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Health Policy for Low-Income People in Minnesota

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Minnesota takes pride in its long history of providing generous health care benefits to the poor. The state supports a comprehensive Medicaid program that includes a rich set of benefits, relatively liberal eligibility, and ample provider payment. Overall it spends 58 percent more per Medicaid beneficiary than the national average. It also funds a General Assistance medical care program and is one of a handful of states that sponsors a subsidized health insurance program for low-income uninsured persons. Beyond these publicly financed health care programs, Minnesota has implemented several major reforms aimed at improving private insurance availability and affordability.

Minnesota has been rewarded for its efforts. In terms of overall health status it is consistently ranked among the top states. Moreover, it boasted the fourth-lowest uninsured rate in the country in 1995, at 9.2 percent. This low rate is in part attributed to employer-sponsored health insurance: 74 percent of nonelderly Minnesotans were insured through their employers in 1995 compared with 66 percent nationwide. A related benefit of the extensive public and private insurance coverage is that hospitals in the state enjoy low levels of uncompensated care: Minnesota hospitals provide uncompensated care equal to 2.9 percent of their expenses on average, or about half the national rate.

> By almost any measure Minnesota's health care system is in good shape.

State Characteristics

In 1995 Minnesota had a population of 4.6 million, which has been growing at roughly the same rate as the United States population since 1990. More than half of the state's population resides in the seven-county metropolitan area including and surrounding St. Paul and Minneapolis, the Twin Cities.

Relatively few Minnesotans are members of racial or ethnic minority groups: African-Americans accounted for only 3.3 percent of the state's 1995 population, followed by Hispanics at 1.8 percent.

Minnesota presently boasts a strong economy. Unemployment is lower than the national average (4.0 percent versus 5.4 percent in 1996). Moreover, per capita income in 1995 ($23,971) was slightly higher than the national average, as was growth in per capita income between 1990 and 1995 (23.7 percent versus 21.2 percent). One in nine Minnesotans—11.2 percent of the state's population—had an income that fell below the federal poverty level (FPL) in 1994, which is lower than the national average of 14.3 percent.

Table 1
State Characteristics

Sociodemographic	Minnesota	U. S.
Population (1994–95) (in thousands)	4,551	260,202
Percent under 18 (1994–95)	27.7%	26.8%
Percent 65+ (1994–95)	10.6%	12.1%
Percent Hispanic (1994–95)	1.8%	10.7%
Percent Non-Hispanic Black (1994–95)	3.3%	12.5%
Percent Non-Hispanic White (1994–95)	92.6%	72.6%
Percent Non-Hispanic Other (1994–95)	2.3%	4.2%
Percent Noncitizen Immigrant (1996)*	3.0%	6.4%
Percent Nonmetropolitan (1994–95)	28.1%	21.8%
Population Growth (1990–95)	5.3%	5.6%
Economic		
Per Capita Income (1995)	$ 23,971	$ 23,208
Percent Change in Per Capita Personal Income (1990–95)	23.7%	21.2%
Unemployment Rate (1996)	4.0%	5.4%
Percent below Poverty (1994)	11.2%	14.3%
Percent Children below Poverty (1994)	14.8%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)	9.2%	15.5%
Percent Medicaid—Nonelderly (1994–95)	7.2%	12.2%
Percent Employer-Sponsored—Nonelderly (1994–95)	73.5%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)	10.1%	6.2%
Smokers among Adult Population (1993)	22.4%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)	5.7%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)	6.4	7.6
Premature Death Rate (Years Lost per 1,000) (1993)	39.4	54.4
Violent Crimes per 100,000 (1995)	356.1	684.6
AIDS Cases Reported per 100,000 (1995)	8.0	27.8

Source: Complete list of sources is available in *Health Policy for Low-Income People in Minnesota* (The Urban Institute, 1997).
* Three-year average of the Current Population Survey (CPS) (March 1996–March 1998, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship. Please note that these numbers have been corrected since the original printing of this report.

Politics and Policymaking

Minnesota is currently served by Republican Governor Arne Carlson, who has held the office since 1990. Within the state legislature, Democrats control both the House and the Senate and have done so almost continuously since the early 1970s, although their margins have been declining.

