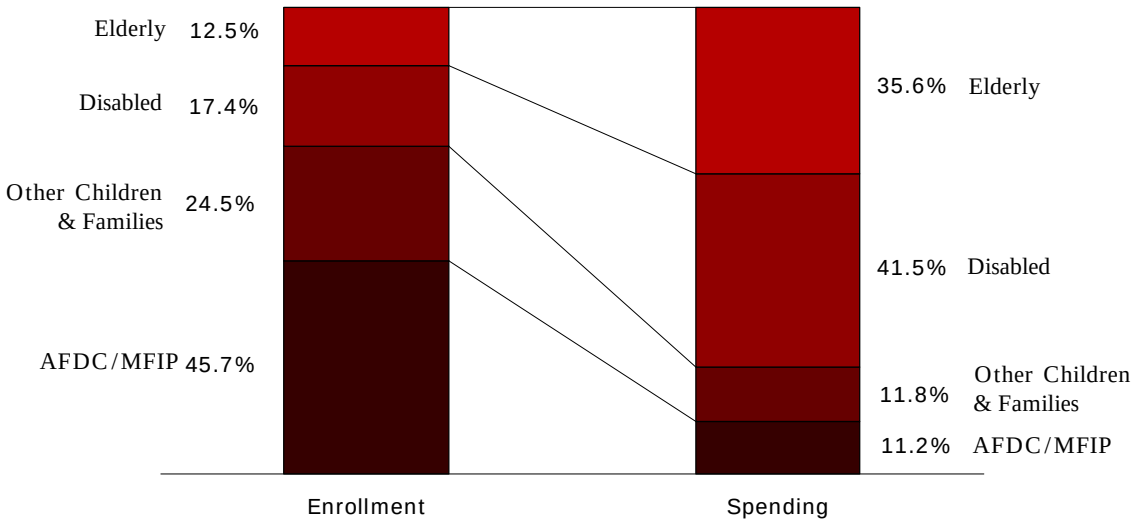
Although the elderly, blind and disabled account for a relatively small share of MA enrollment, together they account for a majority of MA spending.

- In Minnesota, elderly, blind and disabled enrollees make up about 30% of total MA enrollment on average, but account for about 77% of spending. Figure 7 illustrates the differences between the shares of enrollment and spending by enrollment category.

- Average costs vary dramatically by enrollment category — in fiscal year 1998, average cost per enrollee was about $1,800 for AFDC/MFIP recipients, $3,545 for other children and families, $17,625 for disabled enrollees, and $21,038 for elderly enrollees.[7]

- National spending patterns by category of Medicaid enrollment are similar. In 1996, the elderly, blind and disabled accounted for about 26% of Medicaid enrollment and 71% of benefit payments. The Urban Institute estimates that national average spending per Medicaid enrollee in 1996 was $1,145 for children, $1,837 for adults, $8,447 for blind and disabled enrollees, and $10,336 for the elderly.[8]

Figure 7
MA Spending by Eligibility Category



Source: Minnesota Department of Human Services. Data for fiscal year 1998.

MinnesotaCare

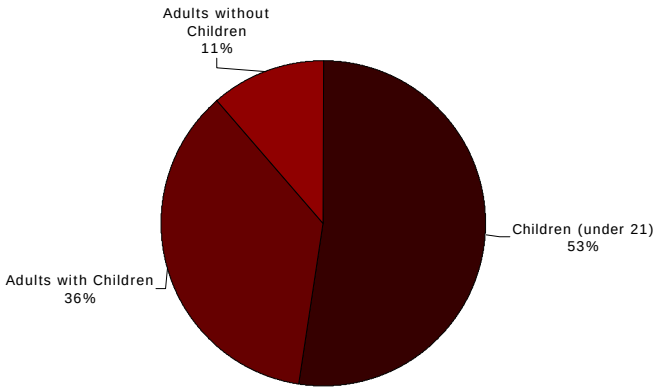
MinnesotaCare was created in 1992 as a sliding-scale subsidized health insurance program for low- and moderate-income people who do not have access to other health insurance coverage. MinnesotaCare replaced the Children's Health Plan, which was established in 1987 with a more limited set of eligibility 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 1998, this limit was about $45,200). 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 "crowdout" of private coverage. 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. A study by researchers at the University of Minnesota concluded that MinnesotaCare has not resulted in significant erosion of private coverage.[9]

