

Minnesota continues to build on its strong health care system, both by expanding coverage to new populations and by refining its service delivery strategies.

Recent Changes in Health Policy for Low-Income People in Minnesota

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Overview

Minnesota has long been a national leader in state efforts to expand health insurance to the low-income population. The state supports a comprehensive Medicaid program, characterized by liberal eligibility policies and a rich set of benefits, as well as a subsidized health insurance program for the low-income population (MinnesotaCare), and a generous General Assistance Medical Care (GAMC) program. In part because of its long commitment to covering its low-income population under Medicaid and MinnesotaCare, Minnesota operates only a small State Children's Health Insurance Program (SCHIP). Currently, Minnesota provides health insurance coverage for children under age 2 living at or below 280 percent of the federal poverty level (FPL), for children age 2 and up and their parents living at or below 275 percent of FPL, and for childless adults living at or below 175 percent of FPL.

Minnesota is also known for its innovation in health care delivery. Starting in 1985, the state began moving its Medicaid population into capitated managed care under one of the first Section 1115 Medicaid waiver demonstrations—the Prepaid Medical Assistance Program (PMAP). By early 2001, Minnesota had successfully established PMAP in nearly all of its counties and continues its efforts to introduce either PMAP or alternative versions of Medicaid managed care in the remaining counties by the end of the year. Under the waiver, savings generated under PMAP are used to support Medicaid eligibility expansions.

The state also had an early (1981) Medicaid waiver to expand the use of home- and community-based care as an alternative to nursing home care. Minnesota has continued to move aggressively at expanding the use of home- and community-based care for both the elderly and disabled populations through a range of Medicaid and state-funded programs. More recently (1995), the state was granted one of the first waivers to allow for the integration of acute and long-term care services funded under Medicaid and Medicare for low-income elderly persons—the Minnesota Senior Health Options (MSHO) demonstration. Building on MSHO, the state recently initiated a similar program to serve the low-income disabled population.

Minnesota continues to build on its strong health care system, both by expanding coverage to new populations and by refining its service delivery strategies. Most notably, Minnesota has efforts under way to expand health care coverage for elderly and disabled persons, to reshape its long-term care system to meet the needs of an aging population at lower costs, to control prescription drug costs for elderly and disabled persons, and to implement quality initiatives for health plans participating in public programs. Minnesota's health care efforts in 2001 were bolstered by a strong economy and high levels of employer-sponsored health insurance coverage, a substantial tobacco settlement, and a commitment from elected officials and the public to the state's considerable health care system.

However, there are signs of increasing stress in the health care system, including rising health care costs (particularly prescription drug costs), a severe shortage of health care workers, and increasing uncompensated care in urban areas. Through 2001, the state's large budget surpluses allowed Minnesota to respond to those stresses while still providing sizable tax cuts and tax rebates. For example, the state implemented a program to subsidize prescription drug costs for low-income elderly persons and persons with disabilities. And in its 2002–2003 budget, Minnesota provided additional funds for, among other things, increases in wages and benefits for health care workers, health care worker training and education, and increased support for safety net providers. Whether those funds are adequate to address the challenges to the state's health care system remains to be seen.

Perhaps most ambitious, Minnesota is in the early stages of a major restructuring of its long-term care system to more efficiently address the health care needs of its aging population. The state is investing heavily in home- and community-based care (with a growing emphasis on consumer-directed care), while reducing institutional care for its elderly and disabled populations. Minnesota is also exploring ways of integrating social services such as housing, social supports, and other services into its long-term care system. Because of the scope of Minnesota's home- and community-based services, state officials have not felt it necessary to date to prepare a specific plan that addresses the *Olmstead* decision.

Minnesota faces several challenges as it looks to the future. How these issues are resolved will be shaped both by the state of the economy and by the political environment in Minnesota, which has shifted to the right in recent years. The election of Jesse Ventura as governor in 1998 added a third party to Minnesota state government and a subsequent increase in contentiousness to state government. Furthermore, the Republicans gained control of the house, giving greater voice to those in support of spending limits, tax cuts, and fewer eligibility expansions for health care programs.

Minnesota is considering proposals to alter the funding mechanism for MinnesotaCare (the state's subsidized health insurance program for the low-income population), from taxes on providers, HMO premiums, and drug wholesalers to the use of either the general budget or tobacco settlement funds. The resolution of this issue could have a lasting impact on program funding given rising health care costs and competing demands on the state budget and tobacco funds.

The health care worker shortage will continue to be a major issue in Minnesota. Low wages, minimal benefits, and the demands of health care jobs have exacerbated the shortage, which has affected every sector of the state's health care system. Minnesota's efforts thus far have not been enough to reduce the shortage, and the state is now considering a variety of strategies to attract new workers to the health care field.

Finally, Minnesota must deal with the needs of its growing immigrant population. Minnesota has seen a dramatic increase in its minority population, which has affected the cultural, economic, and political environments in the state. The state is working to address the new and different health care needs of this population, which has subsequently increased health care costs.

Minnesota has shown over time that it is capable of meeting the challenges facing its health care system. Despite the shift toward controlling state spending and tax reform, there remains a strong public commitment to health care programs. This will likely help Minnesota to maintain its leadership role in providing health care services for the low-income population.

This report examines the major health issues facing Minnesota between 1997 and early 2001. During this period, states were given new opportunities in health policy for low-income people. Many developments increased state flexibility, including welfare reform and the delinking of Medicaid from cash assistance, new funding for children's health insurance coverage under SCHIP, repeal of federal minimum standards for nursing home and hospital reimbursement under Medicaid (i.e., the repeal of the Boren Amendment),

TABLE 1. Selected Minnesota Characteristics

	Minnesota	United States
Population Characteristics		
Population (2000) (in thousands) ^a	4,919	281,422
Percent under age 18 (1999) ^a	26.2%	25.7%
Percent Hispanic (1999) ^b	1.9%	12.5%
Percent black (1999) ^b	3.3%	12.8%
Percent Asian (1999) ^b	2.2%	4.1%
Percent nonmetropolitan (1996) ^b	31.2%	20.3%
State Economic Characteristics		
Per capita income (2000) ^c	\$32,101	\$29,676
Percent change per capita income (1995–1999) ^d	14.6%	10.8%
Unemployment rate (2001) ^e	3.9%	4.5%
Family Profile		
Percent children in poverty (1998) ^f	10.3%	17.5%
Percent change children in poverty (1996–1998) ^f	–12.7%	–15.0%
Percent adults in poverty (1998) ^f	6.1%	11.2%
Percent change adults in poverty (1996–1998) ^f	–22.8%	–10.4%
Political		
Governor's affiliation (2001) ^g	Independent	NA
Party composition of senate (2001) ^h	39D-27R-1I	NA
Party composition of house (2001) ^h	65D-69R	NA
Percent of Poor Children Covered by Welfare		
1996 (AFDC) ⁱ	79.0%	59.3%
1998 (TANF) ⁱ	73.2%	49.9%
Income Cutoff for Children's Eligibility for Medicaid/State Children's Health Insurance Program (Percent of Federal Poverty Level)		
1996 ^{j,k}	216%	124%
1998 ^l	276%	178%
2000 ^{l,m}	276%	205%

Table 1 notes begin on page 28.

and federal willingness to grant waivers under Medicaid (and now SCHIP). Fiscal capacity also rose—from booming revenues during the long economic expansion of the 1990s and from new tobacco settlement funds.

However, new pressures on revenues and state policy arose from recent federal economizing under Medicaid and Medicare, notably including cuts in safety net support believed to be abused by some states; political pressures for state tax cuts; and, starting in 2001, an economic slowdown and recession. To examine how states have responded to both federal constraints and state flexibility during the last half decade, this study of Minnesota and 12 other states examines state priority setting and program operations in health policy affecting the low-income population.¹ We assessed changes and continuities in the last five years, building on an earlier baseline study.²

Information for the study of Minnesota came from in-person interviews on site in April 2001, sometimes supplemented by telephone and written responses. Interviewees included state officials, consumer and provider associations, and other knowledgeable observers. Secondary sources included publicly available documents, newspapers, and Web sites. Selected interviewees were given the opportunity to comment on a draft, and changes were tracked through passage of the 2002–2003 biennium budget at the end of June 2001. The terrible events of September 11, 2001, have accelerated the downturn in the national economy. This deterioration in the overall economy has created fiscal problems in

Minnesota and has increased the budget pressure on Medicaid and other programs for the low-income population.

Background

Demographics

In 2000, Minnesota had a population of 4.9 million people (see table 1), which has been growing at about the same rate as the nation. Minnesota is a rural state, with over 30 percent of the population living in nonmetropolitan areas, a much larger proportion than of the nation as a whole. Still, over half of Minnesota's residents live in the Twin Cities (Minneapolis and Saint Paul) or in the immediately surrounding counties. Beyond the Twin Cities, Minnesota has only a few urban areas.

When compared to the nation, Minnesota's minority population is relatively small, 11.8 percent compared to 30.9 percent nationally. However, this represents an increase of over 112 percent since 1990, well above the 43.5 percent increase in minorities for the nation as a whole.³ Much of this shift is due to an influx of immigrants, who have come to Minnesota from Central and South America, Africa, and Asia, often as refugees. Although still a small share of Minnesota's population, these immigrants have brought significant cultural, economic, and health-related changes to the state.

