Health Policy for Low-Income People in Minnesota

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The Urban Institute

State Reports

Assessing the New Federalism
An Urban Institute Program to Assess Changing Social Policies
Health Policy for Low-Income People in Minnesota

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This report is part of The Urban Institute’s *Assessing the New Federalism* project, a multi-year effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Project codirectors are Anna Kondratas and Alan Weil.

The project has received funding from the Annie E. Casey Foundation, the Henry J. Kaiser Family Foundation, the W. K. Kellogg Foundation, the John D. and Catherine T. MacArthur Foundation, the Commonwealth Fund, the Robert Wood Johnson Foundation, the McKnight Foundation, and the Fund for New Jersey. Additional funding is provided by the Joyce Foundation and the Lynde and Harry Bradley Foundation through a subcontract with the University of Wisconsin at Madison.

The authors would like to thank the many state, county, and local officials and others who participated in interviews and provided information. The views expressed are those of the authors and should not be attributed to The Urban Institute, its trustees, or its funders.
Assessing the New Federalism is a multi-year Urban Institute project designed to analyze the devolution of responsibility from the federal government to the states for health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments, along with changes in family well-being. The project aims to provide timely nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute’s Web site. This paper is one in a series of reports on the case studies conducted in the 13 states, home to half of the nation’s population. The 13 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. Two case studies were conducted in each state, one focusing on income support and social services, including employment and training programs, and the other on health programs. These 26 reports describe the policies and programs in place in the base year of this project, 1996. A second set of case studies to be prepared in 1998 or 1999 will describe how states reshape programs and policies in response to increased freedom to design social welfare and health programs to fit the needs of their low-income populations.

The income support and social services studies look at three broad areas. Basic income support for low-income families, which includes cash and near-cash programs such as Aid to Families with Dependent Children and Food Stamps, is one. The second area includes programs designed to lessen the
dependence of families on government-funded income support, such as educa-
tion and training programs, child care, and child support enforcement. Finally,
the reports describe what might be called the last-recourse safety net, which
includes child welfare, homeless programs, and other emergency services.

The health reports describe the entire context of health care provision for
the low-income population. They cover Medicaid and similar programs, state
policies regarding insurance, and the role of public hospitals and public health
programs.

In a study of the effects of shifting responsibilities from the federal to state
governments, one must start with an understanding of where states stand.
States have made highly varied decisions about how to structure their
programs. In addition, each state is working within its own context of private-
sector choices and political attitudes toward the role of government. Future
components of Assessing the New Federalism will include studies of the varia-
tion in policy choices made by different states.
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Minnesota has a long history of providing generous health care benefits to the poor. Proud of this tradition, the state supports a comprehensive Medicaid program that includes a rich set of benefits, liberal eligibility, and relatively generous provider payment. Overall it spends 57 percent more per Medicaid beneficiary than the national average. It also funds a generous General Assistance program and is one of a handful of states that sponsors a subsidized health insurance program for the low-income uninsured. Beyond these publicly financed health care programs, Minnesota has implemented several major reforms aimed at improving private insurance access and affordability.

Minnesota has been rewarded for its efforts: In terms of overall health status Minnesota is consistently ranked among the top states. It boasted the fourth-lowest rate of uninsurance among the nonelderly in the country at 9.2 percent in 1995. Employer-sponsored health care coverage was also high at 74 percent in 1995. The state enjoys low levels of hospital uncompensated care: Minnesota hospitals provide uncompensated care equal to 2.9 percent of their expenses, about half the national rate. Minnesota state agencies have generally good relations with both health care providers and insurers.

Summary of Findings

Health care has been a top priority on the state’s political—and spending—agenda for the past several years. Most prominently, in 1992 state legislators, in a bipartisan effort, enacted HealthRight—now called MinnesotaCare. Among other provisions 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 laws 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 ever since.

In the past two years, however, the state has retreated from some MinnesotaCare provisions. In 1995 legislation, for example, the state’s commitment to universal coverage was redefined as the goal of reducing the uninsured rate to 4 percent by January 2000. A variety of factors have 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 government control of health care and rely more on the market. However, the market has produced a high degree of consolidation among health plans and providers, which has raised antitrust concerns among state policymakers. The dilemma is that 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 but rather is trying to prevent further health plan mergers among the largest plans.

While the state is relying more on the market, it continues to be highly active in health care and is undertaking several important initiatives.

**Managed Care for Publicly Assisted Populations**

A key initiative is the statewide expansion of managed care for all publicly assisted populations, including Medicaid. In 1996 Minnesota began to expand its Prepaid Medical Assistance Project (PMAP)—a Section 1115 waiver demonstration that has operated in the Minneapolis and St. Paul metropolitan area since the mid-1980s—to areas outside the Twin Cities. The expansion, viewed largely as a cost-saving measure, was expected to be completed statewide by January 1997 but has been delayed. While Minnesota has substantial experience with managed care, it has encountered several difficulties in broadening PMAP.

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 state association representing Minnesota counties. Counties entered the debate because they saw a 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 in the managed care debate include a right-to-life consumer group and health care providers. The upshot of the 1996 session was that the state is now required to obtain county board approval before it can implement PMAP in a new area. The state has made some progress in extending the use of managed care in its Medicaid program but not nearly as much as it had hoped: By the end of 1996, PMAP was operating in only eight new counties.

In the 1997 legislative session the counties’ role in Medicaid managed care was again a topic of discussion, and further adjustments were made. In a negotiated agreement reached among the counties, the state Medicaid agency, and the state Department of Health, lawmakers enacted legislation that requires counties to agree to managed care enrollment beginning on or before January 1, 1999. Counties must elect to have either PMAP or a county-based purchasing arrangement. Counties that want to purchase or provide services must submit a proposal to the state by September 1, 1997.

**The MinnesotaCare Program**

Another major health care initiative is the MinnesotaCare program, a subsidized health insurance program for uninsured families with children with incomes up to 275 percent of the federal poverty level (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. The MinnesotaCare program is financed through taxes on health care providers and plans as well as enrollee premiums.

As of July 1996, MinnesotaCare had a $300 million surplus. While the MinnesotaCare program is generally viewed favorably, this surplus has stirred some controversy. Health care providers would like to cut back or repeal the tax, while advocates would like to use the surplus for other health-related purposes such as paying for seniors’ drugs or expanding program eligibility. The financing of MinnesotaCare surfaced as an important policy matter in the 1997 legislative session; legislation was passed expanding the MinnesotaCare program to include single adults with incomes up to 175 percent of the FPL. To deal with the program surplus, legislators also agreed to reduce the provider tax from 2 percent to 1.5 percent and eliminated a premium tax on health maintenance organizations (HMOs).

**Insurance Reforms**

The MinnesotaCare legislation included a range of reforms in insurance regulation, the most important of which were the small-group and individual insurance market reforms. State Department of Commerce officials felt that these reforms had been a success, especially in the small-group market. Insurance provision by small employers increased dramatically, and annual changes in premiums became less volatile. Department of Commerce officials warned, however, that the overall level of state regulation of insurance
markets was causing commercial insurers to leave the state and that competition among health plans in rural areas could suffer as a result. Commerce officials also believed that the state would not likely pass further insurance reforms. It was feared that additional regulation might drive more employers into the self-insured market. Already, 50 percent of the private insurance market in the state is self-insured.

**Long-Term Care**

Minnesota’s long-term care program has not escaped the state’s recent attempts to contain the growth of health care costs. 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 expectations for the level of care 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 Medicaid 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 entirely from patient care, others are seeking collaborative arrangements with the Medicaid managed care plans, and still others are trying to maintain their current role. Also, legislation enabling counties to contract directly with providers for their Medicaid and General Assistance populations recently passed. Counties hope that this approach will give them more control over both the financing and delivery of health care services.

**Other Safety Net Providers**

Safety net hospitals and community health centers in Hennepin County, the local site visited, are under little financial stress, as a result of a healthy economy and generous public programs. There is low demand for uncompensated care from hospitals, and health centers are less frequently sources of care for the poor than in other states. However, managed care is affecting safety net providers. The increasing dominance of managed care systems, along with the
emergence of hospital systems, is encouraging all hospitals to examine their costs and seek opportunities for savings. Similarly, the community health centers in Hennepin County are responding to managed care by forming a consortium called the Neighborhood Network to obtain greater bargaining power with managed care organizations, diversifying their funding base, and improving efficiency.
Introduction and Background

Minnesota has long been viewed as an innovative state with generous health care programs for its poor citizens. Long before most other states, Minnesota began to address rising health care costs and lack of access to health care. It has been rewarded for its efforts with a relatively low uninsurance rate, low levels of uncompensated care, a healthy population, and generally good relations between state agencies and both health care providers and insurers.

This report focuses on the development and implementation of health care policy in Minnesota in 1996. In addition to reviewing the development of state health care policies, this series provides a detailed look at one or more localities in each state to gain an understanding of how the policies are implemented and the effects the policies are having on health care providers, with a special focus on safety net providers. The local site in Minnesota is Hennepin County, the county where Minneapolis is located.

This study is based on documents and interviews with key persons in Minnesota. Interviews with state and local officials (from Hennepin County and the city of Minneapolis), legislators, health care providers, and advocacy organizations were conducted during two one-week site visits to Minnesota in mid-1996. Subsequent telephone interviews were also conducted. The state, providers, and others submitted additional documentation.

This report lays out the major issues, initiatives, and challenges in health care policy that faced Minnesota in the summer of 1996. After a brief background description of the state, the report describes the state’s current health
care agenda and gives some sense of prevailing attitudes among key health stakeholders. The report provides a detailed review of state health care programs and initiatives, with a special focus on Medicaid, and then delves into the specifics of Minnesota’s financing and delivery system, including discussions on managed care for the publicly assisted, provider payment issues, and the health care market. The report examines how state health policies are affecting the health care safety net (highlighting the experience in Hennepin County) and discusses state policies for the elderly and persons with disabilities. The report concludes with a discussion of what the future may hold for health care in Minnesota.

Sociodemographics

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 (table 1). One in nine Minnesotans—11.2 percent of the state’s population—has an income that falls below the federal poverty level (FPL), again about the same as in the rest of the nation. 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. The state, however, does have a sizable Native American population and a Southeast Asian community that is located largely in the Twin Cities of St. Paul and Minneapolis. More than half the state’s population resides in the seven-county metropolitan area including and surrounding the cities of St. Paul and Minneapolis. Beyond the Twin Cities, the state has only a few urban centers, including Duluth, Rochester, and Moorhead. Compared with the rest of the nation, a large share of Minnesotans (about 30 percent) live in rural areas.

Health Status and Health Care Indicators

Minnesota has one of the lowest uninsured rates in the country. In 1995, the state’s percentage of uninsured—9.2 percent—was the fourth-lowest in the United States. A number of factors contribute to Minnesota’s relatively high insurance rate: a relatively generous Medicaid program, a large subsidized state health insurance program, and a high rate of coverage by employer-based health insurance. Recent rankings place Minnesota at the top of all states in terms of overall health status. A 1996 analysis by ReliaStar indicates that for the fourth time in the past seven years, Minnesota ranked “healthiest” in the nation based on a number of public health indicators, including infant mortality and incidence of coronary heart disease and AIDS.

Economic Indicators

Like much of the rest of the country, Minnesota currently boasts a strong economy. Unemployment is lower than the national average (4.0 percent in 1996 versus 5.4 percent for the nation). Per capita income in 1995 was $23,971, about the same as that for the United States. Growth in per capita income between 1990 and 1995, however, was slightly higher in Minnesota than in the rest of the nation (23.7 percent versus 21.2 percent).
### Table 1 Key State Characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Minnesota</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sociodemographic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population (1994–95)* (in thousands)</td>
<td>4,551</td>
<td>260,202</td>
</tr>
<tr>
<td>Percent under 18 (1994–95)*</td>
<td>27.7%</td>
<td>26.8%</td>
</tr>
<tr>
<td>Percent 65+ (1994–95)*</td>
<td>10.6%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Percent Hispanic (1994–95)*</td>
<td>1.8%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Percent Non-Hispanic Black (1994–95)*</td>
<td>3.3%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Percent Non-Hispanic White (1994–95)*</td>
<td>92.6%</td>
<td>72.6%</td>
</tr>
<tr>
<td>Percent Non-Hispanic Other (1994–95)*</td>
<td>2.3%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Percent Noncitizen Immigrant (1996)*</td>
<td>3.0%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Population Growth (1990-95)*</td>
<td>28.1%</td>
<td>21.8%</td>
</tr>
<tr>
<td><strong>Economic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Capita Income (1995)*</td>
<td>$23,971</td>
<td>$23,208</td>
</tr>
<tr>
<td>Percent Change in Per Capita Income (1990-95)*</td>
<td>23.7%</td>
<td>21.2%</td>
</tr>
<tr>
<td>Percent Change in Personal Income (1990-95)*</td>
<td>30.0%</td>
<td>27.7%</td>
</tr>
<tr>
<td>Employment Rate (1996)*</td>
<td>71.7%</td>
<td>63.2%</td>
</tr>
<tr>
<td>Unemployment Rate (1996)*</td>
<td>4.0%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Percent below Poverty (1994)*</td>
<td>11.2%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Percent Children below Poverty (1994)*</td>
<td>14.8%</td>
<td>21.7%</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent Uninsured—Nonelderly (1994–95)*</td>
<td>9.2%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Percent Medicaid—Nonelderly (1994–95)*</td>
<td>7.2%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Percent Employer Sponsored—Nonelderly (1994–95)*</td>
<td>73.5%</td>
<td>66.1%</td>
</tr>
<tr>
<td>Percent Other Health Insurance—Nonelderly (1994–95)*</td>
<td>10.1%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Smokers among Adult Population (1993)*</td>
<td>22.4%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Low-Birth-Weight Births (&lt;2,500 g) (1994)*</td>
<td>5.7%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)*</td>
<td>6.4</td>
<td>7.6</td>
</tr>
<tr>
<td>Premature Death Rate (Years Lost per 1,000) (1993)*</td>
<td>39.4</td>
<td>54.4</td>
</tr>
<tr>
<td>Violent Crimes per 100,000 (1995)*</td>
<td>356.1</td>
<td>684.6</td>
</tr>
<tr>
<td>AIDS Cases Reported per 100,000 (1995)*</td>
<td>8.0</td>
<td>27.8</td>
</tr>
<tr>
<td><strong>Political</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governor’s Affiliation (1996)*</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Party Control of Senate (Upper Chamber) (1996)*</td>
<td>42D-24R-1U</td>
<td></td>
</tr>
<tr>
<td>Party Control of House (Lower Chamber) (1996)*</td>
<td>70D-64R</td>
<td></td>
</tr>
</tbody>
</table>

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e. Personal contributions for social insurance are not included in personal income.


f. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.

g. CPS three-year average (March 1994–March 1996 where 1994 is the center year) edited using the Urban Institute’s TRIM2 microsimulation model.

h. “Other” includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.


n. Race-adjusted data, National Center for Health Statistics, 1993 data.