Health care has been a top priority on the state's political agenda for the past several years. Most prominently, in 1992 state legislators, in a bipartisan effort with support from Governor Carlson, enacted HealthRight, now called MinnesotaCare. Among other things, the MinnesotaCare legislation, which is actually a series of laws passed each year between 1992 and 1995, guaranteed universal coverage for all Minnesotans by January 1, 1997; created a subsidized health insurance program (also called MinnesotaCare); and required that all publicly funded populations be shifted to managed care. The legislation also included several insurance reforms in the small-group and individual markets and regulated the rate of health care spending growth. The provisions included in MinnesotaCare have fundamentally shaped the health care policy debate in the state.

In the last two years, the state has retreated from some MinnesotaCare provisions. In 1995 legislation, for example, the state's commitment to universal coverage was redefined as a goal to reduce the uninsured rate to 4 percent by January 2000. A variety of factors has contributed to this policy shift. One is that health care reform failed at the national level, diminishing the momentum behind state reform efforts. Another factor is that Minnesota state politics, like national politics, have become decidedly more conservative, causing the state to back away from a more active government role in health care and rely more on the market.

The State Budget

Reflecting the robust economy, Minnesota's budget has had a healthy surplus in the past two budget cycles, enabling the state to fully fund its cash flow account as well as establish a budget reserve account.

Among the major budget sectors, Medicaid was the third largest in terms of state general-fund spending in 1995. (The largest items were primary and secondary education, followed by higher education.) Medicaid has also been one of the fastest-growing general-fund budget items, with expenditures increasing 15 percent per year from 1990 to 1995 versus 7 percent for the overall state general-fund budget. State general-fund expenditures for Medicaid in 1995 totaled $1.4 billion, or 15 percent of general-fund spending. When state and federal expenditures on Medicaid are combined, Medicaid is the second-largest budget item, consuming nearly 20 percent of the state's total budget in 1995.

Detailed Medicaid Trends

Together, state and federal spending on Minnesota's Medicaid program reached nearly $3 billion in 1995 (table 2). More than half (56 percent) of expenditures on benefits were for long-term care services, compared with 40 percent nationwide. The elderly and disabled accounted for 73 percent of the expen-

Table 2
Medicaid Expenditures
by Eligibility Group and Type of Service,
Minnesota and United States
(Expenditures in Millions)

	Minnesota			United States		
	Expenditures	Average Annual Growth		Expenditures	Average Annual Growth	
	1995	1990–92	1992–95	1995	1990–92	1992–95
Total	**$2,905.7**	**15.3%**	**12.3%**	**$157,872.5**	**27.1%**	**9.9%**
Benefits						
Benefits by Service	$2,725.1	13.9%	12.8%	$133,434.6	18.8%	11.0%
Acute Care	1,176.0	15.5%	18.9%	79,438.5	22.1%	13.0%
Long-Term Care	1,549.1	13.0%	8.9%	53,996.1	14.8%	8.3%
Benefits by Group	$2,725.1	13.9%	12.8%	$133,434.6	18.8%	11.0%
Elderly	$967.3	15.4%	9.8%	$40,087.4	16.7%	8.1%
Acute Care	95.5	7.0%	9.0%	9,673.7	18.5%	11.9%
Long-Term Care	871.8	16.5%	9.9%	30,413.7	16.2%	7.0%
Blind and Disabled	$1,011.2	11.3%	15.4%	$51,379.4	17.7%	12.9%
Acute Care	380.9	19.2%	30.1%	29,760.7	22.8%	15.2%
Long-Term Care	630.3	8.8%	9.1%	21,618.7	12.3%	10.1%
Adults	$239.8	15.4%	6.5%	$16,556.9	20.4%	9.2%
Children	$506.9	15.4%	17.6%	$25,410.9	24.3%	13.3%
Disproportionate Share Hospital	$24.2	121.0%	16.7%	$18,988.4	261.5%	2.7%
Administration	$156.3	25.7%	12.5%	$5,449.4	9.8%	12.8%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

ditures on long-term care and acute care combined. In terms of growth rates, acute care spending has outpaced long-term care spending, and spending on children has outpaced that on the elderly and disabled—similar to national trends. From 1992 to 1995, annual increases in acute care spending in Minnesota averaged 19 percent, compared with 9 percent for long-term care. Spending on children increased an average of 18 percent per year versus 13 percent for all beneficiaries. Yet children averaged only $1,719 in Medicaid expenditures per beneficiary in 1995, whereas the average elderly and disabled beneficiary incurred costs of $17,004 and $14,550, respectively (table 3).