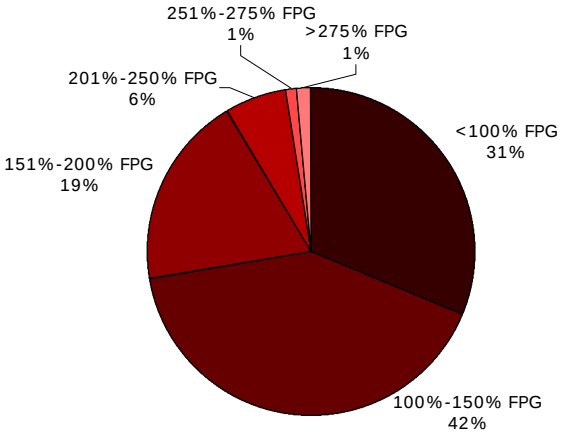
The majority of MinnesotaCare enrollees are children, and most have family incomes below 200% of poverty. In December 1998, there were about 105,000 people enrolled in MinnesotaCare, or about 2.1% of the population. Over half (53%) of the enrollees are children, an additional 36% are parents, and 11% are adults without children. Nearly three-quarters of MinnesotaCare enrollees (72%) have family incomes below 150% of poverty, and over 90% have family income less than 200% of poverty.[10] Figures 8 and 9 illustrate the demographics of MinnesotaCare's enrollees. Table 4 shows historical enrollment and spending information for MinnesotaCare.

Figure 8
MinnesotaCare Enrollment by Eligibility Category



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

Figure 9
MinnesotaCare Enrollment by Income Category (Percent of Federal Poverty Guidelines)



Source: Minnesota Department of Human Services and Minnesota Department of Health, "MinnesotaCare Transition Plan," March 1998; data as of November 1997.

Table 4

MinnesotaCare Enrollment and Spending History

State FY	Avg. Monthly Enrollment	Spending ($ Millions)	Avg. Monthly Spending Per Enrollee	Growth In:	
				Total Spending	Spending Per Enrollee
1993*	35,217	$13	$30.31	–	–
1994	62,232	$33	$44.52	159.6%	46.9%
1995	77,417	$56	$60.50	69.0%	35.9%
1996	88,276	$80	$75.19	41.7%	24.3%
1997	93,136	$98	$87.80	23.2%	16.8%
1998	97,864	$108	$92.04	10.1%	4.8%

Source: Minnesota Department of Human Services.

*1993 data include MinnesotaCare's predecessor, the Children's Health Plan.

Sources of funding: In fiscal year 1998, total spending for MinnesotaCare was about $108 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 and children enrolled in MinnesotaCare. The remaining costs are financed through the Health Care Access Fund (HCAF). The HCAF's primary sources of revenue are a 2% tax on all health care providers[11] and premiums paid by MinnesotaCare enrollees. Table 5 shows historical spending information for MinnesotaCare, broken down by funding source. For fiscal year 1998, the federal contribution covered about 13% of the cost, premium payments by enrollees covered an additional 20%, and the remaining 67% was paid through other Health Care Access Fund revenues. Figure 10 shows the sources of revenue for the healthcare access fund.