Finally, Minnesota has a growing elderly population. Minnesota boasts the second longest life expectancy in the nation (Hawaii has the longest), and has one of the highest concentrations of people over age 85.⁴ In 2000, 12.1 percent of the population in Minnesota was 65 or older; by 2030 that is expected to double to nearly one in four Minnesota residents.⁵ Furthermore, reduced fertility rates and the geographic remoteness of many families has increased the number of older Minnesota residents who are living alone.⁶

Economic Indicators

Minnesota benefited from a strong economy over the late 1990s and into 2000. In 2000, unemployment in Minnesota was lower than the national average, while per capita income was higher. Consistent with these differences, the percentages of children and adults in Minnesota living in poverty were substantially lower than in the nation in 1998: 10.3 percent of Minnesota children and 6.1 percent of Minnesota adults compared to 17.5 percent and 11.2 percent for the nation (see table 1). This represents a 23 percent decline in poverty among adults in Minnesota between 1996 and 1998, well above the 10 percent decline in the nation as a whole. As with most other states, there is early evidence of an economic slowdown in Minnesota in 2001; however, it appears that Minnesota will continue to outperform the nation as a whole.⁷

Health Insurance Coverage

Minnesota has an uninsurance rate that is less than half of the national average, at 5.2 percent for children and 7.5 percent for adults (see table 2). This reflects both the state's high level of employer-sponsored insurance (ESI) coverage and generous public health care programs. Public coverage (including Medicaid, MinnesotaCare, and other state programs) for those living below 200 percent of the poverty level is about the same as the national average for Minnesota's children and is well above the national average for Minnesota's adults.⁸ ESI coverage is above the national average for both adults (80.1 percent versus 72.3 percent) and children (76.9 percent versus 66.7 percent) and is above the national average for both higher-income and lower-income adults and children.

Political Developments

The most notable political development in Minnesota over the last five years has been the election of third-party candidate, fiscally conservative/socially liberal, former pro-wrestler Jesse Ventura (I) to replace former Governor Arne Carlson (R) in 1998.⁹ At the same time, the state house of representatives also changed hands, from the Democratic Farmer-Labor

TABLE 2. *Health Insurance Coverage, by Family Income and Type of Insurance, Minnesota and the United States, 1999*

	Children (Ages 0–18) ^a (%)		Adults (Ages 19–64) ^b (%)	
	Minnesota	United States	Minnesota	United States
Below 200% FPL				
Employer-sponsored	45.5	38.7	47.1	41.7
Medicaid/SCHIP/state	35.4	35.2	19.9	14.7
Other coverage	7.2	3.8	13.4	8.8
Uninsured	12.0	22.4	19.7	34.9
Above 200% FPL				
Employer-sponsored	88.7	85.3	87.5	83.7
Medicaid/SCHIP/state	4.2	3.8	1.7	1.1
Other coverage	4.5	4.9	6.1	5.8
Uninsured	2.6	6.0	4.8	9.4
All Incomes				
Employer-sponsored	76.9	66.7	80.1	72.3
Medicaid/SCHIP/state	12.7	16.4	5.0	4.8
Other coverage	5.2	4.5	7.4	6.6
Uninsured	5.2	12.5	7.5	16.3

a. Kenney, Genevieve, Lisa Dubay, and Jennifer Haley. 2000. "Health Insurance, Access, and Health Status of Children." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute.

b. Zuckerman, Stephen, Jennifer Haley, and John Holahan. 2000. "Health Insurance, Access, and Health Status of Adults." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute.

FPL = federal poverty level

SCHIP = State Children's Health Insurance Program

Note: Figures in bold represent values that are statistically significantly different from the national average at the 0.10 confidence level or better.

(DFL) Party to the Republican Party. The state senate remains under the control of the DFL.

Minnesota's unusual tripartisan government has complicated state politics. For example, during the 2000 legislative session, debate over the distribution of the state's \$525 million surplus and the nature of sustainable tax cuts caused a significant delay on many major legislative items. To resolve the dispute the surplus was divided into thirds, with each legislative chamber and the governor deciding how one-third of the surplus would be spent. The governor reduced car license and registration fees. The house allocated its portion to tax cuts and rebates, while the senate allocated its funds to supplement spending on education, health care, and natural resources.¹⁰

The 2001 legislative session was even more contentious. The regular session ended on May 21, with only one of the state's nine major omnibus tax and finance bills having passed. Facing a government shutdown on July 1, Governor Ventura called a special session of the legislature on June 11 (the first since 1971). After much debate over the details of a tax plan, the governor, senate, and house agreed on significant property and sales tax rebates and cuts, along with new funding for, among other things, expanding health insurance coverage for children and their parents, reforming Minnesota's long-term care system, and K–12 and higher education. The special session ended with the passage of the final budget bills on June 30, avoiding the July 1 government shutdown.¹¹

Governor Ventura's philosophy—summarized in his "Big Plan"—emphasizes "accountable, responsible, and limited government" that provides only what individuals "cannot do for themselves."¹² The latter includes government-provided health care for vul-

nerable populations. Within this context, his administration is focused on restructuring the health care system for “the next 50 years” in anticipation of the coming challenges of a more diverse and rapidly aging population. This includes expanding health insurance for children and elderly and disabled individuals, as well as investing in efforts to eliminate the existing wide health disparities for minority populations and promoting public health initiatives (such as increasing immunizations, reducing teen pregnancies, and promoting mental health).

Market Developments

Health care markets have been relatively stable in Minnesota since 1996 as compared to other states. There have been no health plan exits from the state, few hospital closures, and no declines in employer-sponsored health insurance coverage (or increases in uninsured). Nevertheless, there have been substantial changes within the state’s health markets.

Health Plans. Minnesota was one of the first states to adopt managed care, in both the private sector and the public sector. The private managed care market continues to be dominated by three large health plans: Medica (part of Allina Health System),¹³ Blue Cross and Blue Shield of Minnesota, and HealthPartners. Two additional plans serve significant shares of the public market: Metropolitan Health Plan and UCare Minnesota. By law, managed care plans in Minnesota must be nonprofit organizations. Further, as a condition for licensure in a county, plans must participate in public programs in that county.

Although these factors have contributed to a relatively stable managed care market in Minnesota, there have been significant changes over the past few years. One key change is the growth in managed care in rural areas. In 1995, Minnesota began moving beneficiaries enrolled in public programs in rural areas into managed care. Currently, all beneficiaries in MinnesotaCare and the state-funded GAMC are enrolled in managed care, while the state’s Medicaid managed care program is operating in over two-thirds of Minnesota counties. Efforts are under way to expand some form of Medicaid managed care into the remaining counties.

Despite increases in managed care for public populations, there has been an overall decline in direct enrollment in managed care in Minnesota as employers in the state increasingly turn to self-insurance to contain increasing health care costs. In 1987 managed care enrollment was at a high of 1.2 million people. In 1999, just 987,000 people in the state were enrolled in managed care plans.¹⁴ By self-insuring, employers do not have to comply with the large number of mandated benefits (37) required by Minnesota law and, if they contract with health care plans as third-party administrators rather than health plans, they can avoid paying the portion of HMO premiums that reflect health care taxes (discussed below). In fact, the state of Minnesota began to self-insure its employees in 1999 because of rapid cost increases.¹⁵ In order to be competitive with the options available to employers under self-insurance, the Minnesota Council of Health Plans is lobbying the state legislature to allow health plans to offer options that include fewer mandated benefits.¹⁶

Finally, health plans have sustained substantial losses in recent years on some public programs and in the commercial and Medicare markets. Some health plans have been able to offset these losses with profits made on Medicaid managed care that totaled \$50 million in 1999.¹⁷ However, observers reported increasing health care costs, lower rates under MinnesotaCare and Medicare,¹⁸ and declining commercial enrollment as contributing to continued overall plan losses.

Large Purchasers. The Buyers Health Care Action Group (BHCAG) was formed in 1993 as a purchasing cooperative for 22 large, self-insured employers in Minnesota. At that time BHCAG solicited health care bids and offered health plans to its members. In 1997, BHCAG began to contract directly with providers rather than work through health plans as intermediaries. Under this initiative, called Choice Plus, employers have access to

“care systems”—groups of physicians, clinics, and hospitals—that provide a standard benefit package for a capitated rate. At the end of 2000, approximately 39 employers participated in Choice Plus, which contracted with 28 different provider systems for 140,000 employees and their dependents.¹⁹ As part of a restructuring in 2000, BHCAG contracted with an administrative management company to take over Choice Plus, with plans to begin marketing to small and medium-sized employers.²⁰ This is expected to increase the availability of employer-sponsored health insurance to low-income workers.

Provider Market. Both the hospital and physician markets in Minnesota are relatively consolidated compared with other regions of the country. Mergers and consolidations among providers occurred during the 1980s and 1990s, although there is some continued consolidation in rural areas as managed care has expanded across the state. Consolidation among rural physicians has afforded them more leverage in contracting with health plans and is reported to have helped ease some rural providers’ concerns regarding managed care.

The hospital market in Minnesota has also been affected by rising uncompensated care costs, particularly in the urban areas. Although uncompensated costs in Minnesota have historically been very low, hospitals in Minneapolis and Saint Paul have seen a significant increase in charity care in recent years.

Labor Shortage. As in the rest of the country, Minnesota continues to struggle with a severe shortage of health care workers. Ten percent of Minnesota jobs in health care support are routinely vacant, and these positions are often vacant for 60 days or more.²¹ Low wages, lack of benefits, and the physical and emotional difficulties of health sector service jobs relative to office-based “high-tech” jobs in Minnesota’s booming economy are key factors in prolonging the shortage.²² Despite a wide range of responses by the state, the shortage is expected to worsen in the future as Minnesota’s population ages, increasing the number of people in the state who need acute and long-term care and reducing the number of available workers.