Political Overview

Minnesota is served by Republican Governor Arne Carlson, who has held the office since 1990. Carlson has announced that he will not seek reelection when his term expires in 1998. The state legislature has two chambers, the House and the Senate, both of which are controlled by Democrats. The Democrats have dominated the state legislature almost continuously since the early 1970s. Both chambers of the legislature were up for election in 1996. In the House, Democrats gained one seat during the 1996 election and now have 70 members, compared to 64 Republicans. In the Senate, Democrats hold 42 seats, Republicans, 24, and Independents, 1. Although Democrats have long held the majority in both the House and Senate, their margin has been declining in recent years. Indeed, until the 1996 election, the Democrats had been losing seats.

While Minnesota’s economy has had relatively stable growth throughout the 1990s, there was a potential substantial budget shortfall in the early 1990s, soon after Governor Carlson took office. The governor and the legislature worked together to avert the shortfall, and since that time the state has not faced a major budget crisis. Like many other states, Minnesota has not passed a significant general tax increase in recent years. It seems that not raising taxes is a shared commitment of the governor and the legislature.

During Governor Carlson’s tenure, the one major spending initiative was the 1992 implementation of the MinnesotaCare program, the state-sponsored subsidized health insurance program (see below). The program is financed by a tax on health care providers, a premium tax on HMOs and Blue Cross-Blue Shield, and beneficiary premiums. Although Carlson worked closely with the legislature on passage of the 1992 MinnesotaCare legislation and continues to support the program, he has recently focused his efforts on education reform and intends to work on improving public education during his last two years in office.

State Budget Overview

Reflecting the robust economy, Minnesota’s budget is sound and enjoys a healthy surplus. An indicator of the state’s strong fiscal health is that when creating the 1996–97 budget in 1995, the legislature had a beginning balance of about $900 million out of a two-year general fund budget of $15.8 billion. The additional funds were available because the state and national economies performed better than projected. This performance resulted in higher revenues and lower-than-expected human service expenditures. In 1996 the state recorded another surplus. These additional funds have enabled Minnesota to fully fund its cash flow account as well as establish a budget reserve account. The reserve fund, which was initiated by Governor Carlson, was intended to prepare the state for federal budget reductions.¹

State expenditures for Medicaid in 1995 totaled $1.4 billion, 15 percent of overall state spending (table 2). Among the major budget sectors—Medicaid, corrections, primary and secondary education, higher education, and Aid to
Families with Dependent Children (AFDC)—Medicaid was the third-largest budget item, behind primary and secondary education and higher education. Over the past several years, spending for Medicaid has been growing faster than overall state spending: Between 1990 and 1995, state Medicaid spending grew on average 14.9 percent per year, whereas overall state expenditures grew 6.9 percent per year. Average annual spending increases for AFDC and corrections were high as well—15.0 percent and 13.9 percent, respectively.

When state and federal expenditures are included—as shown in the second panel of table 2—the patterns shift: Spending for Medicaid is the second-largest budget item, consuming nearly 20 percent of the total budget. Increases in spending for corrections and Medicaid were the fastest growing budget sectors between 1990 and 1995, growing an average of more than 13 percent each year and outpacing spending increases for education.

### Table 2 Minnesota Spending by Category, 1990 and 1995 ($ in Millions)

<table>
<thead>
<tr>
<th>Program</th>
<th>State General-Fund Expenditures*</th>
<th>Total Expendituresb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$6,352</td>
<td>$8,872</td>
</tr>
<tr>
<td>Medicaidc,d</td>
<td>676</td>
<td>1,354</td>
</tr>
<tr>
<td>% of Total</td>
<td>(10.6)</td>
<td>(15.3)</td>
</tr>
<tr>
<td>Corrections</td>
<td>127</td>
<td>243</td>
</tr>
<tr>
<td>% of Total</td>
<td>(2.0)</td>
<td>(2.7)</td>
</tr>
<tr>
<td>K-12 Education</td>
<td>1,702</td>
<td>2,817</td>
</tr>
<tr>
<td>% of Total</td>
<td>(26.8)</td>
<td>(31.8)</td>
</tr>
<tr>
<td>AFDC</td>
<td>67</td>
<td>135</td>
</tr>
<tr>
<td>% of Total</td>
<td>(1.1)</td>
<td>(1.5)</td>
</tr>
<tr>
<td>Higher Education</td>
<td>1,264</td>
<td>1,465</td>
</tr>
<tr>
<td>% of Total</td>
<td>(19.9)</td>
<td>(16.5)</td>
</tr>
<tr>
<td>Miscellaneous*</td>
<td>2,516</td>
<td>2,858</td>
</tr>
<tr>
<td>% of Total</td>
<td>(39.6)</td>
<td>(32.2)</td>
</tr>
</tbody>
</table>


a. State spending refers to general fund expenditures plus other state fund spending for K–12 education.
b. Total spending for each category includes the general fund, other state funds, 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. Minnesota did not report these provider payments to NASBO.
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 includes all remaining state expenditures (e.g., environmental projects, transportation, housing, and other cash assistance programs) not captured in the five listed categories.
Setting the Policy Context

Overview of State’s Health Care Agenda

Throughout the 1990s, health care has been a top priority on Minnesota’s political agenda. Most prominently, in 1992 the state enacted the HealthRight legislation—now called MinnesotaCare—that called for sweeping changes to how health care was delivered and financed in the state. The provisions included in MinnesotaCare have set and shaped the health care policy debate in the state for the past several years.

MinnesotaCare is actually a series of laws enacted in 1992, 1993, 1994, and 1995. The initial legislation—enacted through a bipartisan agreement among legislators and the governor—was the direct descendant of the state’s Children’s Health Plan (CHP), which had provided health insurance to low-income pregnant women and children since 1988. The MinnesotaCare laws have two main goals: to broaden access to health care and to contain the increase in health care costs. To achieve these goals, the legislation included many elements: cost-containment measures, health insurance reforms, and provisions aimed at expanding access to the uninsured. Table 3 highlights the principal components of MinnesotaCare.

The laws were far-reaching, touching virtually every dimension of health care delivery and financing. The legislation created a subsidized health insurance program—also called MinnesotaCare—for the low-income population. It also mandated that all publicly funded populations be shifted to managed care. The laws also included insurance reform for employers with fewer than 30 workers, as well as individuals, and cost-containment provisions including state and regional health care spending targets.
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<tbody>
<tr>
<td><strong>MinnesotaCare</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Subsidized Insurance Program</strong></td>
<td>• MinnesotaCare subsidized insurance for families with children up to 275% of the FPL, established through an expansion of Minnesota Children’s Health Plan. Eligibility phased in over time. Financed by a cigarette tax, revenue taxes on hospitals and other providers, a premium tax on health plans, and enrollee premiums</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td>• Required state to develop a plan for covering all publicly assisted populations through managed care</td>
<td>• State to develop a plan to integrate MA, GAMC, and MinnesotaCare</td>
<td>• State to develop a plan to integrate MA, GAMC, and MinnesotaCare</td>
<td></td>
</tr>
<tr>
<td><strong>Insurance Reform (See table 7 for more details.)</strong></td>
<td>• For employers with 2 to 29 workers, small group insurance reforms included: health plans refusing to issue or renew policies; limits on time that preexisting conditions may be excluded from coverage; and higher minimum loss ratios phased in over time</td>
<td>• Universal coverage guaranteed by Jan. 1, 1997</td>
<td>• Small group expanded to include employers with 2 to 49 workers</td>
<td>• Universal coverage goal repealed; goal redefined as 4% uninsured by 2000</td>
</tr>
<tr>
<td></td>
<td>• Established a small employer insurance product</td>
<td></td>
<td>• Ban on gender rating extended to all policies</td>
<td>• Plans for community rating by 1997 repealed</td>
</tr>
<tr>
<td></td>
<td>• Created a state-sponsored voluntary purchasing pool for small employers</td>
<td></td>
<td>• Serving the publicly assisted made a condition of HMO licensure</td>
<td>• Individual mandate not legislated</td>
</tr>
<tr>
<td></td>
<td>• Individual insurance reforms included: a restriction on health plans refusing to renew policies; limits on time that preexisting conditions may be excluded from coverage; and higher minimum loss ratios phased in over time</td>
<td></td>
<td>• Requirement that individuals have insurance coverage to be legislated in 1995</td>
<td>• Standard benefit set not legislated</td>
</tr>
<tr>
<td>Market</td>
<td>Rural Health Care</td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
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</tr>
<tr>
<td>• Set goal of limiting state health expenditure growth rate to 10% per year</td>
<td>• Rural Health Advisory Council established</td>
<td>• Created Minnesota Health Care Commission (MHCC), to develop a cost-containment plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Established antitrust immunity process in which the state allows health care mergers that are judged efficient despite anti-competitive effects</td>
<td>• Expanded role of Office of Rural Health</td>
<td>• Minnesota Health Care Commission’s cost-containment plan legislated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Growth limits on health expenditures for providers and health plans</td>
<td>• Grants made for rural hospitals</td>
<td>• Minnesota Health Data Institute established</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Integrated Service Networks (ISNs)* in force by 1996</td>
<td>• Established loan forgiveness for physicians in rural practice</td>
<td>• Rural Health Advisory Council established</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Regulated All-Payer Option (RAPO)* in force by 1996</td>
<td>• Mandated 20% increase in primary care physician graduates from University of Minnesota</td>
<td>• Six health care regions established within state</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Antitrust immunity further defined</td>
<td>• Ban on Medicare balance billing</td>
<td>• Ban on Medicare balance billing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• All health plans (not staff-model HMOs or CISNs) required to offer an Expanded Provider Network for an additional premium, effective Jan. 1, 1995</td>
<td>• Expanded summer health intern program</td>
<td>• Public health provisions—Commissioner of Health must define core public health functions, allocate responsibility, and set minimum outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health plans may not require providers to sign exclusive contracts</td>
<td>• Loans and technical assistance for Community ISNs</td>
<td>• Managed care organizations must include plan for public health in action plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Voluntary private sector purchasing pools authorized</td>
<td>• Grants to establish rural Community health centers</td>
<td>• Members added to MHCC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Community ISNs’ authorized, effective Jan. 1, 1995</td>
<td></td>
<td>• Administrative simplification (e.g., uniform claims forms for all health care providers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provider and purchaser cooperatives authorized</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ISN and RAPO implementation delayed to 1997</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mergers prohibited among large health plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• RAPO repealed</td>
<td></td>
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</tr>
</tbody>
</table>


* a. Some of the provisions have been updated since 1995. For example, the MinnesotaCare program was expanded in 1997 to include childless adults with incomes up to 175% of the FPL.
   b. MA—Medical Assistance, the state’s Medicaid program.
   c. GAMC—General Assistance Medical Care, the health care portion of the state’s income support program for the indigent.
   d. Integrated Service Networks are health plans that are networks of providers, local governments, purchasers, insurers and/or HMOs that provide a full range of acute and preventive services to enrollees for a predetermined capitated premium. ISNs would compete against one another for enrollees, would serve publicly assisted populations, and would improve community health. Designed as a cost-containment measure, ISNs were envisioned as delivering virtually all health care services to all persons statewide by the late 1990s.
   e. The Regulated All-Payer Option is a physician fee schedule that was designed to control the costs of health care services delivered outside of the ISNs. All payers would pay the same state-set rates to physicians who did not join ISNs. Utilization rates were also limited.
   f. Community ISNs are rural networks that provide prepaid health services to no more than 50,000 enrollees. CISNs were designed to allow local providers, governments, etc., to organize before large ISNs entered the market. CISNs operate under modified HMO requirements.
Table 3 also illustrates that the policies included in MinnesotaCare laws are far from static. State legislators have amended and continue to amend the laws. Most revisions have called for the state to back away from some of the reforms mandated in the initial legislation. In the 1995 MinnesotaCare legislation, for example, the state’s commitment to universal coverage was redefined as 96 percent rather than 100 percent. In addition, plans for community rating of insurance were repealed as part of the 1995 legislation, as was the Regulated All-Payer Option (RAPO), which would have regulated payment rates to physicians not in health maintenance organizations (HMOs) or integrated service networks (ISNs).

A variety of factors have contributed to the state’s reversal of major parts of MinnesotaCare. One is that health reform failed at the national level, diminishing the need to implement state reforms. Another is that health care spending increases have moderated as compared with the early 1990s, so the pressure to contain costs has decreased. Another factor is that the political atmosphere in Minnesota has changed substantially, causing the state to move away from government involvement in health care and rely more on the market. Some of this shift in thinking is motivated by policymakers’ concern that if the government plays too large a role, it may run the risk of diminishing individuals’ personal responsibility.

Nonetheless, the state is still undertaking several important health care initiatives and reforms. MinnesotaCare, the subsidized insurance program, has been implemented and provides health insurance to more than 100,000 Minnesotans. Another significant—and somewhat controversial—initiative is that the state is expanding managed care for all publicly assisted populations, including Medicaid. The state is also implementing the Minnesota Senior Health Options (MSHO) demonstration, which seeks to integrate acute and long-term care systems for the population enrolled in both Medicare and Medicaid.

The state has also recently implemented several insurance and market reforms, many of which were embodied in the MinnesotaCare legislation. Some address how insurance companies issue health policies, including mandating participating companies to offer policies to all small employers as well as guaranteeing insurance renewability and limiting preexisting conditions exclusions. Other reforms deal with how premiums are set and what portion of premiums insurers must pay in health care claims. Still others are aimed at improving consumers’ ability to buy insurance. For example, the state recently established a consumer purchasing cooperative to help small employers secure health care coverage for their employees.

Assessing the New Federalism: Potential State Responses to Additional Flexibility and Reduced Federal Funding

The MinnesotaCare legislation is emblematic of the state’s long history of providing generous benefits to its poor and disabled. Among those interviewed, there was a strong sense of pride about this tradition. Some concern was
expressed about the state possibly being a “welfare magnet.” Respondents were well aware of the charges that Minnesota attracts people because of its comprehensive social services programs, and of the jokes about its generosity (“Moneyapolis”). In recent years, policymakers have become more worried about the immigration of people—the disabled population—to Minnesota seeking social benefits and have adopted some provisions designed to stem the influx. For example, the 1996 legislature passed a law requiring a one-month waiting period before Medicaid benefits can be obtained.

If Minnesota were a magnet, many felt it would be one for welfare, not health care. It seems that officials make a distinction between those two: It is acceptable to move to Minnesota for health care but not for welfare.

While the state is proud of its public programs, it is willing to change them if given the opportunity. For example, as the U.S. Congress debated overhauling the Medicaid program in 1995, the state spent much time considering the effects of federal reforms and devising strategies to address potential changes. According to Department of Human Services officials, all areas of health policy in Minnesota were opened to discussion and change. As one respondent put it, “Everything was on the table.” The department assumed the attitude that there were no sacred cows.