Table 5

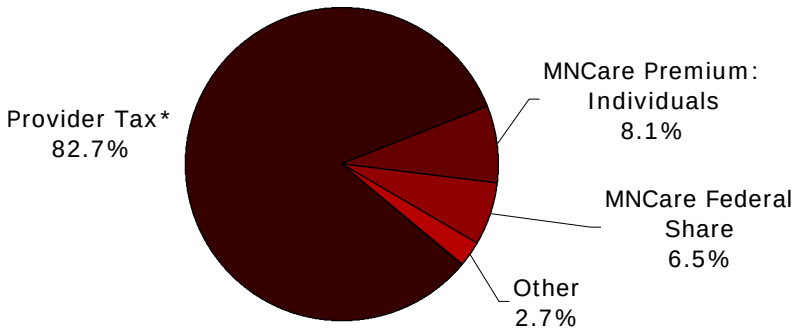
MinnesotaCare Funding Sources

State FY	Total Spending ($000s)	Source of Funding:			Share of Funding:		
		State	Federal	Enrollee Premiums	State	Federal	Enrollee Premiums
1993*	$12,809	$10,328	–	$2,481	81%	0%	19%
1994	$33,249	$22,841	–	$10,408	69%	0%	31%
1995	$56,204	$41,606	–	$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	$108,083	$72,756	$13,776	$21,551	67%	13%	20%

Source: Minnesota Department of Human Services.

*1993 data include MinnesotaCare's predecessor, the Children's Health Plan.

Figure 10
Health Care Access Fund Revenue
1998 Total: $185.9 million



* The provider tax was reduced to 1.5% for calendar years 1998 and 1999, but under current law returns to 2% in 2000.
Source: Minnesota Department of Finance, data for fiscal year 1998.

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.

Who can enroll in GAMC? Low-income people who are not otherwise eligible for MA may enroll in GAMC if their incomes are below 133 1/3% of the eligibility standard for the former Aid to Families with Dependent Children (AFDC) program as it existed on July 16, 1996. Other eligibility requirements such as residency and asset tests also apply.

GAMC enrollment has been declining since 1992. Table 6 provides historical enrollment and spending information for the GAMC program. In state fiscal year 1998, the monthly average enrollment for GAMC was about 31,100, or about 0.7% of the population. In the last several years, enrollment in GAMC has been declining relatively quickly from its high of over 55,000 in 1992.

Table 6

GAMC Enrollment and Spending History

State FY	Avg. Monthly Enrollment	Spending ($ millions)	Avg. Monthly Spending Per Enrollee	Growth In:	
				Total Spending	Spending Per Enrollee
1988	36,948	$80	$179.91	5.9%	4.9%
1989	38,265	$91	$197.18	13.5%	9.6%
1990	42,824	$108	$209.32	18.8%	6.2%
1991	48,929	$124	$211.22	15.3%	0.9%
1992	55,292	$161	$243.10	30.1%	15.1%
1993	54,963	$164	$248.57	1.6%	2.3%
1994	53,796	$161	$249.57	-1.7%	0.4%
1995	53,173	$151	$236.06	-6.5%	-5.4%
1996	43,550	$153	$292.35	1.4%	23.8%
1997	38,428	$145	$314.34	-5.1%	7.5%
1998	31,113	$119	$320.06	-17.6%	1.8%

Source: Minnesota Department of Human Services.

Although total spending for GAMC has declined, spending per enrollee continues to rise. Total spending for the GAMC program declined from a high of nearly $164 million in 1993 to about $119 million in 1998. However, average monthly spending per enrollee increased at a rate of about 6% per year from 1988 to 1998.

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%.

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. MCHA is the nation's largest high-risk pool.

Who can enroll in MCHA? Generally, people who have been refused insurance coverage may enroll in MCHA. Under Minnesota's actions to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, certain people who have exhausted other coverage options may enroll in MCHA without providing proof of rejection by an insurer. In addition, people being treated for certain health conditions are automatically eligible to enroll.

MCHA enrollment has been declining since 1993. After rising rapidly in the late 1980s and early 1990s, MCHA's enrollment peaked at about 35,000 in 1993 and has been declining ever since. At the end of 1997, about 26,000 people were enrolled in MCHA, or an estimated 0.6% of the population. Table 7 presents historical enrollment and spending information for MCHA.