Fiscal Circumstances of the State

General Fiscal Condition and Budget Priorities

Minnesota had significant budget surpluses every year between 1996 and 2001. The surplus grew steadily larger over that period, reaching a projected \$5 billion for the biennium of 1999–2001 (fiscal years 2000 and 2001). However, with the downturn in the economy in late 2001, Minnesota is beginning 2002 with a projected deficit of nearly \$2 billion in fiscal year 2002–2003.

Although the Minnesota Department of Finance did predict a slowdown in the state’s economy for 2001, the state’s recovery was also predicted to be faster than that of the nation as a whole.²³ In addition, government spending in Minnesota has not exceeded target levels, and unlike many other states, Minnesota has not dipped into reserve funds to balance the budget. These factors are one reason the National Conference of State Legislatures (NCSL) recently found Minnesota among seven states in “good” financial condition as compared to states who face substantial spending overruns and/or significant revenue shortfalls.²⁴

The pattern of state spending has changed little since 1995 (see table 3). Medicaid spending was 15 percent of state general-fund expenditures in both 1995 and 2000. The most notable changes in general-fund spending over the period was a shift away from higher education toward K–12 education and a drop in the share of expenditures on public assistance. State officials and market observers attribute the latter to the state’s strong economy and welfare reform.

Given the large surpluses of the late 1990s, tax rebates and tax reform have been major issues in Minnesota under the last two governors. Former Governor Carlson implemented major tax cuts and rebates in 1997 and 1998, including a \$500 million property tax rebate in 1998. Governor Ventura has continued this focus, signing into law the largest tax

TABLE 3. Minnesota Spending by Category, 1995 and 2000 (\$ in Millions)

Program	State General-Fund Expenditures ^a				Total Expenditures ^b			
	Actual	Estimated	Annual Growth (%)		Actual	Estimated	Annual Growth (%)	
	1995	2000	MN	U.S.	1995	2000	MN	U.S.
Total	\$8,834	\$11,958	6	5	\$14,173	\$18,897	6	6
Medicaid^{c,d}	\$1,354	\$1,811	6	5	\$2,765	\$3,570	5	4
% of Total	15%	15%			20%	19%		
K-12 Education	\$2,779	\$4,023	8	7	\$3,139	\$4,616	8	7
% of Total	31%	34%			22%	24%		
Higher Education	\$1,465	\$1,785	4	5	\$1,574	\$1,943	4	5
% of Total	17%	15%			11%	10%		
Public Assistance	\$237	\$126	-12	-6	\$412	\$430	1	-5
% of Total	3%	1%			3%	2%		
AFDC/TANF	\$135	\$66	-13	-9	\$293	\$370	5	-7
% of Total	2%	1%			2%	2%		
Corrections	\$243	\$359	8	6	\$273	\$412	9	6
% of Total	3%	3%			2%	2%		
Transportation	\$49	\$77	9	5	\$1,353	\$1,806	6	6
% of Total	1%	1%			10%	10%		
All Other^e	\$2,707	\$3,778	7	5	\$4,657	\$6,121	6	8
% of Total	31%	32%			33%	32%		

Source: National Association of State Budget Officers 1997. 1996 State Expenditure Report and 2000. 1999 State Expenditure Report.

a. State general-fund expenditures exclude other state funds and bond expenditures.

b. Total spending for each category includes the general fund, other state funds, bonds, and federal aid.

c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as other state funds. In some cases, however, a portion of these taxes, fees, etc., do get included in state spending because states cannot separate them.

d. Total Medicaid spending will differ from data reported on the HCFA-64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA-64 on the federal fiscal year; second, states often report some expenditures (e.g., mental health and/or mental retardation) as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the HCFA-64.

e. This category could include spending for the State Children's Health Insurance Program, institutional and community care for mentally ill and developmentally disabled persons, public health programs, employer contributions to pensions and health benefits, economic development, environmental projects, state police, parks and recreation, housing, and general aid to local government.

Note: Figures may not add to totals shown due to rounding.

cut in the state's history in 1999. Additional reductions were implemented in 2000, including a reduction in state income taxes, a sales tax rebate, and a reduction in car license and registration fees. For the current biennium, the state has made significant cuts in the property tax and has provided another sales tax rebate.

Tobacco Settlement Funds

Minnesota and four other states settled their tobacco lawsuits independent of the Master Settlement Agreement in May 1998. Minnesota received a total of \$6.1 billion, to be paid in a one-time payment of \$968 million in 1998 and followed thereafter by annual payments for an indefinite period of time. In 1999, the legislature divided the one-time payment into three endowed funds: (1) tobacco prevention activities including a media campaign; (2) medical education with payments going to 16 teaching sites across the state; and (3) other public health efforts, including initiatives unrelated to tobacco use and directed at other high-risk behavior in youth.²⁵ Annual tobacco payments to Minnesota are deposited in the state's general fund and are not attached to a particular line item in the budget.

Medicaid, MinnesotaCare, and GAMC: Enrollment and Expenditure Trends

Minnesota maintains four health insurance options for its low-income population: the Medicaid program (called Medical Assistance or MA), the MinnesotaCare program, General Assistance Medical Care (GAMC), and a small SCHIP program. MinnesotaCare, created by the state legislature in 1992 as a replacement and expansion of its former Children's Health Plan, provides subsidized insurance for low-income families with children and childless adults. Minnesota currently receives federal financial participation (FFP) for children and parents enrolled in MinnesotaCare as part of Medicaid and SCHIP eligibility expansions under Section 1115 waivers. The GAMC program, which provides subsidized insurance for low-income children and adults not eligible for MA or MinnesotaCare, is fully state-funded.

In FY 2000, there were 363,605 enrollees in MA, 123,365 in MinnesotaCare, 23,295 in GAMC, and 24 in SCHIP. Federal spending under MA and MinnesotaCare was \$1,640.0 million and \$50.4 million, respectively, while the state spent \$3,180.0 million and \$196.3 million, respectively. State spending under GAMC was \$126.7 million.²⁶ Data on state and federal expenditures under SCHIP were not available.

In the rest of this section we examine enrollment and expenditure data under the auspices of the Medicaid program, which includes both Medicaid enrollees and MinnesotaCare enrollees for whom the state receives FFP. The data we present are for 1998, at which point Minnesota received FFP for children enrolled in MinnesotaCare but not for their parents. As discussed below, FFP for parents in MinnesotaCare was added after 1998.

Medicaid Enrollment

Enrollment for Medicaid in Minnesota (MA and MinnesotaCare enrollees for whom the state receives FFP) was 448,000 in 1998, a slight reduction from 1995's enrollment (see table 4). This slight decline masks a shift in the composition of the caseload, with enrollment for children increasing by 15,000 and adult enrollment dropping by 18,000 over the period. Enrollment by elderly, blind, and disabled individuals changed little between 1995 and 1998.

It is likely that the increase in enrollment for children and the drop for adults in Minnesota is the combined effect of a strong economy and welfare reform and program rules.²⁷ In 1998, the state received FFP for children on MinnesotaCare living at up to 275 percent of the poverty level, but not for their parents. Thus, a child on MinnesotaCare in a family with higher income would be included in these figures but his or her parents would not. As discussed below, Minnesota now receives FFP for parents living at up to 275 percent of the poverty level, resulting in an increase in that part of the Medicaid caseload since 1998.

Medicaid Expenditures

Total Medicaid spending (including state and federal funds) in Minnesota in 1998 was \$3.1 billion, a growth rate of 2.5 percent per year from 1995 (see table 4). Minnesota's spending grew more slowly than in the nation as a whole, largely due to much slower growth in long-term care services. Minnesota's spending on long-term care increased only 1.4 percent per year compared to the national increase of 6.5 percent annually. In part, this slower growth reflects the state's successful efforts to reduce long-term care expenses by reducing institutional and nursing home care for the elderly and persons with disabilities. In more recent periods, Medicaid expenditures have grown more rapidly in Minnesota; however, according to the National Association of State Budget Officers, Minnesota remained below the national average (8 percent versus 9 percent) in 2000.²⁸

TABLE 4. Medicaid Enrollment and Expenditures in Minnesota, 1998

	Minnesota, 1998			Average Annual Growth (%), 1995-1998					
	Total Annual Expenditures (in millions)	Avg. Monthly Enrollment (in thousands)	Avg. Annual Expenditures per Enrollee	Total Annual Expenditures		Avg. Monthly Enrollment		Expenditures per Enrollee	
				Minnesota	United States	Minnesota	United States	Minnesota	United States
Total Expenditures	\$3,133	-	-	2.5	3.9	-	-	-	-
Medical Services									
By Eligible Group		448	\$6,438	2.4	5.1	-0.2	-1.0	2.6	6.1
Elderly	\$2,882	52	\$19,427	1.7	4.3	0.2	0.1	1.4	4.2
Blind and disabled	\$1,013	69	\$17,636	3.8	8.5	0.4	3.6	3.4	4.7
Adults	\$1,216	74	\$2,568	-10.2	-1.4	-7.1	-4.4	-3.3	3.1
Cash assistance	\$189	45	\$2,237	-13.6	-10.4	-8.1	-14.9	-6.1	5.3
Other enrollees	\$102	28	\$3,101	-5.4	7.8	-5.5	9.3	0.1	-1.4
Children	\$88	253	\$1,835	7.3	2.7	-2.0	-1.5	5.3	4.3
Cash assistance	\$464	102	\$1,534	-6.5	-8.8	-6.6	-12.2	0.1	3.9
Other enrollees	\$157	151	\$2,038	18.8	12.4	10.0	9.8	7.9	2.4
By Type of Service									
Acute care	\$2,882	-	-	2.4	5.1	-	-	-	-
Long-term care	\$1,190	-	-	3.8	4.0	-	-	-	-
	\$1,692	-	-	1.4	6.5	-	-	-	-
DSH	\$56	-	-	3.5	-7.3	-	-	-	-
Administration	\$195	-	-	7.7	8.5	-	-	-	-

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.