When considering various alternatives, the department was deeply concerned about how the federal government would rewrite the Medicaid rules. If the federal government wrote them so that the Medicaid program would be significantly cut, Minnesota would have been in a difficult position both politically and financially.

As part of its discussions, the department considered a number of cost-saving strategies. The state’s priorities were as follows: Minnesota would first try to save money by making delivery systems more efficient and cost-effective by moving all publicly assisted persons into managed care. If more savings were needed, the state would seek to change benefits. One idea was to make the Medicaid benefit package akin to what is offered to state employees. The rationale behind this strategy was that most Medicaid clients do not need all the services offered by the program and require only a package that addresses basic health care needs. The third level of programmatic changes contemplated was program eligibility. Specifically, the state considered adjusting the program limits so that standards would be consistent across all covered populations. For example, the state might cover everybody below 100 percent of the FPL. Other eligibility changes considered were introducing a premium and an asset test.
State Health Insurance Programs and Initiatives

Overview of State Health Insurance Programs and Insurance Initiatives

Minnesota’s principal health care programs are administered by two departments—the Department of Human Services (DHS) and the Department of Health (MDH). DHS is responsible for the bulk of direct-service health programs, including Medicaid, General Assistance Medical Care, and the MinnesotaCare program. In addition, DHS oversees programs that provide substance abuse and mental health services as well as programs that serve the developmentally disabled.

MDH comprises two main bureaus—the Bureau of Health Protection and the Health Systems and Special Populations Bureau (HSSPB). Environmental health, disease prevention and control, public health laboratory, and finance and administration fall under the purview of the Bureau of Health Protection; family health services, community health services, health policy and systems compliance, and facility and provider compliance are the responsibility of HSSPB. The latter administers several federal block grant programs such as Women, Infants, and Children (WIC), Maternal and Child Health (MCH), and the Preventive Health and Health Services (PHHS) programs. It also oversees the state-run Community Health Services (CHS) program, which provides subsidies to local public health departments to carry out a range of activities including family health, health promotion, and home health care.
At the local level, Minnesota’s 87 county human service agencies play a large role in both administering the state’s health programs and providing direct services. For example, the county welfare office is responsible for conducting Medicaid eligibility determinations and enrolling clients in managed care plans, if the county is participating in the state’s managed care demonstration. Counties also run several MDH programs including WIC and MCH as well as the state CHS program.

Beyond publicly funded health programs, Minnesota has several initiatives aimed at expanding health insurance coverage in the private market, such as small-group and individual insurance reforms and purchasing cooperatives. Many of these efforts, a great number of which were included in the MinnesotaCare legislation, are developed and administered by the Department of Commerce. In the next sections we discuss Minnesota’s key health programs and insurance initiatives, with a special focus on Medicaid.

The Medicaid Program
Overview of Medical Assistance

Minnesota’s largest publicly financed health care program is Medicaid, called Medical Assistance or MA. The Minnesota MA program covered nearly 550,000 individuals in 1995 at a cost of about $3 billion. MA is a comprehensive insurance program with both a broad set of benefits and liberal eligibility policies. MA offers many Medicaid optional benefits, and medically needy recipients receive the same benefit package as the categorically needy. Minnesota is substantially more generous in its eligibility for Medicaid than the average state: In 1994, its MA program covered 55 percent of the nonelderly whose income was below the FPL, compared with 46 percent for Medicaid programs nationally. The maximum allowed income for AFDC as a percentage of poverty in 1994 was 51.8 percent in Minnesota versus 41.9 percent for the nation. Through a 1902(r)(2) expansion adopted in 1993, MA extends coverage to pregnant women and infants less than two years old in families whose income is below 275 percent of the FPL. MA also has a generous medically needy program: The maximum income allowed for the medically needy program is 65 percent of the FPL for Minnesota compared with 48 percent nationally. In addition to having liberal income standards, MA imposes no asset limits on families and children.

Some medical providers are paid well under the MA program, compared with other states. Inpatient hospital payments for Medicaid patients not in managed care are made under a diagnosis-related-group (DRG) system in which rates are based on hospital-specific costs. State officials believe they are paying hospitals, on average, 113 percent of costs. Nursing homes are paid under a system in which rates are equal for public and private payers. Because of the generosity of the payment rates, the state has been successful in averting going to court over payment rates. In 1996, however, nursing homes did sue the state, claim-
ing that Minnesota did not have a bona fide “Boren methodology” for setting rates. Eventually the nursing homes dropped the suit without going to trial.

**Expenditure and Enrollment Trends: 1990–95**

Compared with other states, Medicaid expenditure growth in Minnesota was relatively modest in the early 1990s. Between 1990 and 1992, for example, Medicaid expenditures grew an average of 15.3 percent each year in Minnesota versus 27.1 percent for the nation (table 4). Minnesota's lower rate may be attributable both to the fact that the economic recession of the early 1990s did not hit the state as hard as it did the rest of the country, and to the state's limited use of the Medicaid disproportionate share hospital (DSH) program. While table 4 shows that Minnesota's DSH expenditures grew 121 percent each year between 1990 and 1992, they accounted for a relatively small share—2 percent in 1992—of the state's overall Medicaid program spending. By contrast, DSH payments for all states grew more than 250 percent per year between 1990 and 1992, and in 1992 accounted for nearly 15 percent of overall spending.

During the 1992–95 period, Minnesota's Medicaid expenditure growth averaged 12.3 percent each year, somewhat higher than the national average of 9.9 percent. However, for technical reasons, the 12.3 rate overstates Minnesota's expenditure growth. In state fiscal year 1995, Minnesota made advance payments of $238 million to providers as it moved to a new Medicaid management information system. If these advance payments are netted out from 1995 expenditures, Minnesota's Medicaid spending growth during the 1992–95 period is in keeping with national trends.

Minnesota's slower spending growth in 1992–95 compared with 1990–92 is primarily attributable to a deceleration in spending for long-term care: Between 1990 and 1992 long-term care spending grew 13 percent per year, whereas between 1992 and 1995 spending growth dropped to 9 percent per year. At the same time, annual spending growth for acute care increased. Between 1990 and 1992, expenditures for acute care grew 15.5 percent each year, while between 1992 and 1995 they grew 18.9 percent each year. Reflecting the accelerated growth in acute care, spending on the disabled and children—typically high users of acute care—grew faster in Minnesota than in the rest of the country.

Table 4 also highlights the fact that Minnesota—compared with other states—spends a large share of its Medicaid budget on long-term care. In 1995, 57 percent of Minnesota's Medicaid expenditures on benefits went to pay for long-term care services, whereas the national average was 40 percent. By contrast, 43 percent of Minnesota's Medicaid spending was for acute care, while nationally 60 percent of Medicaid funds went to pay for such care. Minnesota also differs from the rest of the country in how spending is distributed among eligibility groups. Most prominently, 35 percent of Minnesota's Medicaid funds in 1995 went for services for the elderly. Nationally, 30 percent of Medicaid funds went for services for the elderly.
### Table 4: Medicaid Expenditures by Eligibility Group and Type of Service, Minnesota and United States ($ in Millions)

<table>
<thead>
<tr>
<th></th>
<th>Expenditures</th>
<th>Average Annual Growth</th>
<th>Expenditures</th>
<th>Average Annual Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>$1,541.7</td>
<td>$2,050.9</td>
<td>$2,905.7</td>
<td>15.3%</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits by Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Care</td>
<td>$1,463.7</td>
<td>$1,899.1</td>
<td>$2,725.1</td>
<td>13.9%</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>939.4</td>
<td>1,199.9</td>
<td>1,549.1</td>
<td>13.0%</td>
</tr>
<tr>
<td>Benefits by Group</td>
<td>$1,463.7</td>
<td>$1,899.1</td>
<td>$2,725.1</td>
<td>13.9%</td>
</tr>
<tr>
<td>Elderly</td>
<td>$548.5</td>
<td>$730.3</td>
<td>$967.3</td>
<td>15.4%</td>
</tr>
<tr>
<td>Acute Care</td>
<td>64.4</td>
<td>73.7</td>
<td>95.5</td>
<td>7.0%</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>484.0</td>
<td>656.6</td>
<td>871.8</td>
<td>16.5%</td>
</tr>
<tr>
<td>Blind and Disabled</td>
<td>$531.8</td>
<td>$658.5</td>
<td>$1,011.2</td>
<td>11.3%</td>
</tr>
<tr>
<td>Acute Care</td>
<td>121.9</td>
<td>173.1</td>
<td>380.9</td>
<td>19.2%</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>410.0</td>
<td>485.4</td>
<td>630.3</td>
<td>8.8%</td>
</tr>
<tr>
<td>Adults</td>
<td>$149.3</td>
<td>$198.6</td>
<td>$239.8</td>
<td>15.4%</td>
</tr>
<tr>
<td>Children</td>
<td>$234.1</td>
<td>$311.7</td>
<td>$506.9</td>
<td>15.4%</td>
</tr>
<tr>
<td>DSH</td>
<td>$8.6</td>
<td>$42.0</td>
<td>$24.2</td>
<td>121.0%</td>
</tr>
<tr>
<td>Administration</td>
<td>$69.4</td>
<td>$109.7</td>
<td>$156.3</td>
<td>25.7%</td>
</tr>
</tbody>
</table>

*Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.*
As mentioned earlier, Minnesota has a relatively generous Medicaid program in terms of services and provider payments. This generosity is reflected in how much Minnesota spends per Medicaid enrollee (table 5). In 1995 Minnesota spent an average of $5,014 per enrollee, versus $3,202 for the country. Spending differences are particularly dramatic for the elderly and disabled. For the elderly, Minnesota spent $17,004 per enrollee in 1995, versus the national average of $9,738; for the disabled, Minnesota spent $14,550 per enrollee, versus the national average of $8,022. Spending on adults and children was also higher in Minnesota than in other states.

Many of these expenditure differences are attributed to the generous benefit package provided by Minnesota’s MA program. In addition, the state has historically paid its providers, particularly nursing homes, generously. The per-enrollee expenditure differences also reflect Minnesota’s greater reliance on institutional care, especially nursing homes. Nationally, Minnesota ranks among the states having the highest number of nursing home beds per capita. The state also has a high rate of nursing home use: About 7.6 percent of elderly Minnesotans live in nursing homes, whereas nationally the rate is only about 5 percent.

Between 1992 and 1995, Minnesota experienced a 2.8 percent annual growth in its Medicaid enrollment, about half the rate of the country as a whole (table 6). This lower growth rate is attributed in part to a deceleration in enrollment growth for the AFDC adult population. In Minnesota the number of AFDC adults enrolling in Medicaid declined by 5.1 percent per year between 1992 and 1995, whereas nationally the growth rate remained slightly positive. Slower enrollment increases for children and the elderly also contributed to Minnesota’s lower-than-average enrollment growth during the 1992–95 period.

The remaining discussion on Medicaid in this section deals primarily with issues related to families and children. The elderly and disabled are discussed later in this report.

Recent Medicaid Eligibility Policies

Minnesota has adopted two major eligibility changes in recent years. The first was a Section 1902(r)(2) expansion in 1993 that increased the Medicaid eligibility threshold to 275 percent of the FPL for pregnant women and infants less than two years old (no asset test is given). The other relates to the state’s Section 1115 waiver program. Specifically, Minnesota is now receiving Medicaid federal financial participation (FFP) for children below age 21 who are enrolled in the MinnesotaCare program. The expansion population is estimated at 68,000 children statewide. (See the section directly below for more detail on this eligibility change.) Other than these two changes, the state has not enacted any major eligibility policies—including eligibility cuts—in recent years. The 1997 legislative session, however, did introduce an asset test for pregnant women with minor children: this population will now be subject to a $3,000 limit on nonexempt assets.
Table 5  Medicaid Expenditures per Enrollee by Eligibility Group, Minnesota and United States

<table>
<thead>
<tr>
<th></th>
<th>Minnesota</th>
<th>United States</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Spending per</td>
<td>Average Annual</td>
<td>Spending per</td>
<td>Average Annual</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enrollee</td>
<td>Growth</td>
<td>Enrollee</td>
<td>Growth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$3,643</td>
<td>$3,794</td>
<td>$5,014</td>
<td>2.1%</td>
<td>9.7%</td>
<td>$2,397</td>
</tr>
<tr>
<td>By Group</td>
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</tr>
<tr>
<td>Elderly</td>
<td>$11,762</td>
<td>$13,448</td>
<td>$17,004</td>
<td>6.9%</td>
<td>8.1%</td>
<td>$6,839</td>
</tr>
<tr>
<td>Cash</td>
<td>5,783</td>
<td>6,024</td>
<td>5,999</td>
<td>2.1%</td>
<td>-0.1%</td>
<td>3,329</td>
</tr>
<tr>
<td>Noncash</td>
<td>13,628</td>
<td>15,648</td>
<td>20,235</td>
<td>7.2%</td>
<td>8.9%</td>
<td>10,377</td>
</tr>
<tr>
<td>Blind and Disabled</td>
<td>$12,567</td>
<td>$12,979</td>
<td>$14,550</td>
<td>1.6%</td>
<td>3.9%</td>
<td>$6,378</td>
</tr>
<tr>
<td>Cash</td>
<td>9,819</td>
<td>10,600</td>
<td>13,212</td>
<td>3.9%</td>
<td>7.6%</td>
<td>4,969</td>
</tr>
<tr>
<td>Noncash</td>
<td>18,076</td>
<td>18,401</td>
<td>16,827</td>
<td>0.9%</td>
<td>-2.9%</td>
<td>12,047</td>
</tr>
<tr>
<td>Adults</td>
<td>$1,571</td>
<td>$1,637</td>
<td>$1,960</td>
<td>2.1%</td>
<td>6.2%</td>
<td>$1,301</td>
</tr>
<tr>
<td>Children</td>
<td>$1,075</td>
<td>$1,137</td>
<td>$1,719</td>
<td>2.9%</td>
<td>14.8%</td>
<td>$770</td>
</tr>
</tbody>
</table>