Table 7
MCHA Enrollment and Spending History

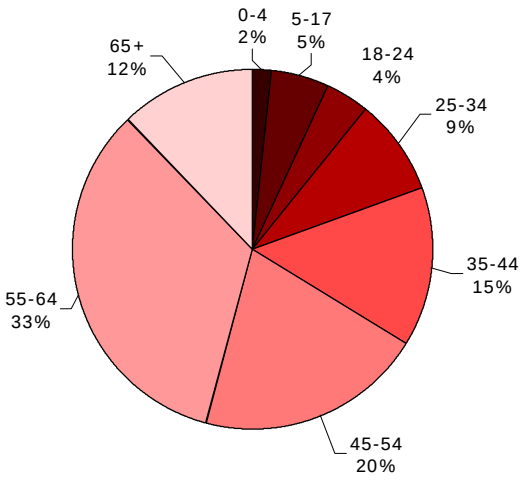
	Enrollment	In Millions of Dollars: Claims	Premiums	Losses	Avg. Monthly Claims Per Enrollee
1988	14,383	$27.1	$14.2	$14.0	$168.68
1989	18,812	$38.4	$18.5	$21.7	$192.67
1990	25,272	$49.5	$25.7	$26.1	$187.03
1991	29,794	$60.3	$35.5	$28.5	$182.39
1992	33,805	$76.7	$43.6	$37.7	$201.08
1993	35,296	$87.0	$51.5	$40.6	$209.77
1994	33,477	$92.5	$54.2	$44.4	$224.22
1995	30,470	$94.6	$52.4	$48.8	$246.58
1996	27,552	$87.7	$48.9	$42.9	$251.25
1997	26,314	$90.9	$47.5	$47.7	$281.22

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

- Since about 16% of MCHA's enrollment is in Medicare Supplement products, the actual number of Minnesotans relying on MCHA as their *primary* source of coverage in 1997 was about 22,000, or 0.5% of the population.

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 1997, one-third of MCHA enrollees were between the ages of 55 and 64, and an additional 20% were ages 45-54. Figure 11 shows the age distribution of MCHA enrollees.

Figure 11
MCHA Enrollment by Age Group
1997



Source: Minnesota Comprehensive Health Association, 1996/97 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. In 1997, premium revenues of $47.5 million covered 52% of MCHA's $90.9 million in claims. MCHA's overall operating loss for 1997 was $47.7 million.

Growth in self-insurance has eroded the segment of the private market that shares responsibility for covering MCHA's losses. During the 1980s and early 1990s, rapid growth in the number of employers choosing to self-insure rather than transfer the risk for health care claims to an insurer resulted in MCHA's losses being spread over a smaller share of the private health insurance market.[12] The 1997 Minnesota legislature appropriated $15 million to MCHA for 1998 and 1999 to assist in covering losses.

Endnotes

[1] Francis J. Eppig and George S. Chulis, "Trends in Medicare Supplementary Insurance: 1992-96," *Health Care Financing Review* 19 (1), Fall 1997.

[2] Based on Health Care Financing Administration data for managed care enrollment as of December 1, 1997 and total enrollment as of July 1, 1997.

[3] Data from HMO annual reports to the Minnesota Department of Health.

[4] Data from Health Care Financing Administration.

[5] Average monthly basis, calculated from Health Care Financing Administration, HCFA-2082 Report data for federal fiscal year 1997.

[6] The former Aid to Families with Dependent Children (AFDC) program was replaced by the Minnesota Family Investment Program (MFIP).

[7] Minnesota Department of Human Services.

[8] John Holahan, Brian Bruen, and David Liska, "The Decline in Medicaid Spending Growth in 1996: Why Did It Happen?", Kaiser Commission on Medicaid and the Uninsured Issue Paper, September 1998.

[9] 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.

[10] Minnesota Department of Human Services and Minnesota Department of Health, "The MinnesotaCare Program: Transition Plan," March 1998.

[11] The provider tax was reduced for 1.5% for calendar years 1998 and 1999, but under current law will go back up to 2% in 2000.

[12] 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 assessment. For more information about self-funding, see "Self-Funding of Health Care Benefits," Health Economics Program Issue Paper, Minnesota Department of Health, March 1997.