As of 1995, Minnesota's Medicaid program had enrolled more than half a million people, 54 percent of whom were children. Enrollment levels for children increased substantially from 1990 to 1992, at an average annual rate of 12 percent, which was nearly equal to the national rate. Between 1992 and 1995, enrollment growth slowed to 3 percent per year, equal to about half the national rate. During this same period, the size of the disabled population continued to grow by more than 11 percent per year (table 3).

Medicaid Managed Care

A key state initiative to stem Medicaid expenditure growth is the enrollment of beneficiaries in capitated managed care plans. In 1996 Minnesota began to expand its Prepaid Medical Assistance Project (PMAP), a Section 1115 demonstration that has operated in the Twin Cities area since the mid-1980s, to other areas of the state. Statewide enrollment of Aid to Families with Dependent Children (AFDC), poverty-related, and elderly beneficiaries was expected to be completed by January 1997. However, Minnesota has encountered several difficulties in broadening PMAP and, as a result, the expansion has been greatly delayed.

During the 1996 legislative session, several advocacy groups successfully lobbied the legislature to postpone the expansion of PMAP. One leading group involved in the lobbying was the association representing Minnesota counties. Counties entered the debate because they saw a highly diminished role for themselves in the health care system if public dollars were shifted to managed care organizations and away from county health departments, which in recent years had become increasingly dependent on Medicaid funding. Other groups that became embroiled in the managed care debate included a right-to-life consumer group and health care providers. The outcome of the 1996 session was a requirement that the state obtain county board approval before implementing PMAP in a new area.

In the 1997 legislative session, the counties' role in Medicaid managed care was again a topic of discussion, and further adjustments were made. Under new legislation, counties must agree to managed care enrollment beginning on or before January 1, 1999. However, they may elect to use either PMAP or a county-based purchasing arrangement.

The MinnesotaCare Program

Another major health care initiative Minnesota has undertaken is the MinnesotaCare program, a subsidized

Table 3
Medicaid Enrollment and Expenditures per Enrollee: Contributions to Total Expenditure Growth

	Minnesota			United States		
		Average Annual Growth			Average Annual Growth	
	1995	1990–92	1992–95	1995	1990–92	1992–95
Elderly						
Total expenditures on benefits (millions)	$967.3	15.4%	9.8%	$40,087.4	16.7%	8.1%
Enrollment (thousands)	56.9	7.9%	1.6%	4,116.6	5.1%	3.0%
Expenditures per enrollee	$17,004	6.9%	8.1%	$9,738	11.0%	5.0%
Blind and Disabled						
Total expenditures on benefits (millions)	$1,011.2	11.3%	15.4%	$51,379.4	17.7%	12.9%
Enrollment (thousands)	69.5	9.5%	11.1%	6,405.2	9.8%	9.5%
Expenditures per enrollee	$14,550	1.6%	3.9%	$8,022	7.1%	3.1%
Adults						
Total expenditures on benefits (millions)	$239.8	15.4%	6.5%	$16,556.9	20.4%	9.2%
Enrollment (thousands)	122.3	13.0%	0.3%	9,584.2	11.5%	4.6%
Expenditures per enrollee	$1,960	2.1%	6.2%	$1,728	8.0%	4.4%
Children						
Total expenditures on benefits (millions)	$506.9	15.4%	17.6%	$25,410.9	24.3%	13.3%
Enrollment (thousands)	294.8	12.2%	2.5%	21,566.0	13.1%	4.8%
Expenditures per enrollee	$1,719	2.9%	14.8%	$1,178	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

health insurance program for uninsured families with children with incomes up to 275 percent of the FPL and individuals with incomes up to 175 percent of the FPL. The program was implemented in October 1992, and as of June 1997 it covered more than 100,000 low-income Minnesotans through managed care plans. The MinnesotaCare program is financed through taxes on health care providers and insurers, as well as enrollee premiums.