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>401.8</td>
<td>500.5</td>
<td>543.6</td>
<td>11.6%</td>
<td>2.8%</td>
<td>28,856.7</td>
<td>35,765.1</td>
<td>41,672.0</td>
<td>11.3%</td>
<td>5.2%</td>
</tr>
<tr>
<td><strong>Elderly</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3,412.2</td>
<td>1,713.1</td>
</tr>
<tr>
<td>Cash</td>
<td>46.6</td>
<td>54.3</td>
<td>56.9</td>
<td>7.9%</td>
<td>1.6%</td>
<td>1,713.1</td>
<td>2,031.8</td>
<td>2,327.3</td>
<td>0.8%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Noncash</td>
<td>11.1</td>
<td>12.4</td>
<td>12.9</td>
<td>5.8%</td>
<td>1.3%</td>
<td>1,699.1</td>
<td>2,083.8</td>
<td>2,429.8</td>
<td>4.1%</td>
<td>4.6%</td>
</tr>
<tr>
<td><strong>Cash</strong></td>
<td>35.5</td>
<td>41.9</td>
<td>44.0</td>
<td>8.6%</td>
<td>1.6%</td>
<td>4,040.9</td>
<td>5,159.8</td>
<td>6,405.2</td>
<td>9.8%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Noncash</td>
<td>42.1</td>
<td>50.7</td>
<td>69.5</td>
<td>9.5%</td>
<td>11.1%</td>
<td>3,236.8</td>
<td>3,853.4</td>
<td>4,973.5</td>
<td>9.1%</td>
<td>8.9%</td>
</tr>
<tr>
<td><strong>Blind and Disabled</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>804.1</td>
<td>1,021.7</td>
</tr>
<tr>
<td>Cash</td>
<td>28.2</td>
<td>35.3</td>
<td>43.8</td>
<td>11.8%</td>
<td>7.5%</td>
<td>6,738.7</td>
<td>8,373.3</td>
<td>9,584.2</td>
<td>12.7%</td>
<td>11.9%</td>
</tr>
<tr>
<td>Noncash</td>
<td>14.1</td>
<td>15.5</td>
<td>25.7</td>
<td>4.8%</td>
<td>18.5%</td>
<td>4,651.6</td>
<td>5,342.5</td>
<td>5,441.4</td>
<td>7.2%</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>Adults</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>120.4</td>
<td>137.3</td>
</tr>
<tr>
<td>Cash</td>
<td>95.0</td>
<td>121.3</td>
<td>122.3</td>
<td>13.0%</td>
<td>0.3%</td>
<td>3,204.9</td>
<td>3,657.8</td>
<td>3,768.7</td>
<td>11.5%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Noncash</td>
<td>71.8</td>
<td>98.6</td>
<td>108.6</td>
<td>22.9%</td>
<td>4.3%</td>
<td>4,718.7</td>
<td>7,463.9</td>
<td>10,251.4</td>
<td>25.8%</td>
<td>11.2%</td>
</tr>
</tbody>
</table>

Source: The Urban Institute, 1997. Based on HCFA 2082 data.
PMAP Section 1115 Demonstration

Minnesota has operated a Section 1115 demonstration for families and children since 1985. The Prepaid Medical Assistance Program (PMAP) was one of the five original Section 1115 Medicaid competition demonstrations and has operated continuously as a demonstration since the 1980s. The goals of the demonstration are to control public expenditures, promote competition in the health care marketplace, and improve access to care.

When PMAP began it mandated virtually the entire Medicaid population in three counties—including most aged, blind, and disabled persons as well as the AFDC-related population—to enroll in capitated managed care plans. After the first year, though, the blind and disabled were disenrolled from the demonstration and have since been served on a fee-for-service basis. By 1994, PMAP had expanded into five other counties in the Twin Cities area.

In 1995 Minnesota received another Section 1115 waiver that gave the state the authority to expand the PMAP demonstration statewide. Beginning in January 1996, PMAP enrollment began in eight counties in the northeastern and central regions of the state. This represented the state’s first major effort to extend PMAP to locations outside the Twin Cities area. State Medicaid officials had hoped to move the entire Medicaid population (except for the blind and disabled and a few other exempt groups) into managed care by 1997. The state has encountered some difficulties, however, in its PMAP expansion effort (see section on Financing and Delivery System).

The new Section 1115 waiver, granted in April 1995, includes an eligibility expansion, as mentioned in the section above: Minnesota receives Medicaid FFP for children under age 21 who qualify for the MinnesotaCare program. (The state had previously received FFP for part of this population because some of the children were already eligible for Medicaid through other eligibility categories or expansions.) Although Minnesota is receiving FFP for the expansion population, Medicaid eligibility has not been formally extended to the group. Indeed, the expansion population is required to enroll in the MinnesotaCare program. Although not served by the MA program, the expansion group is provided the full Medicaid benefit package rather than the more restrictive benefits offered under the MinnesotaCare program.

An interesting feature of the waiver is that some children now have the option of joining either Medicaid or the MinnesotaCare program. Specifically, children who were covered by Medicaid before the 1995 waiver—for example, children between one and five years old whose families have incomes below 133 percent of the FPL—can now enroll in either program. The waiver includes a similar option for pregnant women: To improve continuity between Medicaid and MinnesotaCare, the Section 1115 waiver expanded MinnesotaCare so that pregnant women whose incomes are below 275 percent of the FPL now have the option of enrolling in MinnesotaCare. Before the 1995 PMAP waiver, this
population was required to enroll in MA. Again, whatever program the women select, the state earns FFP.

**Welfare Reform and Medicaid Eligibility for Families and Children**

Under the new federal welfare program, Temporary Assistance to Needy Families (TANF), the 1997 Minnesota legislature voted to replace AFDC with its welfare waiver project—Minnesota Family Investment Program, or MFIP. Generally following the federal defaults for Medicaid eligibility under TANF, Minnesota will implement MFIP statewide—with some modifications. Started in 1994, MFIP was operating in seven counties in 1996. The goals of MFIP include reducing poverty and supporting work. The program has generous earned-income disregard and encourages mutual responsibility through a time-triggered work requirement.

**Welfare Reform and Medicaid Eligibility for Immigrants**

In the 1997 session, Minnesota legislators also adopted a number of comparatively generous immigrant health care provisions in response to the 1996 federal welfare law. In general the state accepted the federal defaults for immigrants’ Medicaid eligibility. For example, it will continue to cover legal noncitizens who were living in the country before August 22, 1996. For any legal noncitizen admitted to the United States after that date, Medicaid benefits will be provided after the person has lived in the country for five years.

In addition, the state enacted several important provisions designed to provide health care to immigrants using state funds. Specifically, the state plans to use state funds to provide a Medicaid “wraparound” for newly arriving qualified noncitizens for five years from their date of entry into the United States while they are barred from federally financed Medicaid by the new welfare law. This state-only program is offered with the provision that the noncitizen must cooperate with the Immigration and Naturalization Service to pursue a change in immigrant status, including citizenship, that would qualify the person for Medicaid with FFP.

The 1997 Minnesota legislature also adopted a provision that qualifies certain pregnant noncitizens, who are undocumented, for state-funded health care coverage, which would provide services through pregnancy and 60 days postpartum. Labor and delivery services are excluded, as they would be reimbursed under the emergency-only Medicaid benefit.

**Other Publicly Funded Health Programs**

**General Assistance Medical Care**

Since 1973 Minnesota has operated a General Assistance Medical Care (GAMC) program. It is a state-funded program that covers acute health care for Minnesota residents who are not categorically eligible for MA but who
meet income and asset requirements comparable to the MA medically needy standards. For the most part, the state views MA and GAMC as being the same program. In fact, state officials generally refer to the programs as MA/GAMC. GAMC clients are enrolled in the same managed care plans as the MA population and are being phased into managed care at the same time as MA clients.

To qualify for GAMC, a household must have income not in excess of 120 percent of AFDC eligibility maximums and have no more than $1,000 in household assets. The GAMC eligibility standards also allow generous disregards for work income. The one recent eligibility change to the program was made in 1993, when about 1,000 undocumented aliens were dropped from the rolls.

In 1995, GAMC served about 51,000 Minnesotans, but between 1993 and 1995 enrollment decreased by 20 percent. This trend is expected to continue through 1997. As with MA, state officials cited the strong economy and the introduction of the MinnesotaCare program as the key factors contributing to decreased enrollment. In addition, the eligibility change mentioned above contributed to the enrollment drop.

**The MinnesotaCare Program**

MinnesotaCare, formerly the Children’s Health Plan, is a state-subsidized health insurance program providing limited health insurance benefits to uninsured families and single adults who meet income and other eligibility guidelines. As mentioned above, it was established under the 1992 MinnesotaCare law.

Implemented in October 1992, the program is funded by a provider tax, enrollee premiums and copayments, and, until recently, a premium tax on HMOs. Taxes and client premiums are placed in a MinnesotaCare-dedicated program fund called the Health Care Access Fund (HCAF), which is used to finance the program. Monthly premiums are based on family size and income. In 1997, an asset limit was established—$30,000 total net assets for a household of two or more and $15,000 for a household of one. Previously no asset test was used in determining eligibility. In addition to premiums, enrollees are charged copayments. For adults, copayments are required on some services such as prescription eyeglasses and drugs. Adults are also subject to a 10 percent copayment on inpatient hospital care and a $10,000 annual benefit limit for hospital care. As discussed above, pregnant women and children (up to age 21) receive the full Medicaid benefit package as part of the 1995 Section 1115 waiver, so they are not subject to many of the benefit limits or copayments mentioned above.

In addition to income criteria, eligibility criteria include having had no access to employer-sponsored health insurance for the past 18 months, being uninsured for the previous 4 months, and living in the state for at least 6
months prior to application. Note that eligibility criteria for children (defined as between ages 1 and 17) are different from those for adults. For example, the 4-month uninsured and 18-month employer access rules do not apply to children.

According to state officials, 90 percent of the MinnesotaCare population is below 200 percent of the FPL, and two-thirds are under 150 percent of the FPL. Over half are children, and two-thirds of MinnesotaCare participants live outside the Twin Cities area. This strong rural presence is attributed to the lesser availability of employer-sponsored insurance in “greater” or rural Minnesota as compared with the Twin Cities metropolitan area. As of June 1997, 100,000 Minnesotans were enrolled in MinnesotaCare.

Until recently MinnesotaCare enrollees were served on a fee-for-service basis, but beginning in July 1996 they started to be enrolled into mandatory managed care programs. This change is being phased in and began with the Twin Cities area. Statewide managed care for the MinnesotaCare population was completed in spring 1997.

There are several issues surrounding the MinnesotaCare program. Some of them are political: The Republicans’ agenda calls for repealing the MinnesotaCare program. While the governor is committed to the program, some Republicans are opposed to it because they feel it is a government intrusion into the private market, whereas others are against subsidized insurance programs or the way the program is financed.

Supporters of the program, by contrast, herald it as a major reason for the state’s declining AFDC enrollment. According to DHS estimates, there are 13,700 fewer recipients (about 4,100 families) on AFDC than there would have been without MinnesotaCare. This translates into a total of $2.7 million in annual AFDC and Medicaid savings (federal and state). Accounting for the $700,000 in MinnesotaCare subsidies funded by the state, the net savings is estimated at $2 million.

Other MinnesotaCare issues include the surplus in HCAF, which totaled about $300 million in July 1996. Two main factors have contributed to the surplus. First, the cost of serving families with children who enrolled in the program was lower than expected because of lower-than-predicted utilization rates. Second, adults without children have been enrolling at lower-than-expected rates. Use of the surplus has ignited much debate. In the 1996 legislative session, some provider groups (medical specialists and dentists, in particular) called for reducing or repealing the provider tax, or increasing provider payment rates under MinnesotaCare. These groups are particularly opposed to the tax because they treat MinnesotaCare patients less frequently than do primary care doctors, so they derive fewer benefits from the program. Other stakeholders wanted to use HCAF funds for other health-related purposes such as paying for seniors’ drugs, expanding program eligibility, or funding potential federal Medicaid cutbacks.
Another issue involves program eligibility. In 1996, both houses of the legislature passed a bill allowing MinnesotaCare to expand coverage to single adults with incomes up to 150 percent of the FPL; it had been at 125 percent. Despite his support for the program, the governor vetoed the measure because he did not want to shift the focus of the program from children, the original target population. This action increased the furor over the HCAF surplus. Although the program has a large surplus, the governor vetoed a bill that would have spent some of it. In an administrative move, the governor bumped eligibility up to 135 percent of the FPL for childless adults, funding permitting.

In the 1997 legislative session, the HCAF surplus was again a topic of debate. With the support of the governor, lawmakers adopted two key changes to the MinnesotaCare program to address the issue. First, the program was expanded to include single adults whose incomes were below 175 percent of the FPL, an increase from the 135 percent level in 1996. Second, the provider tax was reduced from 2 percent to 1.5 percent for at least two years. If the HCAF continues to have a positive balance, the reduction can continue. Third, the one percent tax on HMOs was eliminated for at least two years. Fourth, as mentioned earlier, an asset requirement was established.

**Minnesota Comprehensive Health Association**

Minnesota also sponsors a high-risk insurance pool called the Minnesota Comprehensive Health Association (MCHA). Established in 1976, MCHA is the nation’s oldest high-risk pool and subsidizes health insurance for individuals who cannot obtain coverage from other sources. Minnesotans are eligible to purchase MCHA coverage if they meet the following requirements: have lived in the state for at least six months and have been refused coverage or had an offer of coverage at higher than the standard premium or have been treated within the past three years for at least one of the “presumptive conditions” (e.g., AIDS, chemical dependency, stroke, or cystic fibrosis) listed in the authorizing statute.

MCHA is financed by enrollee premiums and by assessments on all insurers. Premiums are limited to 125 percent of the standard commercial premium for an average individual. MCHA’s enrollment has decreased from a peak in 1993 of 35,000 to a 1995 level of about 29,000. State officials suggested that the enrollment decline was due to health insurance reforms that have been adopted as part of the overall MinnesotaCare legislation (see next section).

While MCHA has extended coverage to many otherwise uninsurable Minnesotans, the pool is facing a financing crisis. State officials said that MCHA posted a roughly $36 million deficit in 1996, partly because of the cap on premiums for individuals insured through the pool. Premiums cover only 52 percent of MCHA’s costs, leaving 48 percent to be covered by assessments on health plans. The deficit has been growing each year. The state has recommended finding a broader assessment base to fund the pool. For example, one
proposal is to use some of the surplus funds in the HCAF, which finances the
MinnesotaCare program, to supplement other MCHA funding sources. In fact,
in the 1997 legislative session, this strategy was adopted: About $15 million
from the HCAF will be used to close the MCHA funding gap.

Insurance Reform Initiatives

The 1992 MinnesotaCare law contained several provisions aimed at reforming
the private health insurance markets. The intent of these reforms was to
expand access to health insurance coverage, make coverage more affordable,
and help the state reach its goal of reducing the uninsured rate to 4 percent by
January 1, 2000, a centerpiece of MinnesotaCare. The insurance reforms
included in MinnesotaCare laws took a variety of forms.

Table 7 highlights some of the key reforms of the small-group and individual
insurance markets and places them in three groups—rules of issue, premium
ing rating restrictions, and other. The rules-of-issue reforms in the small-group mar-
ket included provisions that prevent health insurance companies from refusing
to issue coverage (“guaranteed issue”) or to renew coverage (“guaranteed
renewability”) to small employers. Individuals, by contrast, were guaranteed
only renewability, not issuance, of an insurance policy. The law also contained
limits on exclusions of preexisting conditions: Health insurance companies may
not refuse to cover preexisting conditions for longer than 12 months. This pro-
vision was adopted for both small-group employers and individuals.