Note: Does not include the U.S. Territories. Enrollment data shown are estimates of the average number of people enrolled in Medicaid in any month during the fiscal year. Expenditures per enrollee shown reflect total annual expenditures on medical services for each group, divided by the average monthly enrollment within that group. "Cash assistance" refers to enrollees who receive AFDC/TANF or SSI or who are eligible under Section 1931 provisions. "Other enrollees" include the medically needy, poverty-related expansion groups, and people eligible under Medicaid Section 1115 waivers. "Acute care" services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners' care, payments to managed care organizations (MCOs), and payments to Medicare. "Long-term care" services include nursing facilities, intermediate care facilities for the mentally retarded, inpatient mental health services, home health services, and personal care support services. "DSH" stands for disproportionate share hospital payments.

Note: Figures may not add to totals due to rounding.

Disproportionate share hospital (DSH) payments have not been a significant source of funds for the Medicaid program in Minnesota—only \$56 million in 1998. Minnesota’s small program was dramatically cut as a result of the Balanced Budget Act of 1997, which reduced the state’s \$33 million federal allotment to roughly \$16 million due to an error in federal and state reporting. Congressional action resulted in a reinstatement of the full \$33 million in federal funding for fiscal years 1998 and 1999, but federal funding for fiscal years 2000–02 remained at \$16 million. Minnesota congressional members are working to reinstate the full amount of funding.²⁹

As was true for total expenditures, expenditures per enrollee in Minnesota grew more slowly than the rest of the nation: 2.6 percent compared to 6.1 percent for the nation (see table 4). However, Minnesota spends significantly more per enrollee than the nation for all services, reflecting Minnesota’s relatively generous coverage of services and provider payments. This trend is especially evident for long-term care, where Minnesota spends \$15,855 per elderly enrollee compared to the national average of \$9,485; and \$11,402 per blind and disabled enrollee compared to \$4,549 for the nation (not shown in table). These differences reflect Minnesota’s heavy reliance on nursing home care, history of paying its nursing homes relatively generously, and significant investment in home- and community-based care.

Health Insurance Coverage

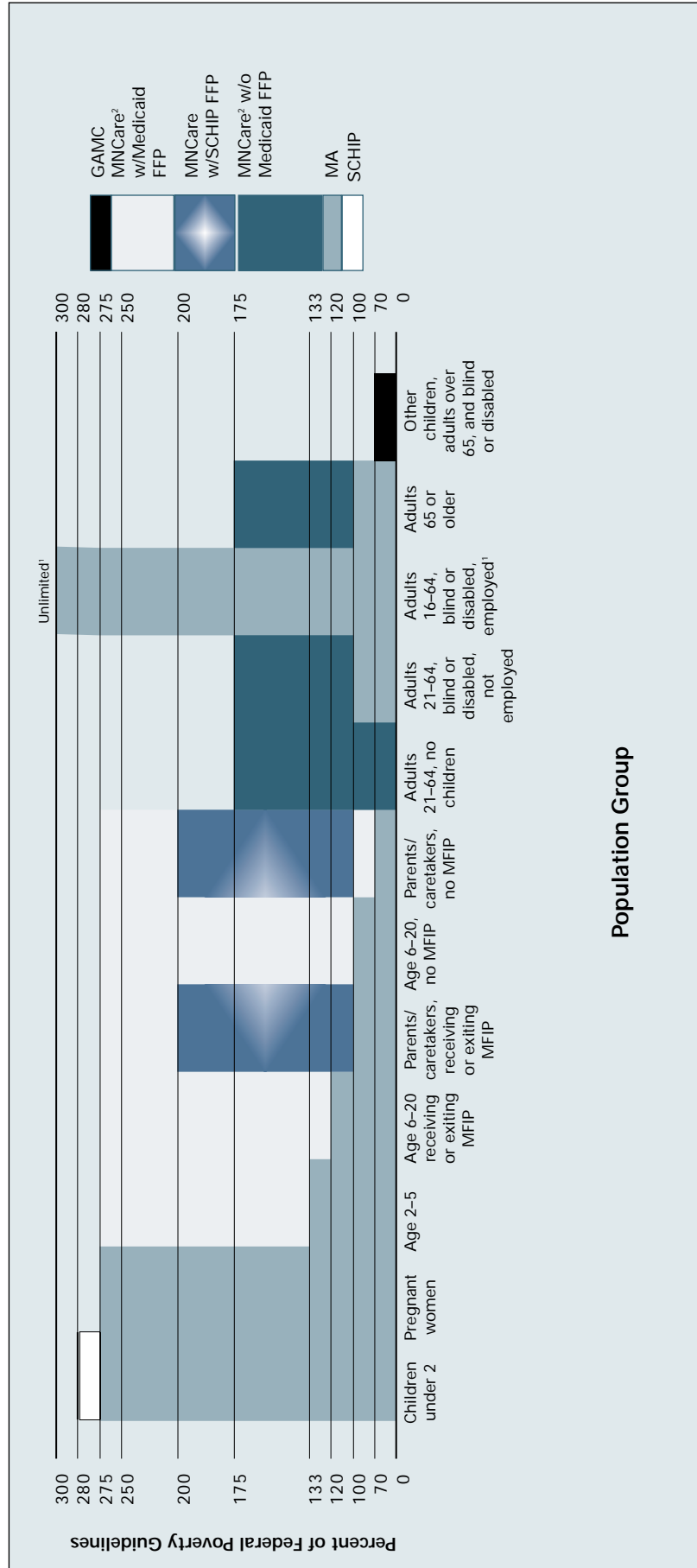
Minnesota has established generous eligibility standards for its health insurance programs (see figure 1). Between MA and MinnesotaCare, the state offers coverage for children, their parents, and pregnant women with family incomes up to 275 percent of the poverty level. (The state receives FFP for these populations, regardless of whether they are enrolled in MA or MinnesotaCare.) Children under 2 years old with family incomes between 275 and 280 percent of the poverty level are eligible under the state’s SCHIP program. As of July 1, 2001, elderly individuals and blind and disabled individuals who are not working are covered under MA with incomes up to 100 percent of the poverty level and under MinnesotaCare with incomes up to 175 percent of the poverty level. (Prior to July 1, the income limit for elderly, blind, and disabled persons under MA was 70 percent of the poverty level.) Blind and disabled persons who are working are covered under MA, regardless of income level.³⁰ Other single adults and childless couples with incomes up to 175 percent of the poverty level are covered under MinnesotaCare. Finally, GAMC provides coverage for selected adults and children living below 70 percent of the poverty level.³¹

State Children’s Health Insurance Program (SCHIP)

The federal legislation that established SCHIP allotted \$28.4 million in SCHIP funding for Minnesota for 1998, which was to increase to \$37 million in 2001. As the SCHIP legislation required that the funds be used on new programs rather than supplementing programs already in place, Minnesota had little opportunity to use its federal allotment. In 1997, Minnesota already received Medicaid FFP for children living at or below 275 percent of the poverty level under MinnesotaCare, and state officials did not want to expand eligibility beyond that level. Instead, the state sought a waiver or congressional intervention that would allow it to use the funds to reach the estimated 48,000 children who remain uninsured and eligible for MA or MinnesotaCare. When that effort failed, Minnesota submitted and received approval in 1998 for a small SCHIP program as a “placeholder” program to prevent the state’s allotted SCHIP funds from being redistributed to other states. Minnesota’s SCHIP program offers coverage to children under age 2 living between 275 and 280 percent of the poverty level. The program covers about twenty children.³²

In December 2000, Minnesota applied for an amendment to its existing 1115 waiver under new Health Care Financing Administration (HCFA, hereafter referred to under its new name, the Centers for Medicare & Medicaid Services (CMS)) guidelines that would

FIGURE 1. Eligibility Thresholds for SCHIP, Medicaid, MinnesotaCare, and GAMC, 2001



1. Although income levels for the working disabled are unlimited, premium payments scaled to income are required above 200 percent of the poverty level.

2. MinnesotaCare requires premium payments scaled to income for most enrollees, regardless of FFP receipt.

Notes:

GAMC = General Assistance Medical Care

MNCare = Minnesota Care

FFP = Federal financial participation

MA = Medical Assistance/Medicaid

SCHIP = State Children's Health Insurance Program

MFIP = Minnesota Family Investment Program

allow it to use SCHIP funds to improve its existing programs. The state received CMS approval in June 2001 to, among other things, receive SCHIP funds with an enhanced federal match for parents or relative caretakers of children enrolled in MinnesotaCare living between 100 and 200 percent of the poverty level. Although Minnesota already receives Medicaid FFP for this population, SCHIP provides a higher percentage match than the state currently receives.³³ The state funds freed up by the federal match are to be used to support program improvements for children.

Changes in Eligibility under MA

Eligibility for MA in Minnesota has historically been very extensive, and the state has continued to expand eligibility around the margins. Recent expansions of coverage include a small adjustment for inflation in the income standards for Medicaid under Section 1931 provisions;³⁴ an increase in the income standards for aged, blind, and disabled individuals from 70 to 100 percent of the poverty level; the removal of an asset test for pregnant women and children; and the extension of MA benefits to higher-income employed disabled persons.³⁵ The state has also garnered Medicaid FFP for adults enrolled in its MinnesotaCare program under its Section 1115 waiver. Federal matching funds were extended to include the parents and caretakers of children enrolled in MinnesotaCare with incomes up to 175 percent of the poverty level in 1999 and up to 275 percent of the poverty level in 2001.³⁶ (Minnesota has received FFP for children on MinnesotaCare with household incomes up to 275 percent of the poverty level since 1995.) In addition, beginning in July 2002, the income limit for children under MA will be raised to 170 percent of poverty, while the income limit for parents will be raised to 100 percent of poverty.