Insurance Reforms and the Market

MinnesotaCare legislation enacted in 1992 and 1994 included a range of private insurance reforms, the most important of which were small-group and individual insurance market reforms. Subsequently, insurance provision by small employers has increased, and annual changes in premiums have become less volatile. State officials warned, however, that the overall level of state regulation of insurance markets was causing some commercial insurers to leave the state and that competition among health plans, particularly in rural areas, could suffer as a result. It seemed unlikely that the state would pass further insurance reforms, as it was feared that additional regulation might drive more employers into the self-insured market. Fifty percent of the insurance market in the state is self-insured already and, thus, outside the boundaries of a number of state regulations.

A high degree of consolidation among health plans and providers has raised antitrust concerns. State policymakers recognize the potential gains in efficiency that could accompany market consolidation and restructuring. At the same time they appreciate that these savings may never be realized by consumers if there are too few sellers in the market. At present, the state is not moving to dismantle the consolidation that has already taken place. Rather, it is trying to prevent further health plan mergers among the largest plans and to regulate provider mergers through a process in which providers receive protection against antitrust prosecution in exchange for adhering to state-supervised standards.

Long-Term Care

Minnesota's long-term care program has not escaped the state's recent attempts to contain Medicaid cost growth. Short-run priorities for reforming long-term care involve system redesign: increasing the use of managed care, integrating long-term and acute care systems, decreasing administrative costs, changing pricing strategy for nursing home services, and increasing third-party revenues (i.e., Medicare and private insurance). The state's long-run strategy is "to define a new level of care expectation" for continuing care services among state residents. The state feels there is room to lower the level of care expectation, given the current generosity of its Medicaid program:

Minnesota's Medicaid spending per elderly and disabled enrollee is nearly double national levels.

The Public Health System

As in many states, the public health system in Minnesota has used Medicaid fee-for-service reimbursements to move beyond traditional public health functions into patient care. Now, as the state looks to managed care as a means of controlling Medicaid spending, public health agencies must contend with the ramifications. At the state level, a major strategy in dealing with the PMAP demonstration has been the Core Functions Initiative. This initiative seeks to refocus public health activities around traditional, population-based activities, such as environmental health and health promotion. At the local level, some health departments are moving away from patient care entirely, others are seeking collaborative arrangements with Medicaid managed care plans, and still others are trying to maintain their current role. Recent legislation enabling counties to establish Medicaid demonstrations called county-based purchasing models, rather than implement PMAP, should provide counties with more control over the financing and delivery of health care services.

Challenges for the Future

By almost any measure Minnesota's health care system is in good shape. The state has one of the lowest uninsured rates in the country. It has a strong tradition of caring for the poor and the disabled by supporting broad and generous public health care programs. It has also implemented reforms aimed at expanding private insurance coverage. Supporting this strong health care infrastructure is a sound state economy.

While Minnesota's health care challenges might not be as numerous or as formidable as those in other states, the state will probably need to address several major health care issues in the future. Because Minnesota has a history of being on the vanguard of health care policy, its handling of these matters will be watched closely.

Perhaps the most important issue is what the future holds for PMAP, the state's Section 1115 managed care demonstration project. Given that counties now have the authority to develop their own county-based purchasing models, it is possible that Minnesota could have many different Medicaid managed care strategies operating at once. If several counties opt to establish county models, this raises important questions about the continuity and effectiveness of Minnesota's Medicaid program.

The viability of safety net providers is yet another issue the state will confront in coming years. There are several changes taking place in the health care market that could affect such providers, the most important force being managed care. The Twin Cities already have a high HMO market penetration rate. This rate will likely increase in the future as employers continue to rely on managed care and as the state proceeds with its effort to enroll the publicly insured populations—currently covered by Medicaid, General Assistance, and MinnesotaCare—into managed care. Because of these trends, safety net providers will likely be increasingly pushed to compete with their private counterparts. In addition, providers will be forced to accept discounted payment rates, requiring them to seek savings. These changes may affect the quality and accessibility of care for the low-income population.

Another important challenge is whether Minnesota can successfully implement its long-term care redesign plans. In many respondents' opinions, these long-term care initiatives are critical to controlling Medicaid program costs both in the short and long terms, as Minnesota spends more than half of its Medicaid budget on long-term care. Implementing these long-term care initiatives, however, will require the state to contend with several powerful interest groups, including the nursing home industry and consumers.

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