MinnesotaCare also addressed how insurance companies set premiums. The
original MinnesotaCare law called for community rating to take effect by 1997.
However, this provision was repealed by the state legislature in 1995. Now
MinnesotaCare limits how far above or below their base premium insurers can
set rates for small employers and individuals. These ranges are called “rate
bands.” Insurers are allowed to adjust premiums based on factors such as age
and geography. Premium differences based on the actual claims histories of
the insured are prohibited.

Another important premium provision included in MinnesotaCare estab-
lished “minimum-loss ratios” for health insurance companies. Under this pro-
vision, insurers, by law, must pay a minimum amount in health care benefits
to insured customers relative to what insurers receive in premiums. This pro-
vision limits how much an insurer can keep as profit or to pay administrative
costs. Minimum-loss ratios were set separately for the small-employer market
and the individual market. In the 1997 legislative session, some changes were
made to these minimum loss standards. Specifically, for insurers with less than
3 percent of the market, provisions eliminated phase-in of loss ratios and
instead sets loss ratios for these companies at 68 percent for the individual mar-
ket, 71 percent for employers with 2 to 9 employees, and 75 percent for employ-
ers with 10 to 49 employees.
Effects of Insurance Reforms

Department of Commerce officials believe that the small-group reforms have been a success. Based on a 1994 survey, the department estimated that the small-group insurance reforms had increased the share of workers in small firms who had employer-sponsored health insurance by as much as 12 per-

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**Table 7**

*Highlights of MinnesotaCare Insurance Reforms*

<table>
<thead>
<tr>
<th>MinnesotaCare Reform Provision</th>
<th>Small Group (2–49)</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rules of Issue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limits on Preexisting Condition Exclusions</td>
<td>1992 law: 12-month waiting period for conditions diagnosed or treated six months prior to initiation of new policy.</td>
<td>1992 law: 12-month waiting period for conditions diagnosed or treated six months prior to initiation of new policy.</td>
</tr>
<tr>
<td>Portability</td>
<td>Insurers must waive preexisting condition exclusions if the insured had 30 days of continuous coverage under a prior policy.</td>
<td></td>
</tr>
<tr>
<td>Guaranteed Renewability</td>
<td>1992 law mandated that insurers cannot refuse to renew a policy.</td>
<td>1992 law mandated that insurers cannot refuse to renew a policy.</td>
</tr>
<tr>
<td>Guaranteed Issue</td>
<td>1992 law stated that insurers must offer policies to any interested small group; no coverage requirements are generally specified.</td>
<td>No provision.</td>
</tr>
<tr>
<td><strong>Premium Rating Restrictions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate Bands/Adjusted Community Rating</td>
<td>1995 law repealed plans for community rating by 1997.</td>
<td>1992 law: adjustments allowed for age, geography, and other factors. Bands will be phased in over time.</td>
</tr>
<tr>
<td>Minimum Loss Ratio</td>
<td>1992, 1993 laws mandated that minimum loss ratio will be 82%.</td>
<td>1992, 1993 laws mandated that minimum loss ratio of premiums to losses is set at 66% in 1994. Will increase 1% per year, reaching 72% in 2000.</td>
</tr>
<tr>
<td><strong>Other Insurance Market Reforms</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-Risk Pools</td>
<td>Premiums capped at 125% over standard premium for persons enrolled in Minnesota Comprehensive Health Association (MCHA), the state-run, high-risk pool.</td>
<td></td>
</tr>
<tr>
<td>Purchasing Cooperatives</td>
<td>Established the Minnesota Employees Insurance Program (MEIP), a small-business purchasing cooperative.</td>
<td></td>
</tr>
</tbody>
</table>

cent. This is consistent with national trends that show increases in small-employers’ probability of offering insurance when small-group reforms are instituted (Jensen and Morrisey 1996). The department also credited the newly established premium rate bands with helping to stabilize annual fluctuations in health insurance premiums.

While the small-group reforms have been viewed as effective in expanding employee coverage, they have caused the number of insurance carriers issuing policies to small employers to drop substantially: Forty-three percent of insurance carriers that served small groups in 1992 had left that market by 1994. This exodus was attributed in large part to the MinnesotaCare insurance reforms, particularly the minimum-loss ratios. Some of our respondents, including Department of Commerce officials, felt that insurance availability has become a problem in rural areas.

Department of Commerce officials felt that the state would not pass further insurance market reforms. It was feared that additional regulation might drive more employers into the self-insured market. Already, 50 percent of the insurance market in the state is self-insured. As a result, when government programs are taken into account, state regulations apply to only about one-third of the overall health insurance market. Further erosion of the state’s ability to regulate insurance was seen as undesirable.
Financing and
Delivery System

Changes in the Health Care Market

Health Plans

Minnesota was one of the early pioneers of managed care. HMOs began developing in earnest in the state in the early 1970s and have been steadily gaining market share in both the private and public sectors ever since. Statewide data for 1994 show that about 30 percent of the population was enrolled in HMOs. In addition, more than 40 percent was enrolled in preferred provider organizations (PPOs). However, managed care has not developed uniformly throughout the state. Rural areas have not experienced nearly the same managed care penetration as the Twin Cities. While 43 percent of the Twin Cities population was in HMOs in 1995, other regions in Minnesota averaged only an 8 percent HMO penetration rate (Baumgarten 1996). Unlike most other states, Minnesota’s health plans, by law, are nonprofit. This characteristic, coupled with the high HMO penetration rate, fundamentally shapes the health care market in Minnesota.

The growth in managed care has proceeded hand in hand with consolidation among health plans. The health plan market in Minnesota is dominated by three large health plans: Medica (part of the Allina Health System), Blue Cross and Blue Shield of Minnesota (BCBSM), and HealthPartners. In 1993, these three plans accounted for more than 90 percent of HMO enrollment and 78 percent of managed care enrollment (which includes PPOs), and collected 72 percent of all fully insured premium revenue statewide, according to state estimates (Minnesota Department of Health 1995b). BCBSM dominates in rural
areas, with 65 percent of the HMO market in these areas, whereas Medica and HealthPartners dominate the seven-county Minneapolis–St. Paul area, with almost 90 percent of its HMO market (Baumgarten 1996).

Out of concern over this degree of consolidation in the health plan market, in 1994 the state’s attorney general sought and received a legislative moratorium on mergers among the three largest health plans in the state. The moratorium was set to expire in 1997, but the attorney general was planning to seek an extension as of July 1996. The state hospital association indicated that the original moratorium proposed a ban on mergers among the existing hospital systems as well, a ban the association opposed and had removed from the legislation.

Provider Markets

In both the hospital and physician markets, independent providers have largely disappeared, particularly among hospitals in the Twin Cities. Hospital consolidations and closures began in the 1980s in response to the increasing bargaining power of HMOs and the low prices HMOs demanded (Christianson et al. 1995). In the metropolitan area, consolidation of the hospital market has resulted in three large hospital systems—Allina, HealthEast, and Fairview—that account for 64.5 percent of inpatient days (Baumgarten 1996). Statewide, hospital systems own 58 percent of staffed beds in urban counties and 17 percent of staffed beds in nonurban areas. Most nonurban areas have only one hospital, typically independent.

Physicians are also highly consolidated compared with other regions of the country. In 1993, 95 percent of Minnesota physicians were in a group practice (Minnesota Department of Health 1995b). This figure represents a 37 percent increase compared with 1979. There is some evidence that practices are being bought by HMOs and hospitals as well as merging with other practices. Affiliations among practices that do not involve a merger of assets, called “clinics without walls,” are also on the rise. The state listed six such organizations in 1995 (Minnesota Department of Health 1995b). Dentists, on the other hand, have remained mostly in solo or very small group practices.

Regulation of Mergers and Acquisitions

Mergers and consolidations are assessed for antitrust violations by the attorney general’s office. Mergers of hospitals or health plans proceed unchallenged unless the attorney general feels the merger poses an anticompetitive threat. Concerns over anticompetitive pricing behavior are more prominent than concerns over the impact that mergers might have on access to care. An attorney general’s official reported that once mergers are allowed to proceed, they are not formally monitored. Instead, the office relies on the informal intelligence of the media and other health care contacts (including competitors) to identify anticompetitive activities that might not have been anticipated.
Between 1992 and 1997, Minnesota’s Department of Health offered merging entities antitrust immunity. Immunity, if granted, required that the state regulate and monitor the activities of the merged entity, which must accept regulation as the price of being allowed to merge despite detrimental competitive effects. However, antitrust immunity is rarely sought. For example, the attorney general encouraged the parties involved in negotiating the 1996 merger of the University of Minnesota Hospital into Fairview Health Systems to apply for antitrust immunity through the Commissioner of Health. Fairview and University officials declined to undergo the antitrust immunity process because of the additional reporting requirements involved, and the merger will proceed without state oversight (Scott 1996). In the 1997 legislative session, the antitrust immunity process was repealed.

The Role of Large Purchasers

Purchasing groups wield considerable power in the state. The two most influential are the State Employees Insurance Program (SEIP) and the Buyers Health Care Action Group (BHCAG), a consortium of large self-insured employers. SEIP influenced the market through a change in its purchasing practices. After experiencing an average premium increase of 42 percent in 1989, SEIP moved to a strategy of funding the entire premium cost only for the lowest cost plan offered to employees. As employees moved to the low-cost plan, plans began to lower prices in order to maintain or gain enrollees. In 1990, the rate of annual growth in premiums fell to 13.7 percent. The growth rate continued to decline steadily, and by 1995, SEIP saw premiums actually decrease by 1.7 percent.

In 1993 BHCAG, acting as a purchasing cooperative for 22 large, self-insured employers, began soliciting health plan bids and offering a health plan to its members. It represents 400,000 employees, retirees, and dependents from these firms. Businesses in BHCAG are encouraged to offer other plans in addition to the BHCAG plan, so only about 40 percent of eligible persons were enrolled in the BHCAG plan as of November 1994 (Minnesota Department of Health 1995b). BHCAG differed from other group purchasing efforts in that it mandated that plans develop practice parameters, provider standards, and outcomes measures for quality and cost-effectiveness. Desire for BHCAG business also fueled price competition among health plans. Now, BHCAG may again lead marketplace change by putting out a new request for proposals for direct contracts between its self-insured employers and provider networks, called “care systems.” Care systems provide a standard benefit set to all BHCAG members, while being paid on a fee-for-service basis up to an expenditure target (Baumgarten 1996).

According to officials at the Department of Employee Relations, which administers the state employee health plan, SEIP recently joined BHCAG and is exploring ways to include the state public-assistance populations in a group purchasing arrangement. Combining these populations would enhance the buyers’ market power by creating a group that would represent about 25 percent of the state’s health insurance market.
Medicaid Disproportionate Share Hospital (DSH) Payments

Even before the federal government began promoting the creation of Medicaid DSH in the middle and late 1980s, Minnesota had the Disproportionate Population Adjustment (DPA). The DPA serves the same role as other states’ DSH programs; that is, it increases payments to hospitals that provide a large amount of care to low-income populations. Under 1996 federal rules, Minnesota is categorized as a low-DSH state, with a $64 million limit on DPA. However, the state spends only about $50 million to $55 million on the DPA program. About half of the DPA payments are distributed to hospitals as add-ons to payment rates. In addition to augmenting DRG rates paid for Medicaid patients, lump-sum DPA payments are made to two hospitals: Hennepin County Medical Center and the University of Minnesota Hospital receive about half of Minnesota’s DPA through this mechanism.

The DPA program did not change as a result of federal DSH laws that were passed as part of the Omnibus Budget Reconciliation Acts (OBRA) of 1991 and 1993. In 1991, when federal officials started limiting DSH, some Minnesota legislators wanted to institute the more aggressive forms of provider taxes designed to increase federal Medicaid matching payments and create an expanded DPA program. However, unlike other states, Minnesota made a deliberate decision not to enter the DSH “game.” The Department of Human Services opposed expanding DPA on the grounds that (1) the state was getting into the DSH program too late and (2) payment rates would have to be set too high to distribute the DPA money back to providers as add-ons to their Medicaid rates. Hospitals also opposed setting up a provider-tax program, because they believed that taxes might not be returned. Several respondents suggested that exploiting the DSH loophole more than the state did was against the Minnesota way—“We are always up front in Minnesota.” The state preferred not to take the risk of a disallowance by the federal government.

The distribution of DPA payments was somewhat complicated by the introduction of Medicaid managed care (PMAP) in Hennepin County in July 1990. During the first two years of PMAP, DPA money was distributed directly to hospitals on a “per discharge” basis. However, as managed care has grown, distributing DPA payments directly to hospitals for Medicaid managed care recipients has decreased. Instead, in July 1992, the state began adjusting capitation rates paid to health plans so that they include DPA (and graduate medical education) payments for hospitals. Each plan’s rates are adjusted based on which hospitals it uses to treat its patients. According to state officials, DPA is allowed to “trickle down” to the hospitals from the health plans. In the 1997 legislative session, however, a provision was adopted that carves out medical education payments from PMAP rates. These payments will now be distributed from a newly established medical education trust fund.
Boren Amendment Issues and Provider Payment Generosity

Hospitals

The state has a very positive view of its hospital payment system for Medicaid patients not in managed care plans. On average, the state believes it is paying hospitals generously at 113 percent of costs. Hospitals concurred that they were satisfied with Medicaid rates for inpatient services. In fact, one state official would welcome a Boren amendment suit on hospital payment to demonstrate the generosity of the inpatient payment system. However, officials admitted that outpatient payment is less generous. This characterization was generally supported by the hospitals interviewed. The state felt that if federal action led to pressure to control Medicaid spending, inpatient rates would probably come down.

Nursing Homes

The state maintains a nursing home payment system in which rates are equalized across public and private payers. The consensus observed among the then-Medicaid director, a state legislator, and a nursing home association was that the threat of a Boren amendment suit (or, possibly, a pending suit) was preventing the state from reducing nursing home rates. The Medicaid director asserted that current rates were, on average, above costs and characterized this situation as inefficient and a major barrier to further reform of long-term care. The legislator contended that the Boren amendment forced the state to grant inflation adjustments to nursing homes, hospitals, and intermediate care facilities for the mentally retarded (ICFs/MR) at a time when state employees often had to go without cost-of-living adjustments.

One state nursing home believed that if the Boren amendment were repealed and the state attempted to reduce payments significantly, issues surrounding “costly” quality assurance requirements or service coverage would arise. This association believed that for-profit facilities, in response to reduced payments, would either drop out of the Medicaid program altogether or create welfare-only branches. If the Boren amendment remained intact, the association claimed that nursing homes would have a viable lawsuit at some point.

Other Providers

The Boren amendment was also cited as a factor affecting rates paid to ICFs/MR. However, when home care providers sued the state in an attempt to force it to apply the Boren amendment to their rates, they lost the suit.

Managed Care for Publicly Assisted Populations

Minnesota has substantial experience with Medicaid managed care. As described earlier, in 1985 the state received its first Section 1115 waiver to operate the Prepaid Medical Assistance Project in selected counties in the Twin
Cities area. PMAP has operated continuously as a demonstration ever since. The AFDC populations and the elderly are served under PMAP while the disabled continue to be served on a fee-for-service basis.