A particularly significant expansion has been the extension of the MA program to working persons with disabilities at higher income levels. In 1999, Minnesota enacted the Medical Assistance for Employed Persons with Disabilities (MA-EPD) program, which offers MA coverage to employed disabled persons under age 65 at any income level but with assets below \$20,000. Persons with incomes above 200 percent of the poverty level pay premiums for the program scaled to their income level. Enrollment in the program, at 5,500 in December 2000, has exceeded state expectations, and proposals to address higher-than-expected program costs are being considered.³⁷

Changes in Eligibility under MinnesotaCare

Minnesota supplements its generous MA coverage with the MinnesotaCare program, which provides subsidized health insurance to low-income residents without access to affordable insurance coverage from other sources. When the program began in 1992, the state set income eligibility levels for children and their parents at 185 percent of the poverty level. Since that time, Minnesota has expanded eligibility in a number of ways. Currently, children and their parents are eligible with incomes up to 275 percent of the poverty level. Single adults and couples without children are eligible with incomes up to 175 percent of the poverty level.³⁸ The changes in eligibility rules for MinnesotaCare between 1992 and 2001 include the following:

- 1992: Children and adults with children eligible at incomes at or below 185 percent of FPL
- 1993: Children and adults with children eligible at incomes at or below 275 percent of FPL
- 1994: Single adults and couples without children eligible at incomes at or below 125 percent of FPL
- 1996: Single adults and couples without children eligible at incomes at or below 135 percent of FPL
- 1997: Single adults and couples without children eligible at incomes at or below 175 percent of FPL

- 2002: Single adults eligible with assets below \$15,000; families and couples without children eligible with assets below \$30,000

Efforts to Simplify Eligibility and Enrollment Processes

Although Minnesota's array of health care coverage options is generous, navigating the complex eligibility rules and enrollment processes across the various programs can be difficult. Minnesota recently completed a review of program rules and structure that led to an ongoing effort to streamline the application and enrollment processes within and across the state's programs. Changes to date include shortening application and renewal forms, simplifying the verification requirements for the application, disconnecting automated processes that link cash and medical assistance, and aligning program renewal dates for households that include both MA and MinnesotaCare enrollees.³⁹

In addition to these changes, Minnesota has been responding to a 1999 class action lawsuit filed on behalf of 10,000 low-income residents with limited English proficiency. The lawsuit alleged that Minnesota had violated requirements under Title VI of the Civil Rights Act and other federal and state laws by not providing adequate services to persons with limited English proficiency. The lawsuit was settled in December 2000 and requires the state to make translation and other language-related improvements in program applications and other forms.⁴⁰

Finally, in October 2000, Minnesota announced that 22,000 MA enrollees may have been mistakenly dropped from MA coverage when their cash assistance benefits under the Minnesota Family Investment Program (MFIP) ended. The state estimates that 30 percent of those are either already reenrolled in MA or participating in MinnesotaCare. For those remaining without coverage, the state has instituted the MA Reinstatement Project to provide assistance in reenrollment and reimbursement of any medical costs accrued over the period of disenrollment.⁴¹

Beyond these efforts by the state, Governor Ventura recently announced a new public-private initiative, Cover All Kids, which brings together a coalition of public and private organizations (including the Children's Defense Fund and the Minnesota Council of Health Plans) to improve access to care for children in Minnesota. Goals of the program include increasing public awareness of insurance options, addressing health disparities, and easing access to preventive care for children.⁴²

Other Initiatives to Increase Health Insurance Coverage

In addition to health insurance programs directed specifically at the low-income population, Minnesota maintains a high-risk pool called the Minnesota Comprehensive Health Association (MCHA). Established in 1976, MCHA subsidizes health insurance for individuals who cannot obtain coverage from other sources. The pool is funded through premiums collected from participants and from annual assessments on insurance companies, HMOs, and other insurance providers. The pool has faced ongoing financial difficulties, as premiums and assessments on health plans have not been sufficient to cover costs. Although the legislature has provided periodic subsidies to maintain the financial stability of the pool, the state is considering alternative mechanisms to increase the viability of the pool. Most recently, Governor Ventura has suggested creating an endowed fund or providing booster payments to ensure the solvency of the fund. Changes to benefits and the structure of the funding mechanism are also being considered.⁴³

Budgetary Perspective and Expectations for the Future of Health Care Programs

Health care funding continues to have strong economic and political support in Minnesota. Nevertheless, the state faces challenges in the form of rising health care costs, increased costs due to eligibility expansions, and pressure to alter the funding mechanism for MinnesotaCare.

As in the rest of the country, Minnesota faces rising costs for prescription drugs and new technologies in its public programs. Increased immigration in Minnesota has brought

additional translation costs and the need for culturally sensitive care. In addition, Minnesota has retained coverage for some immigrant populations the federal government no longer supports under Medicaid. Because health care is such a significant share of the state's budget, pressure is increasing to control the growth in health care costs.

The state's expansions of coverage under MA and MinnesotaCare in recent years have also contributed to increases in health care spending. Most recently, the expansion of MA to employed disabled persons resulted in a much greater enrollment (and higher costs) than the state had anticipated.

Finally, although public support for MinnesotaCare is high, there are ongoing efforts to alter the funding mechanism for the program. MinnesotaCare is funded through premiums and copayments paid by program enrollees and taxes on providers, HMO premiums, and drug wholesalers. The tax revenues and enrollee premiums are deposited into the Health Care Access Fund, which is used to finance the program. Although the Health Care Access Fund has operated with a significant surplus in recent years, state projections indicate that the program will actually outpace its revenue sources in six to seven years.⁴⁴

There is strong opposition in the state to the taxes that fund MinnesotaCare, with providers and plans pushing for general fund or tobacco fund support for the program. Legislative action in 1997, 1999, and 2000 reduced both the provider and premium taxes. In 1997 the legislature reduced the provider tax from 2 percent to 1.5 percent for two years and granted a two-year (fiscal years 1998 and 1999) exemption to the premium tax for health plans that met cost containment goals. A provision was also included that would allow the premium tax to "turn on" if a structural imbalance was found in the Health Care Access Fund.⁴⁵ In 1999, the legislature instituted a freeze in the provider tax at 1.5 percent until 2002. In 2000, the freeze on premium taxes was continued through 2002 and a 1 percent tax on health plan premiums was instituted for 2003. Funding for the MinnesotaCare program remains a contentious issue in the state.

Acute Care Issues

In this section, we explore developments related to acute care in Minnesota, including the implementation of managed care for the state's public programs; issues affecting hospitals; the ongoing health care labor shortage; the state's Prescription Drug Program; and finally, the impact an increase in immigrants has had on health care in Minnesota.

Managed Care for Medicaid, MinnesotaCare, and GAMC⁴⁶

Implementing Managed Care Statewide. As noted earlier, Minnesota has a long history of Medicaid managed care, beginning with its PMAP program in 1985 under one of the original Section 1115 Medicaid competition demonstration waivers. In 1995, Minnesota received another 1115 waiver that gave the state the authority to expand PMAP statewide. This was the state's first significant effort to extend PMAP beyond the Twin Cities metropolitan area and into the state's many rural counties.

Minnesota's initial efforts to expand PMAP fell short of the goal of statewide implementation by 1997. The state's efforts to implement PMAP in rural areas faced significant resistance from a range of stakeholders, including some county officials, providers, and consumer advocacy groups. Counties that objected to PMAP did so primarily because they feared the loss of Medicaid revenues and potential cost-shifting from plans in addition to resenting the lack of customization of the program for rural counties. Some consumer groups feared "rationing care" under managed care. Some providers opposed PMAP because they wished to avoid managed care, while others feared being left out of managed care networks.

Between 1997 and 2000, the state Medicaid agency, the legislature, and stakeholders worked together to develop alternative models of managed care. Two strategies were developed. First, counties were given a larger voice in PMAP design and implementation as part of a new "enhanced PMAP" model. Second, counties were given the option of pur-

suings county-based purchasing (CBP) arrangements. Under CBP, counties are responsible for creating and operating their own Medicaid payment and delivery systems for a capitated payment from the state.

Currently, 60 of Minnesota's 87 counties are operating PMAP, with a total of 183,000 enrollees. Three additional counties are expected to implement PMAP in 2001. Twenty-five counties (including two current PMAP counties) are pursuing CBP. One group of nine counties is planning to implement CBP in Fall 2001. The state expects the remaining counties to implement either PMAP or CBP by the end of the year.

Minnesota has received an extension of the PMAP waiver through 2002, and state officials have indicated their intention to pursue a second extension through 2005. Among other things, the 2002 extension includes approval for voluntary PMAP enrollment of children and adults who are seriously and persistently mentally ill and/or emotionally disturbed, and approval for a prepaid dental project. It also includes approval for the state to vary the payment methodology for health plans to incorporate quality improvement incentives.