As mandated in the MinnesotaCare laws, the Department of Human Services is currently expanding its managed care efforts by requiring all three of its publicly assisted populations (Medicaid, GAMC, and MinnesotaCare) to enroll in managed care. State officials view the expansion of managed care as a way to save public dollars. It is also hoped that managed care will improve health care access for the Medicaid population. To expand managed care, Minnesota applied for another Section 1115 waiver requesting authority to expand PMAP statewide and to enroll the blind and disabled in one county. Movement into managed care began in February 1996 with expansion into eight new counties (five in the northeastern part of the state near Duluth and three near the St. Cloud area). Expansion statewide was expected to be completed by January 1997 but has been delayed because of opposition from some counties and other politically active opponents of managed care (discussed below). As of July 1996, about 155,000 Medicaid clients were enrolled in PMAP, about 36 percent of the total Medicaid population.

Plan Participation and Plan Types

Both types of commercial managed care plans—mainstream plans and plans dedicated predominantly to Medicaid clients—have participated in the PMAP program. Currently, no health plans are operating in Minnesota that do not enroll Medicaid clients. As of July 1996, the state had eight contractors for MA/GAMC populations and eight for MinnesotaCare. In many counties, the same plans serve both populations. According to DHS officials, the state has not had trouble recruiting plans to participate in PMAP.

The state has, however, had some trouble recruiting health plans to participate in MinnesotaCare. The biggest problem has been that the plans view the MinnesotaCare capitation rate as too low. In 1996, the MinnesotaCare rate was less than half the base rate for MA/GAMC, in part because MinnesotaCare provides for a very limited hospital benefit. Since plans make money by keeping people out of hospitals, the opportunities to hold expenditures below the capitation rates are more limited in MinnesotaCare than in Medicaid.

To encourage plans to serve the MinnesotaCare population, the state has employed several strategies. First, the state has told plans that if they want a PMAP contract (which is generally viewed as financially desirable), they have to sign a MinnesotaCare contract (which is generally viewed as undesirable). Second, the state has encouraged plan participation in unpopular areas by suggesting that it would withhold plans’ rights to serve more desirable areas. For example, if a plan wants to serve the Twin Cities area, the state might also require the plan to serve a rural area.
Yet another state tactic to recruit plans to participate is enforcing state Rule 101. This rule, included in the MinnesotaCare legislation, requires providers and health plans to serve Medicaid, GAMC, and MinnesotaCare patients as a condition of doing business with other financially attractive state health programs—such as the state employees’ health plan, the workers’ compensation system, and plans offered to city, county, and school-district employees. As of July 1996, state officials had not applied the Rule 101 provision to either providers or health plans. However, the provision itself may pose enough of a threat to encourage providers to participate.

One geographic area where the state has had problems in securing plan participation in MinnesotaCare (and has considered invoking Rule 101) is in Olmstead County, where the Mayo Clinic is located. In the view of DHS, Mayo submitted an unacceptable contract proposal that was not executed in “good faith.” The state has considered the options of dropping the Mayo Clinic’s HMO license or canceling the HMO’s contracts with school district employees in its area. In fact, the Department of Health, which has responsibility for HMO licensure, sent a letter to the Mayo Health Plan informing it that its HMO license may be in jeopardy.

As mentioned above, as of July 1996 Minnesota had eight contractors for PMAP and eight for MinnesotaCare. For PMAP, one plan serves only the Medicaid population—Itasca County Medical Care (IMCare). IMCare is operated by a rural county directly north of the Twin Cities area. IMCare operates as an unlicensed health insuring organization. (Itasca County was one of the original three PMAP counties and has been caring for Medicaid clients since 1985.)

Two other plans serve principally the Medicaid population—UniversityCare (UCare) and Metropolitan Health Plan (MHP). UCare is operated by the University of Minnesota Hospital and was developed exclusively to serve the MA/GAMC population when the PMAP demonstration began in the mid-1980s. In July 1996, UCare started serving the MinnesotaCare population when it was enrolled in managed care. MHP, operated by Hennepin County Medical Center, is 90 percent Medicaid. Like IMCare and UCare, it started when the PMAP demonstration began in 1985. In addition to MA/GAMC, MHP started to serve MinnesotaCare clients in July 1996.

**Setting Capitation Rates**

DHS pays a capitation rate each month to the health plans that covers all Medicaid services except home and community-based services, nursing facility services, and ICF/MR services. Clients are assigned to rate cells based on several factors, including age, sex, Medicare eligibility, institutional residence, and county of residence. The last factor is divided into three cells—Hennepin County, other metropolitan counties, and nonmetropolitan counties. In general, each plan is paid the same amount for a client in a given rate cell.
Historically, Minnesota has set its capitation rates to reflect past costs in the fee-for-service sector. However, capitation rates have always been set below the fee-for-service per capita cost to reflect the expectation of savings from managed care. Savings are legislated at 10 percent for families with children and 5 percent for the elderly.

Perhaps the biggest issue surrounding capitation rates is how to set rates for Medicaid/GAMC clients who live in rural areas. Based on the above methodology, DHS initially recommended that rates in the nonmetropolitan areas be set at 50 percent of the metropolitan rates. Rural counties—particularly those in the northeastern part of the state that were the first PMAP expansion area under the new Section 1115 waiver—revolted. Led by northeastern counties, rural counties banded together and went to the legislature to appeal the 50 percent rate. In 1995 they negotiated that rural rates be legislatively set at 85 percent of the metropolitan rates, not including Hennepin County. (The rural base rate is about three-quarters of Hennepin’s rate.) Many view the rural payment issue as far from settled.

The state realizes that as it continues to expand its Medicaid/GAMC enrollment in managed care, it will lose the fee-for-service data that it needs to set capitation rates according to its current methodology. Two alternatives are being considered. First, DHS is discussing the possibility of negotiating capitation rates in conjunction with SEIP through the Department of Employer Relations. The theory behind this association is that DHS would be able to negotiate better rates because it would be part of a larger book of business. Second, the state is revisiting the possibility of a competitive bidding model for the MA/GAMC population. The state tried such an approach with the MinnesotaCare population and it was a failure: Health plans came back with bids much higher than the state had expected. Eventually, the state abandoned competitive bidding and set rates for MinnesotaCare. At the same time, the state is trying to develop a risk-adjustment method. Under such a strategy, the state envisions, for example, that if one plan enrolled a sicker population, plans with healthier populations would be required to transfer part of the capitation payment to the plan that experienced adverse selection.

**Resistance to Medicaid Managed Care**

While the state had intended to expand PMAP statewide and test managed care for the disabled, these plans were scuttled during the 1996 legislative session. Several advocacy groups successfully lobbied the legislature to delay the expansion of PMAP and to eliminate the proposed managed care pilots for the disabled. Two leading advocacy groups involved in the lobbying were the Association of Minnesota Counties and Minnesota Citizens Concerned for Life (MCCL), one of the state’s right-to-life groups. Other lobbying groups included the Mental Health Association and Legal Services. Minnesota counties entered the managed care debate because they saw a highly diminished role for themselves in the health care system if public health dollars were shifted to managed care organizations and away from county health departments.
MCCL opposed the PMAP expansion because the group equated managed care with rationing of health care, which in turn constitutes involuntary euthanasia (Lalonde 1996). MCCL became involved in state health policy debates in the 1992 legislative session, in which it opposed provisions in the MinnesotaCare legislation that called for growth limits on health care spending because MCCL felt that such limits could also lead to health care rationing. The general sense among state officials and other stakeholders was that the MCCL is a strong, growing force in Minnesota’s debates on health care policy.

These groups were successful in temporarily thwarting the state’s planned expansion of managed care for publicly assisted populations. In the 1996 session, lawmakers required the state to obtain county board approval before expanding PMAP into a new area. As for the disabled, the planned pilot programs to test mandatory managed care for the disabled were delayed indefinitely. However, in the 1997 session, the legislature approved and funded DHS to proceed with two disabled pilot projects.

In 1997 the legislature made further changes to the counties’ role in PMAP. As a result of a negotiated agreement between the Department of Human Services, the Department of Health, and the Association of Minnesota Counties, counties are now required to begin enrollment on or before January 1, 1999, through either PMAP or a county-based purchasing arrangement. Counties have until September 1, 1997, to submit proposals indicating their intention to develop their own models; final proposals must be submitted by July 1, 1998. In addition, the legislation gives counties the option to terminate PMAP at a future date. A county that is participating in PMAP may submit a proposal to the state indicating its intention to terminate PMAP and replace it with a county-based purchasing model.

If a county opts to operate a county-based model, the legislation mandates certain requirements. For example, counties must purchase the full range of covered services for a fixed payment not to exceed the estimated state and federal cost. The county must also ensure that Medicaid beneficiaries are offered a choice, and it must assume some of the financial risks associated with its model.
Delivering Health Care to the Uninsured and Low-Income Population

State Public Health Department

The Minnesota Department of Health and its local counterparts in recent years have been undergoing significant changes triggered in large part by their connection with the Medicaid program. As in many states, the public health system in Minnesota, through Medicaid fee-for-service reimbursements, has over the years expanded its activities beyond traditional public health functions into direct service provision.

Since the early 1980s, the state legislature and administration have pursued a policy of leveraging Medicaid dollars to fund public health and social service activities of counties whenever possible. In light of the infusion of Medicaid dollars, the state decided not to increase state-funded grants to local public health departments. Now, as the state looks to managed care as a means of controlling Medicaid spending, the public health system must contend with the ramifications.

It is difficult to estimate the extent to which Medicaid funding has supported the public health infrastructure. In terms of direct service provision at the local level, however, Medicaid reimbursements increased from 9.4 percent to 19.4 percent of total funding between 1987 and 1994. In addition, Minnesota’s relatively generous Medicaid program, along with its MinnesotaCare program, has allowed the public health department flexibility in
allocating its revenue sources. For example, in its Maternal and Child Health block grant application, MDH requested a waiver from the federal requirement that states earmark 30 percent of MCH funds for preventive and primary care services for children and adolescents. The health department did so because it felt the state’s extensive commitment to providing primary care services through Medicaid and MinnesotaCare reduced the need for MCH funding for this purpose; instead, MDH redirected its MCH block grant funds (through the waiver) to support reproductive health programs focused on prenatal care and family planning services (Minnesota Department of Health 1996b).

At the state level, MDH has taken three major steps to deal with the expansion of the PMAP demonstration. First, in 1994 MDH adopted the Core Functions Initiative to delineate public health entities’ and managed care organizations’ (MCOs’) responsibilities more clearly under the evolving health care system. Specifically, this initiative sought to refocus public health priorities around traditional public health activities, such as infectious disease epidemiology, environmental hazard protection, and health promotion. During the 1996 legislative session, counties that were slated for PMAP expansions were given $1.5 million in special grants to help them through the transition to managed care. According to MDH, this legislation is an acknowledgment that PMAP does, in fact, cause the public health system to lose some funding. MDH intended to request transitional funding for the rest of the counties in the subsequent session. In 1997, the legislature again granted counties funds to assist them through the transition to managed care.

Second, state public health officials have worked with local health agencies and health plans to develop “collaboration plans” (between counties and MCOs) to promote coordination of public health and personal health services. Collaboration plans are semiannual documents that set forth measurement strategies and activities. However, as yet no official enforcement measures are attached to collaboration plans. For example, premium payments to PMAP MCOs are not contingent upon their meeting the outcomes outlined in the collaboration plans. The relationship between local health agencies and health plans may change in the future: An important element of the 1997 PMAP changes adopted by the legislature is a much stronger role for counties in setting and aiding the enforcement of public health goals.

Third, MDH has focused on data collection for outcomes measurement. In this regard, MDH promoted the establishment of the Data Institute and has been pursuing projects to enhance data availability.

Local Health Departments

For many years, Minnesota counties have been involved in carrying out population-based as well as personal health care activities. In terms of direct service provision, county health departments in Minnesota have been most active in providing services to populations with chronic care needs. Eighty-six
percent of the state’s county health departments provided home health care in 1993, compared with 45 percent of county health departments nationally (National Association of County and City Health Officials 1995). A similar proportion of Minnesota counties were delivering services related to chronic diseases. The emphasis on chronic care services rather than maternal and child health services makes Minnesota local health departments unique when compared to most other states’ local health departments.

Much of the direct service provision among local health departments is funded and administered through the state’s Community Health Services program. Local funds contribute a significant share of funding for this program. In 1994, CHS funding amounted to $204.2 million, of which 52 percent was drawn from local sources; 26 percent from Medicaid, Medicare, and Veterans Affairs reimbursements; and 22 percent from state and federal grant monies (Minnesota Department of Health 1996a).

Many of Minnesota’s counties and cities operate hospitals, health centers, or clinics in addition to carrying out core public health functions. More than a third of Minnesota hospital beds are either state- or locally controlled. This is a much higher fraction than for most of the other states being studied. The state has more city hospitals (28 out of 42 locally controlled hospitals) than any other category of local hospital, though it also has a number of county and hospital district facilities—18 in all (American Hospital Association 1996). In rural parts of the state, city and county hospitals have served for many years as the sole health facilities, while local health departments have provided supportive, non-medical services and home care.

Medicaid Managed Care at the Local Level

Responses to Medicaid managed care at the local level have been mixed. Some local health departments (e.g., the Minneapolis city health department) are moving away entirely from direct service provision, others are seeking collaborative arrangements with the Medicaid managed care plans, and still others are trying to maintain their current role. Also, as described above, legislation enabling counties to contract directly with providers or to do county-based purchasing of health services for their Medicaid and General Assistance populations was passed in the most recent legislative session. County-based purchasing will give counties control over both the financing and delivery of health care services.

County health departments have generally opposed the recent move to expand the PMAP demonstration statewide. A major reason for the opposition, of course, is the potential loss of funding for public health departments as managed care grows.

Counties are also opposed to the planned expansion of PMAP because they are concerned about potential cost-shifting. From their view, costs could be shifted back to the counties because MCOs generally apply a medical model in treating Medicaid clients and, in the process, deny coverage for
many nonmedical but related services such as health care screenings and case management. The counties fear that, as providers of last resort by Minnesota statute, local public health entities will have to bear the cost of providing the services MCOs do not provide.

Another reason why counties, especially rural counties, oppose the PMAP expansion is that they feel they could lose control over their health care systems. Much of the planned PMAP expansion area is in rural Minnesota, where managed care has been relatively scarce. Physicians and hospitals are concerned about losing their practices to Twin Cities health plans. Counties also feel that they are being directed to implement an urban managed care model that may or may not work in rural areas.

Furthermore, support for the Core Functions Initiative among counties has been mixed. Some counties feel that the initiative has the potential to draw funding to local public health departments. Many counties also hope that the initiative will resolve tensions between MCOs and public health entities by defining their roles more clearly. However, other counties view the initiative as a top-down policy adopted by MDH and are concerned that it may lose money for the local departments in the long run.

**Hennepin County Health Department**

Hennepin County, the local site for this study, serves as one example of the potential impact of Medicaid managed care on the local public health infrastructure. With its concentration of urban poor and increasing population of minorities in the Minneapolis area, the Hennepin County Health Department (HCHD) faces unique issues with respect to Medicaid managed care and other health system changes.

The county estimates that about 50 percent of its clients (at its clinics and the county hospital—Hennepin County Medical Center (HCMC)) are Medicaid eligible and about 90 percent of the people served by its health programs have incomes below 185 percent of the FPL. Also, interviewees stated that to some extent, the county feels that it is participating in a “race to the bottom” as Medicaid funding becomes more restricted. As one of the wealthier counties in the state, it does not want to be a magnet for indigent populations from surrounding counties.

Hennepin County is also unique in that it has a comprehensive public health system, which is largely built around HCMC and its affiliated health centers. HCMC is a tertiary care facility with approximately 400 staffed beds and acts as the dominant safety net hospital in the area. It operates the largest emergency room in Minnesota and provides primary care services through a network of 12 clinics.

Unlike most other Minnesota counties, Hennepin County has also formed its own managed care plan, Metropolitan Health Plan, through HCMC. As
Minnesota moved toward managed care for the publicly assisted, HCMC created MHP as a marketing and payment vehicle to retain the traditional patient base of HCMC. MHP decided not to compete with private health plans for other business as a political strategy to maintain its image as a safety net plan.

MHP has about one-quarter of the Medicaid managed care enrollees in Hennepin County. However, MHP may be experiencing financial troubles as a result of recent losses in its enrollment: Between 1992 and 1993 MHP enrollment increased by about 3 percent, but between 1994 and 1995 it decreased by 7 percent (Baumgarten 1996).

Aside from its heavy involvement in the Medicaid managed care system, HCHD has worked on a number of other fronts to address the cutbacks in Medicaid funding. The department has attempted to reduce inefficiency in the system, to reallocate funding across programs, and to examine strategies for reorganizing the health and social service system into a more integrated, coordinated entity.

However, HCHD officials do not support the Core Functions Initiative’s goal of refocusing on core public health functions. Instead, they would like to maintain their current role in delivering personal health care services to the extent possible. Not all of Minnesota’s local health departments, however, share this sentiment. The Minneapolis city health department, for example, is in a period of transition from direct provision of services to contracting all health services to private federally qualified health centers (FQHCs) or community clinics. City officials felt that Medicaid managed care and MinnesotaCare have actually expanded access to care for many low-income individuals and that the client base for city-provided services has decreased substantially, thereby diminishing their role in the safety net.

Safety Net Providers

Issues facing the Hennepin County and Minneapolis city health departments will also affect other safety net providers—namely hospitals and health centers. Restrictions in Medicaid funding, along with other changes in the health care market, could pose a threat to these providers’ ability to provide uncompensated care. This section discusses the safety net of hospitals and community health centers in the Minneapolis (Hennepin County) area.²⁰

Hospitals

Hospitals in Minneapolis, including those that treat a disproportionate number of low-income patients, are, in general, financially sound because of low levels of uncompensated care. Across the state, the amount of uncompensated care provided by hospitals is modest in part because of comprehensive
public programs (Medicaid, GAMC, and MinnesotaCare) and insurance reforms, which contribute to a high rate of private insurance coverage. Statewide, Minnesota hospitals provide uncompensated care equal to 2.9 percent of their expenses, compared with a national uncompensated care rate of about 6 percent. Moreover, the Minnesota uncompensated care burden has remained fairly stable since the mid-1980s. Therefore, while there is a safety net in Minneapolis—that is, the city has hospitals that tend to treat more of the low-income population—it is under less pressure than in other areas of the country as a result of treating fewer uninsured patients.

The more important force affecting hospitals in Minneapolis is managed care. The Twin Cities Metropolitan Statistical Area has a considerably higher market penetration (35.6 percent) than the average penetration (25.8 percent) for large markets (InterStudy 1996). In addition, as mentioned above, managed care is mandatory for all nondisabled Medicaid enrollees in Hennepin County and has been since 1985. The MinnesotaCare insurance program is also shifting all enrollees into managed care. As a result of managed care plans’ both competing for private- or public-sector subscribers and trying to control spending to stay within the capitation rates, hospitals are being forced to accept lower payment rates. This trend is encouraging hospitals to examine their costs and seek opportunities for savings.

Moreover, during the late 1980s and early 1990s, a number of hospitals merged or joined systems to be in a better position to negotiate with managed care plans. Since then, most hospitals seem to be remaining financially viable. One exception is the University of Minnesota Hospital, which faced serious financial problems and is merging with a private hospital system. Although this merger has not raised major concerns about access to care for the low-income population, several respondents did feel that private control of a major teaching hospital could reduce the number of medical residency positions below desired levels.

Managed care has also had an effect on referral patterns to hospitals. Despite the existence of the county-owned MHP, Medicaid patients can and do enroll in plans that also serve commercial populations. Specifically, Medica enrolls over half of the county’s Medicaid managed care population. This has the effect of distributing Medicaid admissions to hospitals that may not be considered part of the safety net. For example, within the Medica Medicaid plan, North Memorial Hospital admitted as many Medicaid patients as did HCMC in 1995. Yet from the hospitals’ perspectives, Medicaid is far more important to HCMC, accounting for more than one-quarter of its admissions, than it is to North Memorial, accounting for less than 10 percent of its admissions.

Despite the dominance of managed care in the overall Minneapolis market, many Medicaid enrollees (e.g., the disabled) still receive care paid for on a fee-for-service basis. At HCMC, for example, 28 percent of its 1995 revenues were derived from Medicaid fee-for-service payments, while only 11 percent came from MHP (its own managed care plan).
Health Centers

While the story of care for the poor among safety net hospitals is one of comprehensive state programs and low uncompensated-care burdens, the financial viability of health centers may be in jeopardy. FQHCs are more dependent on Medicaid funding, face larger uncompensated-care burdens than hospitals, and must prepare for the eventual disappearance of their Medicaid cost-based reimbursement. The state intends to phase out Medicaid cost-based payment to FQHCs in the next few years.21 Although FQHCs are less-prominent safety net providers statewide, they are relatively important in Hennepin County: The federal Bureau of Primary Health Care reports that only eight Minnesota organizations received community or migrant health center grants, and five of these were in Hennepin County.

Like other providers, FQHCs in Hennepin County must cope with well-established MCOs. Because of the populations they serve, FQHCs have concerns about being included in MCO networks, the appropriateness of managed care for the public-assistance population, and ensuring access to mental health and specialist services under managed care. However, FQHCs will have time to adjust financially to the expansion of Medicaid managed care. Minnesota has allowed for a three-year transition period during which FQHCs that qualify as Essential Community Providers will continue to receive cost-based reimbursement and must be included in Medicaid MCO networks.

Although the financial health of the clinics visited is stable, they have developed an array of strategies to prepare for the future. For example, community health centers formed a consortium, the Neighborhood Network, to obtain greater bargaining power with MCOs.

Some health centers are also seeking to become more independent of Medicaid funding. One clinic merged with the Hennepin County system in response to an assessment of the funding environment. But another is trying to wean itself from county funds, which it sees as an unstable source of finances. Efforts to become more efficient have included reducing staff or staff benefits, improving the accuracy of physician coding practices, pursuing collections efforts more thoroughly, and trying to improve patient “no show” rates.
Overview and Provider Supply

Mnnesota has pursued a multidimensional strategy, emphasizing home and community-based care and innovative managed care options, among other measures, for providing low-cost, high-quality long-term care (LTC) services to its elderly and disabled residents. Although the share of Minnesota’s Medicaid budget allocated to LTC services has decreased in recent years, these expenditures still accounted for well over half (57 percent) of the state’s Medicaid spending on benefits in state fiscal year (SFY) 1995. Moreover, between 1992 and 1995, Minnesota’s LTC spending growth exceeded national Medicaid LTC spending growth rates: Average annual growth in Minnesota’s LTC Medicaid spending was 8.9 percent compared with 8.3 percent nationally (table 8).

Despite a moratorium on nursing home construction that has been in effect since 1983 and a 13 percent reduction in nursing home bed growth between 1980 and 1990 (Starr and Kane 1996), Minnesota continues to lead the nation in nursing home bed supply with 86 beds per 1,000 elderly persons (Carter 1996). Of the state’s 445 nursing homes, all but four accept Medicaid recipients, who make up 67 percent of the nursing home population. Private-pay and Medicare patients make up 26 percent and 6 percent of the nursing home population, respectively (Carter 1996).
Table 8 Medicaid Long-Term Care Expenditures by Eligibility Group, Minnesota and United States ($ in Millions)

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<th>Minnesota</th>
<th>United States</th>
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<tr>
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Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

a. Intermediate care facilities for the mentally retarded.
The mentally retarded/developmentally disabled (MR/DD) population requiring facility-based, long-term support may receive care from one of 2,600 residential facilities in Minnesota (Prouty and Lakin 1995). Following the national trend, Minnesota has made a concerted effort to downsize facilities. In 1994, 92 percent of Minnesota’s residential service settings were facilities with up to six beds, while nationally, 88 percent of such facilities had one to six beds (Prouty and Lakin 1995).

Home and community-based services are a large and growing component of the state’s Medicaid LTC program. Like nursing home beds, the supply of home care providers in Minnesota is sizable. In 1993, the state had 1.08 agencies per 1,000 elderly residents, compared with 0.37 agencies per 1,000 elderly persons nationwide (Health Care Financing Administration 1995). Minnesota’s Medicaid home care benefit is comprehensive, offering personal care and private-duty nursing services as well as home and community-based waiver programs.

**Long-Term Care for the Elderly**

Long-term care has not escaped the state’s recent attempts to contain the growth of health care costs. Short-run priorities for reforming LTC for the elderly involve system redesign: increasing the use of managed care for the aged, integrating long-term and acute care financing and delivery mechanisms, 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 cost-containment strategy is to fully capitate LTC services and to “redefine the care expectation” for continuing care services among state residents. The basic idea behind the latter is to make the level of care expected by younger populations consistent with what public programs will realistically be able to support in coming years.

**Medicare and Private Funding for LTC**

The state is seeking to maximize Medicare reimbursement for both home care and nursing facility care for the dually enrolled population. One interviewee estimated that approximately 50,000 of the state’s 425,000 Medicaid enrollees are dual eligibles. In the area of home and community-based care, Minnesota is the fourth-lowest in the nation in terms of Medicare home health use, according to state officials. In 1996, the state proposed a “Medicare maximization” policy, aimed at enabling the state to better channel home care claims to the appropriate funding source. A primary component of this initiative is the “up-front payer determination method,” in which providers must fill out a form that helps them determine the best payer for the services provided.

Minnesota is also working on a number of fronts to draw more private funding into LTC. A DHS work group has been considering policy options to encourage individuals to purchase LTC insurance. A starting point may be to offer state employees an LTC insurance product. Another option to draw more private
dollars into LTC would extend the asset “look-back” period from the current 36 months to 72 months. As of September 1996, the state was preparing a waiver request to lengthen the asset look-back period. Finally, Minnesota’s estate recovery program, implemented in accordance with the OBRA 1993 legislation, recovered approximately $12 million in state funds in SFY 1995.

**LTC Delivery System Changes**

The state has also embarked on delivery system changes, including increased use of home and community-based alternatives and the development of managed care for acute and long-term care. Perhaps one of the more well-known and innovative efforts in this area has been the Minnesota Senior Health Options demonstration, which seeks to integrate acute and long-term care systems for the population enrolled in both Medicare and Medicaid. The objective of this demonstration is to create a less fragmented system of care for dual eligibles, a change that will control costs (by reducing incentives to shift costs between Medicare and Medicaid) as well as improve the quality of care for beneficiaries.

To implement the demonstration, the state needed both Medicare and Medicaid waivers from the Health Care Financing Administration (HCFA). In the negotiations, which took place over several years, state and HCFA officials struggled to resolve numerous issues. Two major features of the state’s waiver proposal were particularly problematic from HCFA’s standpoint. First, HCFA opposed the state’s proposal that enrollment of demonstration participants into managed care plans be mandatory with a guaranteed lock-in period of 30 days. HCFA officials did not support mandatory managed care enrollment for Medicare enrollees and felt that the legal authority for risk contracts did not clearly allow for a lock-in provision. Ultimately, HCFA did not approve this request. Dually eligible seniors in the Twin Cities area will have the choice of participating in the MSHO demonstration or remaining in their current arrangement. Second, the state had originally wanted to receive Medicare monies from HCFA, combine Medicaid and Medicare funds into a single source, and reimburse managed care plans directly. HCFA did not approve this request and will pay Medicare providers directly under MSHO.

The demonstration is being implemented in the Twin Cities area. Key elements of the MSHO demonstration are summarized below:

- Enrollment in MSHO is voluntary and is open to individuals aged 65 and older who are dually eligible. MSHO administrators project that up to 4,000 dual eligibles will enroll.

- The benefit package under MSHO includes all services delivered under standard Medicare risk contracts, Medicaid wraparound services (including nursing home care), and services available under the home and community-based waiver program.
• The MCOs will be responsible for providing the first 180 days of nursing facility care per beneficiary on a capitated basis; nursing facility days beyond 180 days will revert to fee-for-service reimbursement.

In a related effort, the state, for a number of years, has encouraged a movement away from institutional forms of continuing care to home and community-based care. Increased use of home and community-based care has been facilitated by the Medicaid personal care attendant program, as well as by two waiver programs for elderly at high risk of institutionalization.

Other Efforts to Control Expenditures

Minnesota policymakers have adopted various other measures to contain costs and improve service delivery. During the 1995 session, the legislature passed the High Functioning Legislation, which stipulated that the most functional nursing home residents would no longer be eligible for nursing home care. Rather, the state would give each individual approximately $250 per month toward the purchase of services. The state estimated that this provision, which requires a HCFA waiver, would affect 500 individuals.

The state is also considering changes to its prospective, cost-based nursing home reimbursement policy. Specifically, the state is exploring alternative reimbursement schemes, such as a contracting payment system, under which the state would purchase a nursing home day for a fixed price. In 1996 the state established a contractual alternative payment demonstration that seeks to save money while encouraging innovations in care delivery. The 120 facilities selected to participate are exempt from certain regulations in exchange for frozen payments, adjusted only for inflation in future years.

Long-Term Care for Persons with Disabilities

The MR/DD Population and Others with Disabilities

Minnesota has a strong tradition of emphasizing home and community-based care for persons with disabilities and particularly for the MR/DD population. Under the Medicaid program, the state has established two home and community-based care waiver programs serving the MR/DD population and two additional waiver programs for the chronically ill and physically disabled. Since 1983 the state has had a moratorium on the creation of new ICF/MR beds. Currently, the state has 3,000 ICF/MR beds, about half of which are in facilities with fewer than six beds.