Significantly, CMS denied a request by the state asking for an exception to the Balanced Budget Act's requirement for plan choice. Although the state has been able to offer at least two plan choices for all PMAP enrollees, several rural counties that are not yet operating PMAP have been able to secure only a single plan for MinnesotaCare enrollees. The state requested an exception, rejected by CMS, that would have allowed a single plan to serve PMAP and MinnesotaCare enrollees in these counties. Despite the decision by CMS to not allow a waiver of client choice, state officials indicated they would continue to allow only a single plan to serve these rural counties rather than returning the MinnesotaCare program to fee-for-service. The resolution of this issue will have important ramifications for both the MinnesotaCare and PMAP programs.⁴⁷

Expanding Medicaid Managed Care to New Populations. Although Minnesota has been on the forefront of efforts to expand managed care to the Medicaid population, one area in which Minnesota has lagged behind many other states is in the inclusion of persons with disabilities in managed care. Although Minnesota's original Section 1115 waiver authorized the expansion of PMAP to blind and disabled individuals as well as aged individuals and families and children, the state disenrolled blind and disabled persons after the first year of program operations because of severe cost overruns. Implementation of a new, more narrowly targeted demonstration program enrolling this population into managed care will begin in late 2001.

Changes in Rate-Setting Methodology. PMAP has proven to be a profitable line of business for plans in Minnesota at a time when other lines of business are not performing well. Many health plans in Minnesota lost money on commercial, Medicare, and MinnesotaCare in 1999 but turned a profit on PMAP.⁴⁸ However, rising health care costs under PMAP are beginning to put pressure on PMAP rates. In an effort to develop a more accurate rate-setting process, Minnesota is changing the state's rate-setting methodology. Beginning with the 2000 contracting year, the state adjusted 5 percent of the PMAP capitation rate using an Adjusted Clinical Grouping (ACG) methodology. This method uses plan encounter data to assess the risk faced by plans relative to each other based on diagnostic information. Urban and rural differences in the costs of providing care as well as the increasing costs of providing care are thought to be better predicted with the ACG adjustment. The state intends to adjust rates using this method every quarter, increasing the percentage of the capitation rate that is adjusted to 30 percent in 2001 and 50 percent in 2002. Although plans support the state's move toward risk adjustment in the PMAP rates, some plan respondents were concerned that the state lacks the data to support the new rate-setting mechanism.

Quality of Care Initiatives. Minnesota is in the early stages of formulating and implementing a comprehensive quality of care strategy for its managed care programs. The eventual goal, according to officials, is for Minnesota to transition to performance-based

contracting with health plans for all of its health care programs. Minnesota has taken several steps toward this goal in recent years by implementing a series of quality of care initiatives in managed care contracts.⁴⁹ Among other things, plan contracts include requirements for annual enrollee satisfaction surveys, reports on service use and effectiveness of care, reports on well-child visits, compliance with Quality Improvement System for Managed Care (QISMC) as outlined by CMS, and annual performance improvement projects for each contract year (e.g., increasing childhood preventive care visits, dental care, smoking cessation, addressing race and ethnic disparities, and addressing reproductive health issues including STDs and teen pregnancy).

Issues Affecting Hospitals

Although hospitals in Minnesota have been quite stable over the past several years, they are beginning to show some of the strains of rising health care costs. Recent bond downgrades and dips in profit margins are cause for concern among hospital administrators and state officials. Several factors have contributed to the current environment. First, uncompensated care has increased in urban areas (attributed in part to growing immigrant populations), placing greater stress on key safety net providers. Second, the shortage of health care workers has affected service delivery and caused a dramatic increase in the number of hospital emergency rooms diverting patients to other hospitals because of staffing issues. Third, hospitals are concerned about reimbursement rates.

Increases in Uncompensated Care. Uncompensated care has traditionally been low throughout Minnesota. However, hospitals in the urban areas of Minnesota, particularly the Twin Cities, have seen a rapid rise in their uncompensated care in recent years. During 1998, Hennepin County Medical Center (in Minneapolis) and Regions Hospital (in Saint Paul) provided over \$50 million in uncompensated care.⁵⁰ These two facilities currently provide more than 50 percent of the state's charity care, a large portion of which is delivered to patients who reside in other areas of the state.⁵¹ These two hospitals have also been affected by changes under the Balanced Budget Act, which significantly reduced Medicare payments.⁵²

Minnesota hospitals successfully lobbied the legislature for financial assistance to help defray the costs of uncompensated care. In 1999 the state authorized \$10 million in state funds to be allocated to hospitals based on the amount of charity care they provide. Hospitals in the Twin Cities received \$8.8 million of these funds.⁵³ A state task force recommended in 2000 that an additional \$20 million in funding be allocated to address uncompensated care costs. However, because of Governor Ventura's commitment to veto any new non-emergency spending, the legislature did not approve additional assistance for hospitals in 2000.⁵⁴ In contrast, in 2001 the state increased funding for public hospitals with high levels of uncompensated care by \$15 million per year and provided \$4 million per year in new funding for community clinics.

Health Care Worker Shortage. Like the rest of the country, Minnesota's health care system continues to struggle with a severe worker shortage. Hospital staffing limitations have caused a significant increase in the number of hospitals on "divert" status for incoming emergency room patients. The recent Minnesota nurses' strike has intensified concerns about the shortage. About 1,300 nurses at two Minneapolis hospitals went on strike in early June seeking both increased compensation and changes in management practices in response to staffing shortages (e.g., limits on patient loads).⁵⁵

There has been a range of responses to the crisis by the state, hospitals, and other health care employers; however, there is little evidence of improvement. In 1998, selected health workers became eligible to practice under a temporary license if they have finished training but not yet passed the licensing exam. Paperwork for some practitioners has also been reduced so that licensing renewals take place every two years rather than annually. In 1999, the legislature allocated \$1.5 million for a two-year worker training and retention program run by the Minnesota Job Skills Partnership program. The state has also relaxed

certification requirements for some workers in an attempt to increase the number of available workers. The legislature also allowed workers from other countries to obtain certification as nursing assistants by passing a competency test rather than the mandated 75-hour educational requirements. In 2001, the legislature established loan forgiveness and scholarship programs to reduce education barriers to increasing the supply of health care workers. The state is also pursuing efforts to increase current workforce efficiency through reduced paperwork requirements and increased use of telemedicine.

Employers in the private sector are also taking steps to ease the shortage. For example, hospitals have joined with the state and some business groups to form a coalition called the Health Care Administrative Partnership with the aim of providing appropriate training in the areas with the most severe shortages of trained workers. Other health care employers, such as Allina, have instituted programs that provide training for low-skilled workers, enabling them to transition into health care jobs requiring a higher skill level.

Hospital Reimbursement Rates. Hospitals in Minnesota have also been affected by adjustments in the state's reimbursement rates. Although the state has not used the repeal of the Boren Amendment to cut rates for hospitals, rate increases are no longer automatic. Prior increases included an automatic adjustment for inflation. After the Boren repeal, the legislature has granted inflationary increases as a part of the budget process, but no such increase was included in the governor's 2002–2003 budget.

Hospitals will face another change in the next year concerning rates. The basis for Medicaid reimbursement rates will shift in the next year to the Ambulatory Payment Classification (APC) method for outpatient services. Hospitals are pleased with this change, as it is expected to increase reimbursement rates.

Addressing Prescription Drug Costs

In response to rising prescription drug prices, Minnesota has focused on helping low-income elderly and disabled persons through a new state program, Minnesota's Prescription Drug Program (PDP), originally called the Senior Drug Program. The program, which began in 1999, serves elderly persons age 65 or older with income at or below 120 percent of the poverty level and assets of \$10,000 or less for an individual or \$18,000 or less for a couple.⁵⁶ (The income standard for the program will increase to 135 percent of the poverty level in January 2002.) The program pays for most prescription drugs after the enrollee pays the \$35 monthly deductible.

As of January 2001, about 5,600 seniors had enrolled in PDP. Officials suggested that a lack of information about the program and confusion by the elderly concerning eligibility guidelines has contributed to the slower than expected enrollment growth. Some elderly residents may also be concerned about potential stigma attached to the program.⁵⁷

The state has worked to reduce these barriers to enrollment in PDP. The original 15-page application was reduced to 4 pages, and the state eliminated an up-front \$120 premium on the program (though enrollees still pay the \$35 per month deductible). The state has also implemented a radio campaign to promote awareness of the program and is working with community organizations and agencies that work with senior citizens to notify elderly residents about the program.

The PDP program will expand to include disabled people under age 65 with income less than 120 percent of the poverty level in July 2002.

Health Care Needs of Minnesota's Minority Population

The influx of immigrants to Minnesota has brought different health care needs to the state, with an increased incidence of tuberculosis and other diseases and an expanded need for culturally sensitive care and translation and interpreter services. Minnesota is also beginning to address long-standing disparities in health status measures between white and minority residents, of which immigrants are an increasing share. A recent survey by the

Minnesota Department of Health found that minority populations in the state were significantly less likely to have health insurance than whites, contributing to their poorer health status.⁵⁸ The 2001 legislature allocated \$10 million to be used to eliminate existing health disparities in the state.

At the same time that the state has been investing in efforts to address the health care needs of its minority populations, other efforts have been aimed at reducing state spending on medical benefits for illegal immigrants. In 1997, the Minnesota legislature passed a law requiring county human services workers to use the federal Systematic Alien Verification for Entitlements (SAVE) to verify the immigration status of applicants when processing application forms for health coverage. The law would have also required state officials to report any undocumented applicants to the Immigration and Naturalization Service (INS), making Minnesota the first state to actively report undocumented individuals to the INS. However, this reporting requirement was repealed by the 2001 legislature prior to its scheduled July 1, 2001, implementation.