As it does with the elderly population, the state would like to contain LTC costs for persons with disabilities by increasing the use of managed care and reducing expectations about the overall level of care. However, past legislative
attempts to expand Medicaid managed care for this population, as well as mea-
sures to curb eligibility and service coverage that would have affected persons
with disabilities, met with strong opposition from advocates, providers, and
beneficiaries; these reforms were ultimately defeated. Moreover, counties’
opposition to increased penetration of managed care may be even stronger in
the area of LTC than for acute care, given that the service infrastructure for
many LTC services is administered largely by counties.

For the time being, it appears that the state’s primary policy with respect to
persons with disabilities is to continue moving away from institutional set-
tings to home and community-based care and gradually increasing managed
care use.

The state still plans to launch pilot programs in three sites to investigate
innovative managed care delivery systems for persons with disabilities.
Implementation is scheduled for January 1, 1998. Before implementation
begins, the state must obtain both Medicare and Medicaid waivers from HCFA,
because many disabled persons are eligible for both programs.

As in many states, Minnesota’s numerous social service and health pro-
grams and funding streams that serve persons with disabilities are not well
coordinated and lead to inefficiencies. To explore ways to improve efficiency
and quality of care, the state is implementing pilot projects in two counties—
Olmstead and Blue Earth. These programs seek to integrate some 80 different
funding streams and delivery mechanisms for LTC for persons with disabilities.

**Mental Health**

In keeping with the movement away from facility-based care, a major policy
of the Mental Health Division has been to rely less on institutional settings
and more on community-based care systems.26

The state’s emphasis has been to downsize the state-run regional treatment
centers (i.e., the state’s psychiatric hospitals) and move the 400 individuals
served by these institutions to community-based settings by 1999. In 1995, the
state closed one psychiatric hospital. Individuals transferred to the commu-
nity had access to a comprehensive array of support services that enabled them
to remain in the community. Most of the support services and community care
were funded by Medicaid dollars, since about 70 to 80 percent of mental health
patients from the closed facility were eligible for Medicaid.

Very few Medicaid enrollees who are institutionalized for mental health dis-
orders are enrolled in managed care plans, and the state expects the transition
to managed care to be slow for this population. Respondents pointed out that
among institutionalized adults with mental illnesses, managed care is far more
prevalent for those who have private health insurance coverage than for those
with public coverage.
The Children’s Mental Health Collaboratives, a two-year-old initiative implemented through the PMAP demonstration, is another effort to streamline the financing and delivery of care to the mentally ill. The idea behind the collaboratives is to provide “one-stop shopping” for parents with seriously mentally ill children. Social service systems surrounding education, corrections, medical care, and other needs are to be integrated under these collaboratives. As the state seeks to integrate a wide range of social service functions, it must grapple with tensions among the various agencies involved in providing care—especially in regard to combining funds.
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 public health care programs. It has also implemented insurance reforms aimed at expanding employer-sponsored health care 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 of other states, it will likely need to address several major health care issues in the future. Because Minnesota has a history of being in the vanguard of health care policy, how it handles these matters will be closely watched.

Perhaps the most important issue is this: What does the future hold for PMAP, the state’s Section 1115 demonstration project? Now that counties have the authority to develop their own county-based purchasing models, Minnesota could have many different Medicaid managed care strategies operating at the same time. If several counties opt to establish county models, this raises important questions about the integrity and effectiveness of Minnesota’s Medicaid program. It also begs a fundamental policy question: Is Medicaid a state or a local program? In addition, if a patchwork quilt Medicaid program develops in Minnesota, it would likely have important cost and administrative implications.

The viability of safety net providers is yet another issue the state will confront in coming years. Although safety net providers in Hennepin County, the local site visited, are generally under less pressure than those in other urban areas in the country, several changes taking place in the health care market could affect such providers, the most important of which is managed care. The
Twin Cities already have a high HMO market penetration rate. This rate will likely increase as employers continue to rely on managed care and as the state proceeds with its effort to enroll the publicly insured populations—Medicaid, General Assistance Medical Care, 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 opportunities for savings. Together, these trends may lead to quality of care and access problems, especially for the low-income population.

Another important change in the health care safety net market in the Twin Cities is the recent merger of the University of Minnesota Hospital with a private hospital system. While respondents did not raise major concerns about how the merger will affect access to care for the low-income population, they did feel that private control of a major teaching hospital could reduce the number of medical residency positions below desired levels. If this occurred, the safety net could, over the long run, be affected.

Another important challenge is whether Minnesota can successfully implement its plans to redesign long-term care. Short-term priorities include increasing the use of home and community-based care in lieu of nursing home care; integrating acute and long-term care services and expenditures as part of the Minnesota Senior Health Options demonstration; and changing the pricing strategy for nursing home services. In the long run, the state hopes to fully capitate long-term care services and, perhaps more important, fundamentally reshape Minnesotans’ level-of-care expectations.

To many respondents, these initiatives to redesign long-term care are critical to controlling Medicaid program costs in both the short and long terms. As discussed, Minnesota spends 57 percent of its Medicaid budget on long-term care, much more than the national average. Moreover, the state’s rate of growth in long-term care spending has been higher than the national rate in recent years. Implementing these long-term care initiatives, though, will require the state to contend with several powerful interest groups, including the nursing home industry, consumer advocacy groups, and consumers themselves.
Notes

1. Beyond the general budget reserve, the state also has a substantial fund balance in some dedicated accounts. For example, the MinnesotaCare program fund had a surplus of $300 million as of July 1996.

2. MinnesotaCare is commonly used to refer to both the series of state laws and the subsidized health insurance program. To reduce confusion, this report refers to the laws as MinnesotaCare and to the insurance program as the MinnesotaCare program.

3. DHS is also responsible for administering a number of social service programs, including Temporary Assistance to Needy Families (TANF) and General Assistance.

4. In addition to PMAP, Minnesota operates the Minnesota Senior Health Options Section 1115 demonstration.

5. These categories include the 1902(r)(2) expansion of 1993, the AFDC program, the Medicaid expansions for pregnant women and children, and Ribicoff provisions.

6. In the 1997 legislative session, the $10,000 inpatient limit was eliminated for parents of MinnesotaCare-enrolled children with household incomes up to 175 percent of the FPL.

7. These estimates are based on a model that predicts monthly AFDC enrollments as a function of various factors, including unemployment rates, the real value of the AFDC cash grant, and out-of-wedlock birthrates. To the extent that there are determinants of the decline in AFDC enrollments in Minnesota that are not in the model but are correlated with the introduction of MinnesotaCare, the effects of MinnesotaCare could be overstated (DHS 1995).

8. The 1993 MinnesotaCare law committed the state to guaranteeing universal coverage by January 1, 1997. In the 1995 legislative session, however, this was revised to read: “the goal” of the state is to reduce the percentage of uninsured residents to 4 percent by January 1, 2000.

9. “Rules of issue” pertain to a set of reforms aimed at reducing impediments to obtaining and maintaining insurance coverage.

10. These three plans are the result of consolidations among six plans that existed in 1985 and together accounted for 95 percent of HMO enrollment. Since 1985, two new plans—Metropolitan Health Plan and UCare—have entered the market, but they serve mostly Medicaid enrollees.

11. Health plans continue to put pressure on hospital prices in the Twin Cities area. In a recent disagreement between BCBSM and Allina Health System over Allina’s hospital prices, BCBSM threatened to terminate its contracts with Allina hospitals. It charged that Allina’s prices were 8 to 9 percent over the market average. BCBSM accounted for 12 percent of Allina’s hospital revenues in 1995.

12. Allina Health System runs a large HMO, Medica. The other hospital systems are independent of HMOs.

13. This purchasing group affected the structure of the health care market in the Twin Cities by issuing a request for proposals (RFP) in 1993 that in part led to the development of one of the largest health plans in the market, HealthPartners, to meet the RFP’s geographic requirements. HealthPartners was formed from the union of Group Health (a staff-model HMO) and MedCenters (an independent practice association); each felt unable to meet the geographic coverage area BHCAG required. The addition of Ramsey Health Care (a hospital, clinic, and research unit) to HealthPartners also was the result, in part, of the BHCAG RFP. HealthSpan Hospital System merged with Medica health plan to form Allina just six days after HealthPartners merged with Ramsey Health Care.

14. Prospective Payment Assessment Commission (ProPAC) data indicate that Minnesota’s Medicaid rates cover only about 88 percent of costs. The difference between the ProPAC and state estimates may be due to the inclusion of a rural bonus and DPA payments in the Minnesota figure.

15. Two HMOs in the state do not serve MA clients, but they are owned by a plan that does.
16. It was reported in September 1996 that Rule 101 no longer applies to health plans. State officials will rely on the regulations for licensure as an HMO to ensure plan participation.

17. MA/GAMC are still using fee-for-service in Olmstead County, so how the Mayo plan would respond to a MA/GAMC contract offer is not known.

18. Many (non-hospital-related) local public health department activities are carried out through the Community Health Services program. The numbers presented are taken from the Community Health Services program budget documents.

19. The Community Health Services program was established by the Community Health Services Act of 1976, which sought to reduce the complexity in the public health system and to improve the state/local partnership in public health. As part of the program, MDH provides (state-funded) subsidies to local public health departments to carry out a range of public health activities, including disease prevention and control, emergency medical services, environmental health activities, family health services, health promotion, and the provision of home health care.

20. The team visited four hospitals: HCMC, the University of Minnesota Hospital, Children’s Hospitals, and Abbott Northwestern Hospital. HCMC is the dominant safety net hospital in the county. Abbott Northwestern should not be viewed as a safety net hospital but was included for contrast and comparison with the other hospitals visited. The team also visited three health centers—Pilot City Health Center, the Indian Health Board, and the Hennepin County North Clinic.

21. In addition to reimbursements from Medicaid, many health centers receive funding from a number of federal grants programs established under the Public Health Services Act, such as Community (Section 330) and Migrant (Section 329) grants. Centers receiving these grants are eligible to become FQHCs upon meeting certain other requirements. From a financial perspective, health centers have an incentive to obtain FQHC status in order to receive cost-based reimbursement from Medicaid and Medicare.

22. The term “residential service systems” excludes nursing home and psychiatric facilities but includes ICFs/MR and services provided through home and community-based care waiver programs.

23. The elderly enrolled in both Medicaid and Medicare receive Medicaid wraparound services through a capitated managed care PMAP plan. PMAP participation is mandatory for the elderly. Those enrolled in HMOs under Medicare may choose a PMAP plan to receive Medicare-covered services as well. Some services, like nursing facility services after Medicare payment ends, are still paid for under Medicaid fee-for-service.

24. This is the period over which the state takes into account one’s assets in making eligibility determinations.

25. As described under Long-Term Care for the Elderly and Persons with Disabilities, Minnesota is one of two states that have adopted an “equalization” statute, which stipulates that any nursing home participating in the Medicaid program cannot charge a private-pay patient higher rates than it would charge the state for a Medicaid patient.

26. A significant advantage of moving individuals out of institutions is to bypass the restriction on payment to institutions for mental diseases under Medicaid (excludes individuals aged 21 through 64). Through community-based programs, the state can draw down federal Medicaid dollars for individuals aged 21 through 64 who are eligible.
References


# APPENDIX

## List of People Interviewed

### State Government

**Department of Human Services**

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<tr>
<th>Name</th>
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**Department of Health**

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<td>Leann Habte</td>
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### Other State Government

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<td>David Haugen</td>
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### State Legislators

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### Governor's Office

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<tr>
<td>John Dyke</td>
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Hennepin County Hospitals
John Blueford  Hennepin County Medical Center
Cliff Fearing  University of Minnesota Medical Center
Brock Nelson  Children’s Health Center
Richard Slack  Abbott Northwestern Hospital

Community Health Centers
Howard Johnson  Pilot City Health Center
Virginia Schuster  Indian Health Board
Kathy Vinson  Hennepin Care North

Provider and Plan Associations
John Kingry  Minnesota Hospital and Health Care Partnership
Dave Feinwachs  Minnesota Hospital and Health Care Partnership
Rich Korman  Minnesota Hospital and Health Care Partnership
Janet L. Silversmith  Minnesota Medical Association
Rick Carter  Care Providers’ Association of Minnesota
Patricia K. Cullen  Care Providers’ Association of Minnesota
Laurel Illston  Minnesota Health and Housing Alliance
Mick Finn  Minnesota Health and Housing Alliance
Deb Siefert  Minnesota Council of HMOs
Debra Kildahl  Minnesota Home Care Association
Lois McKeran  Association of Minnesota Counties
Kim Harms  Minnesota Dental Association

Consumer Advocates
Jim Koppel  Children’s Defense Fund
Ann Henry  Disability Law Project
Maureen O’Connell  Legal Services
Kathy Kelso  Mental Health Association
Catherine Blunda  Minnesota Citizens Concerned for Life

Minneapolis City Government
Dell Hurt  Acting Commissioner of Health

Hennepin County Government
Sue Zuidema  Community Health Department
Linda Doyle  Community Health Department
Dan McLaughlin  Hennepin County Health Care System

Expert
Mary Jo O’Brien  Health Policy Consulting
About the Authors

*Teresa A. Coughlin* is a senior research associate at the Urban Institute’s Health Policy Center, where her research focuses on Medicaid and other health care programs for low-income populations. She is the author of a book on Medicaid and several articles on health care. Most recently, her work has centered on issues of state health care reform, Medicaid managed care, and Medicaid DSH programs.

*Shruti Rajan* is a research associate in the Urban Institute’s Health Policy Center. Ms. Rajan’s work focuses on health insurance coverage and the Medicaid program. Prior to joining the Urban Institute, she researched health policy issues for the Center for Health Affairs at Project HOPE.

*Stephen Zuckerman* is a principal research associate at the Urban Institute’s Health Policy Center. His current research includes a major evaluation of Medicaid waiver programs, the relationship between Medicare physician payment policies and beneficiaries’ access to care, and health care reform. Dr. Zuckerman has authored several specific policy proposals aimed largely at Medicare physician payment.

*Jill A. Marsteller* is a research associate with the Health Policy Center of the Urban Institute. She has investigated the changing organization of delivery and financing systems and the spread of managed care organizations. Her most recent work has concerned health insurance reform and market competition issues. She came to the Institute after working in Employee Benefits Research for KPMG Peat Marwick in Washington, D.C.
Errata

Several published *State Reports* and *Highlights* include an error in Table 1, “State Characteristics.” Incorrect figures were included for noncitizen immigrants as a percentage of the population. Corrections were made on August 13, 1998 to both the HTML and PDF version of these reports on the *Assessing New Federalism* website.

Correct figures for 1996

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The error appears in the following publications:

State Reports:
*Health Policy:* Alabama, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington
**Income Support and Social Services:** Alabama, California, Massachusetts, Michigan, Minnesota, Texas, Washington

Highlights:
**Health Policy:** Alabama, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Oklahoma, Texas, Washington

**Income Support and Social Services:** Minnesota, Texas