Issues in Long-Term Care

In the late 1990s, Minnesota realized it could not continue to support the level of long-term care services it had been providing given the aging of its population. Concerns about future long-term care costs led to a major examination by the state of issues facing the elderly under the state's "Project 2030."⁵⁹ Although Project 2030 began as an examination of cost issues, it was expanded to include a broader examination of issues facing the elderly in Minnesota, including personal responsibility for savings and health, community infrastructure issues (e.g., housing, transportation, and social outlets for seniors), and the state's shrinking labor pool. Project 2030 has provided a framework for discussing significant changes in the long-term care system in Minnesota and developing recommendations for the future.

Project 2030 renewed Minnesota's efforts to increase home- and community-based care and reduce institutional care for elderly and disabled persons. Nursing home use decreased in Minnesota from 8.8 percent in 1980 to 6.8 percent in 1999.⁶⁰ Although still far above the national average of 4.3 percent, this represents a significant shift away from nursing home use in the state toward greater use of home- and community-based care. Legislation passed in 2001 will continue the transformation of the state's long-term care system, as it provides funds for expanded home- and community-based care and reductions in nursing home beds.

Minnesota has also decreased the number of persons with disabilities in institutions. In October 2000, Minnesota marked what it considered the removal of the last person with developmental disabilities from institutional care. The state is now working on ways to relocate and/or divert people with disabilities from nursing homes and other institutions, with an emphasis on reaching disabled children.

Efforts to Increase Home- and Community-Based Care

A key element of Minnesota's efforts to reduce its reliance on institutional care is to expand the use of home- and community-based care both as a substitute for institutional care and as a means of preventing a future need for institutional care. The state operates a number of Medicaid home- and community-based care waiver programs in addition to funding a state program aimed at helping the low-income elderly avoid nursing home care.

Home- and Community-Based Care Waiver Programs. Minnesota currently operates six home- and community-based care waiver programs under Section 1915 of the Social Security Act. Five of those waivers provide home- and community-based services to specific populations at risk of institutionalization:

- Elderly Waiver—serves elderly individuals at risk of nursing home admission.
- MR/RC Waiver—serves individuals with mental retardation or related conditions who are at risk of placement in an intermediate care facility (ICF) for the mentally retarded.
- Community Alternatives for Disabled Individuals (CADI)—serves younger disabled individuals at risk of nursing home placement.
- Community Alternatives for Chronically Ill Individuals (CAC)—serves individuals (mostly children) with chronic illness who are at risk of hospital admission.
- Traumatic Brain Injury Waiver—serves individuals with traumatic brain injury who are at risk of placement in either a nursing home or hospital admission.

Minnesota's sixth waiver represents a major innovation in care delivery. The Minnesota Senior Health Options Program (MSHO) provides coordinated primary, acute, and long-term care services under Medicaid and Medicare services for dually eligible persons age 65 and older. MSHO represents the first of only four joint Medicaid and Medicare waivers granted by the Centers for Medicare and Medicaid Services (CMS).⁶¹ MSHO is currently operating in seven counties in the Twin Cities metropolitan area and three rural counties. As of April 2001, MSHO enrollment totaled 4,138.⁶²

Building on MSHO, the state is moving forward with a new program to enroll younger disabled Medicaid beneficiaries into managed care, called the Minnesota Disability Health Options Program (MnDHO). MnDHO has been approved by CMS as an extension of the waivers authorizing the state's MSHO program. Like MSHO, MnDHO integrates primary, acute, and long-term services under Medicaid and Medicare.⁶³

Finally, Minnesota is hoping to move toward more consumer-directed care with a cash and counseling home- and community-based care waiver. If approved by CMS, Minnesota's program, called the Consumer Directed Home Care Waiver, would enable selected Medicaid recipients to arrange for and purchase their own long-term care services rather than rely on agencies to perform these functions.

State-Funded Home- and Community-Based Care Programs. In addition to Minnesota's efforts under the Medicaid program, the state also supports a program aimed at increasing home- and community-based care for elderly persons who do not qualify for Medicaid, called the Alternative Care Program (ACP). ACP serves state residents 65 years old and older who are at risk of nursing home placement but do not have personal income or assets to cover 180 days in a nursing facility. By providing care in the community the state hopes to avoid paying costly institutional care through Medicaid were enrollees to spend down their resources until they qualified for MA. In 2000, the ACP program served 10,696 people at a cost of over \$49 million.⁶⁴

Minnesota has also increased state funding for home- and community-based care for higher-income elderly under Living at Home/Block Nurse programs. These programs help those age 65 and older to remain in their homes by providing home nurse visits and coordination of health and personal services as needed. Enrollees pay for services on a sliding fee basis. In 1997 the state allocated an additional \$650,000 to expand from 15 to 27 the number of these programs. Increased funding was also provided in 1999, when the legislature allocated \$120,000 to create six more Living at Home/Block Nurse programs. In 1999, 25 programs were operating throughout the state.⁶⁵

Finally, as part of its efforts to address the needs of higher income Minnesota residents who are at risk of becoming eligible for Medicaid, Minnesota is paying special attention to the issue of housing for the elderly. The state is exploring affordable housing, assisted living, and "housing with services" options that would help seniors remain in their community. Minnesota is working to find ways of using existing housing and health care funding more creatively to address a variety of long-term care needs.⁶⁶ As part of this effort, in 2001, the legislature provided funds for community service grants to help develop supportive housing and home and community services across the state.

Nursing Homes

Mirroring national trends, nursing home occupancy rates have been declining in Minnesota over the last decade. State policy and the preferences of the elderly and disabled have both contributed to the reduced demand for nursing home beds. Changing medical practices have also shifted the length of stays in nursing homes from long-term commitments to shorter rehabilitative stays. In addition, some nursing homes have been forced to reduce occupancy because the worker shortage has prevented them from adequately staffing their facilities. Nursing homes are also facing unpredictable changes in reimbursement rates, which are no longer subject to automatic increases under the Boren Amendment.

Nursing Home Payments. Although payments to nursing homes have historically been generous in Minnesota, industry respondents argue that during the mid-1990s costs for nursing home care began to exceed the payment rates set by the state. Increased fuel costs, higher insurance premiums, increased staff recruitment and retention efforts, and increased federal requirements are cited as contributing to higher operating expenses. In addition, Minnesota nursing homes are required to maintain rate equity for privately and publicly funded residents, preventing them from making up revenue shortfalls under Medicaid by increasing private rates.

Traditionally, nursing homes in Minnesota have been paid under a cost-based system, called Rule 50. This system uses a prospective method for setting medical assistance rates for nursing facility care, based on facility-specific costs adjusted with actual costs and inflation on an annual basis. In 1996, the legislature enacted the Alternative Payment System (APS) for nursing homes, as a transitional step toward performance-based contracting. APS rates are set based on the facility's last cost report under the Rule 50 reimbursement system, with an adjustment for inflation each year. In the initial plan, the APS rates were also to include quality incentive payments, although those payments have not yet been incorporated in the rates.⁶⁷ Nursing homes may choose between these two payment methods. Seventy percent of nursing homes in Minnesota currently use the APS payment method.

In 1998 the legislature directed the Department of Human Services (DHS) to develop a plan to implement statewide performance-based contracting for nursing homes by July 2002, eliminating the Rule 50 and APS payment systems. In 2000, the legislature set timelines for the transition to a new payment system that would incorporate both performance-based contracting as well as a new adjustment for case mix. Nursing homes support the shift to a new payment system, which they say will offer them greater flexibility and stimulate competition and innovation.

The reduction in revenue has caused some nursing homes to explore new revenue sources, including providing assisted living facilities or other services for the elderly. Other facilities have carved out a niche by specializing in care for specific populations, such as Alzheimer's or hospice patients, or by providing other specialized services. Other homes have permanently closed wings or their entire operations.

Nursing Home Closures. In 2000, the state legislature established a process for closing nursing homes in Minnesota, with an option to place a limited number of beds on "layaway" for potential return to use at a later date. Placing beds on layaway allows homes to avoid paying insurance or taxes on unused beds for up to five years, when the home must decide to reopen or permanently close the selected beds. The law applies to nursing homes owned or operated by nonprofit corporations controlling more than 22 nursing facilities in the state. The legislature indicated it expected the closure of up to seven facilities in 2001.⁶⁸ Legislation in 2001 continues the state's efforts to close nursing homes, with plans to downsize the nursing home industry by 5,100 beds over the next biennium.⁶⁹

Minnesota's Position on the Olmstead Decision

The U.S. Supreme Court ruled in *Olmstead v. L.C.* that inappropriate institutionalization as a result of state-run public long-term care programs is discrimination against people with disabilities. Because of the scope of Minnesota's home- and community-based care services, state officials have not felt it necessary to prepare a specific response to the Supreme Court's *Olmstead* decision. However, the state has come under pressure from legal and disability advocacy groups who are pushing for a specific plan that addresses *Olmstead*. Advocates have expressed concern about a number of issues related to *Olmstead*, particularly what they see as a lack of state effort to assess and identify individuals currently residing in nursing homes or other facilities for community placement.⁷⁰ State long-term care officials indicated that the state would likely come up with a plan despite the fact that they felt it would be a time-consuming task that would offer little real benefit.

Long-Term Care Worker Shortage

Like other sectors of the health care industry, long-term care providers have been struggling with the worker shortage in Minnesota. Some nursing homes have been forced to eliminate beds or even close entire wings as a result of the shortage because of an inability to meet minimum staffing levels. This has contributed to waiting lists for some nursing homes in the state.⁷¹

The legislature has taken several steps to try to address the shortage of long-term care workers. In 1997, the legislature approved increases in reimbursement rates for a wide range of community-based services paid for by MA, to be used to increase salaries for employees providing health care in the community. In 1998, the legislature provided a \$20 million increase in reimbursements to nursing homes and institutions for the developmentally disabled, with \$8.4 million directed toward a 3 percent increase in employee salaries. The additional funding was structured to trigger federal matching funds of more than \$5 million and affected 40,000 employees across the state. An additional 3 percent salary increase was also mandated for other health care employees. Long-term care workers were also granted a pay increase in 1999, via a 4 percent increase in reimbursement to long-term care agencies for fiscal year 2000, and a 3 percent increase for fiscal year 2001. Of these increases, 80 percent was mandated to increase worker salaries. Finally, legislation passed in 2001 provides 3 percent increases for nursing home and long-term care facilities in 2002 and 2003, with about two-thirds of the increases to be dedicated to wages and benefits.⁷²

The state has also relaxed certification requirements to increase the number of long-term care workers available, as they have done for acute care (see above). Further, nursing homes are now allowed to hire resident attendants under lowered certification standards to assist with eating and drinking for residents. Minnesota is also seeking federal approval for nursing homes to hire feeding assistants who are not certified to assist with eating and drinking. There is some concern that this measure will encounter opposition from CMS, which recently required two neighboring states (Wisconsin and North Dakota) to train and certify feeding assistants.⁷³

Advocates for nursing homes were critical of the state's efforts to improve worker salaries at the time of our site visit (prior to the 2001 legislation). According to them, the nursing home rate increases mandated by the legislature to date had been too restrictive and overly burdensome in targeting specific types of salary increases for specific types of staff. In addition, nursing homes contended that the amount of money allocated to counter the shortage has simply not been enough to offset the historically low wage and benefits gap that is behind the shortage.

Insurance Market Development and State Regulation

The Minnesota legislature has passed two measures aimed at increasing insurance coverage options for small employers. In 1999 the legislature passed the Alternative Care Act,

allowing insurance companies with less than a 3 percent market share in Minnesota to offer small employers insurance products that do not include all of the state's 37 mandated coverage items. Controversy over the inclusion of certain benefits, particularly maternity care, has delayed the offering of new products. Advocates, some health care providers, and the attorney general maintain that federal and state antidiscrimination laws require that maternity benefits be included, while insurance companies would like the flexibility to exclude such coverage.

More recently, the Minnesota Council of Health Plans (MCHP) has begun lobbying the state legislature to allow all plans to offer more flexible insurance options to all Minnesota employers, regardless of size. MCHP estimates that mandated benefits under Minnesota law account for 20 percent of the cost of premiums in the state and are an important factor in the increase in self-insurance among large employers in Minnesota.

Patient Protection Legislation

Minnesota is ahead of national efforts to provide patient protections under managed care. A 1999 comparison of Minnesota's patient protection legislation and the Consumer Bill of Rights as proposed by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry found that Minnesota law already includes nearly all of the proposed elements.⁷⁴ In 1997 the Minnesota legislature enacted the Patient Protection Act, which increased protections on the doctor-patient relationship and enables consumers to access accurate information concerning the financial relationship between providers and health plans. In 1999, the state established a complaint resolution process for disputes between managed care companies and consumers.⁷⁵

Conclusion

Minnesota has long been a leader in state health care programs for the low-income population. The state boasts one of the lowest uninsurance rates in the nation. Its health care programs are characterized by liberal eligibility policies and generous coverage mandates. Further, the state has continued to expand its health care programs over the last few years.

The state has also worked to increase private insurance options offered by employers, and employer-sponsored coverage is at an all-time high in Minnesota. At the same time, the state's high number of mandated benefits and taxes on HMO premiums have contributed to a shift toward self-insurance among many of the largest employers in the state. Although the impact on employees appears to have been minimal to date, some observers are concerned that employers may reduce coverage or shift a greater share of health care costs to employees in an economic downturn.

In terms of long-term care, the state has begun a concerted effort to reform its system and reduce costs. Project 2030 has been instrumental in shaping a new approach to long-term care reform. The state is working toward a system that relies less on nursing home care while increasing home- and community-based care and emphasizing consumer-directed health care for its growing elderly population. The state is also exploring ways of integrating social services such as housing, social supports, and other services into its long-term care system.

Some progress has been made toward these long-term care goals in Minnesota. Nursing home occupancy has decreased, and in October 2000 the state marked the removal from institutional care of the last person with developmental disabilities. Innovative programs such as MSHO and the soon-to-be operational MnDHO use Medicaid and Medicare funding to integrate acute and long-term care for elderly persons and people with disabilities. Spending on home- and community-based care has increased with the range of federal waiver programs offered in Minnesota and the state's Alternative Care Program. Overall, the state has reduced spending growth for Medicaid long-term care from 9 percent between 1992 and 1995 to just 1.5 percent from 1995 to 1999.

Beyond these issues, Minnesota faces additional challenges as it looks to the future. How these issues are resolved will be shaped both by the state of the economy and by the political environment in Minnesota, which has shifted to the right in recent years. The election of Jesse Ventura as governor in 1998 added a third party to Minnesota state government and a subsequent increase in contentiousness. Furthermore, the Republicans gained control of the house, giving greater voice to those in support of spending limits, tax cuts, and fewer eligibility expansions for health care programs.

Minnesota is also considering proposals to alter the funding mechanism for MinnesotaCare, from taxes on providers, HMO premiums, and drug wholesalers to either surplus or tobacco settlement funds. The resolution of this issue could have a lasting impact on program funding given the competing demands on state surplus and tobacco funds. In the absence of any change in the MinnesotaCare funding mechanism, the state will still face a funding crisis if projections are correct that existing health care taxes will no longer fully fund the program as early as 2007.

The health care worker shortage will also continue to be a major issue in Minnesota. Low wages, minimal benefits, and the demands of health care jobs have exacerbated the shortage, which has affected every sector of the state's health care system. Minnesota's efforts thus far have not been enough to reduce the shortage, and the state is now considering new strategies to attract new workers to the health care field.

Another issue that Minnesota must deal with is the needs of its growing immigrant population. Minnesota has seen a dramatic increase in its minority population, which has affected the cultural, economic, and political environment in the state. The state is working to address the new and different health care needs of this population, which has subsequently increased health care costs. Minnesota has shown over time that it is capable of meeting the challenges facing its health care system. Despite the shift toward controlling state spending and tax reform, there remains a strong public commitment to health care programs. This will likely help Minnesota to maintain its leadership role in providing health care services for the low-income population.

Endnotes

1. The other 12 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. The 13 states studied were selected to present a balanced view of state activity and its impact on low-income families. See Kondratas, Anna, Alan Weil, and Naomi Goldstein. 1998. "Assessing the New Federalism: An Introduction." *Health Affairs* 17(3): 17-24.
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9. Elected as a Reform Party candidate, Governor Ventura joined the Independence Party of Minnesota in February 2000.

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31. Andrulis, Dennis, and Gusmano, Michael. 2000. *Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us?* New York: New York Academy of Medicine, Division of Health and Science Policy, Office of Urban Populations; and Princeton, New Jersey: The Robert Wood Johnson Foundation. In addition to offering coverage for those living under 70 percent of the poverty level, those with incomes up to 175 percent of the poverty level may spend-down to become eligible for GAMC.
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67. In 1999 the state began to require nursing homes under APS to provide plans for continuous quality improvement (CQI) based on clinical outcomes and consumer satisfaction. However, no incentives were provided under CQI, and nursing homes are concerned about the costs of maintaining CQI without accompanying financial support for their quality initiatives.
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Table 1 Notes

- a. U.S. Census Bureau. 2001. *Profiles of General Demographic Characteristics 2000*. <http://www.census.gov/Press-Release/www/2001/2khus.pdf>.
- b. Urban Institute calculations derived from the 1999 National Survey of America's Families. Note: All calculations only include residents under age 65.
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- i. Two Urban Institute calculations: (1) Average monthly number of AFDC 1996 recipient children divided by number of children in poverty in 1996: U.S. Department of Health and Human Services. Administration for Children and Families. 1997. *Characteristics and Financial Circumstances of AFDC Recipients FY 1996*. Table 18. "Percent Distribution of AFDC Recipient Children by Age (October 1995–September 1996)"; (2) Average monthly number of TANF 1998 recipient children divided by number of children in poverty in 1998: U.S. Department of Health and Human Services. Administration for Children and Families. 1999. *Second Annual Report to Congress August 1999*. Table 9:22. "Percent Distribution of TANF Recipient Children by Age Group (October 1997–September 1998)." The numbers of children in poverty in 1996 and 1998 are Urban Institute calculations from the National Survey of America's Families II.
- j. Based on three sources: (1) Urban Institute's TRIM [Transfer Income Model]; (2) Smith, Vernon K. 1999. "Enrollment Increases in State CHIP Programs: December 1998 to June 1999." Health Management Associates, July; (3) Urban Institute analysis of 1999 SCHIP [State Children's Health Insurance Program] Annual Report. Rules for 1996 and 1998 are policies in place the majority of the year. Rules for 2000 represent plans approved as of January 1, 2000.
- k. In 1996, the threshold represents the state Medicaid threshold for poverty-related eligibility or AFDC-related eligibility. Higher thresholds for separate state-financed programs (such as in New York) are not represented here.

l. The figure for 1998 represents the higher of the state threshold for Medicaid eligibility, or the state threshold for Medicaid expansions or stand-alone programs enacted under the SCHIP legislation.

m. The figure for 2000 represents the higher of Medicaid or SCHIP eligibility. In 2000, all states covered at least some children through SCHIP; certain groups in some states are only eligible through Medicaid.

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