

Benefit Trends in Minnesota's Small Group and Individual Health Insurance Markets

As a result of double-digit annual increases in health insurance premiums over the past several years, concerns about the affordability of health insurance have grown, both in Minnesota and nationally. One common response to rising insurance premiums has been to shift to health plans that require higher levels of enrollee cost sharing (deductibles, copayments and coinsurance).¹ In 2002, the Minnesota Department of Health conducted a survey of health plan companies that sell policies in the small group and individual markets. Because each product offering must be approved by regulators, trends in these market segments are easier to track than in the unregulated large group market. The results of the 2002 survey provided a useful and unique snapshot of benefits being purchased in these markets.²

This issue brief describes the results of a follow-up survey conducted in 2005 to assess changes in benefits sets between 2002 and 2005. Changes in benefit levels over time are the result of several related factors. First, the number and characteristics of health plans being offered for sale in the small group and individual market has changed significantly. Second, in the case of employer-based insurance, decisions made by employers about which products to offer affect the choices available to individual employees. Finally, individuals purchasing their own coverage or those with a choice of employer plans must weigh upfront costs (premiums) against cost incurred at the time of service to choose the plan that best meets their needs.

While there is great variation in the level of benefits offered in these markets, most plans are structured in similar ways. Many plans have a deductible, which is a specific annual dollar amount that an enrollee is required to pay before an insurance plan begins to cover claims. In addition, most enrollees have some cost sharing for covered services or drugs. It is typically structured in the form of a copayment (the enrollee is responsible for a fixed dollar amount per covered service) or coinsurance (the enrollee is responsible for a specific percentage of the cost of a covered service). Many enrollees also have an annual out-of-pocket limit after which cost sharing does not apply. Finally, some enrollees have benefit caps that set a maximum amount of benefits payable by the insurer for an individual enrollee during his or her lifetime.

Small Group Market

In 2004, approximately 450,000 people obtained health insurance through Minnesota's small group market (9 percent of all Minnesotans). Within the small group market, there is significant variation in the level of cost sharing, both between health plan companies and between different plans offered by the same health plan company. From 2002 to 2005, variation in cost sharing increased as the range of

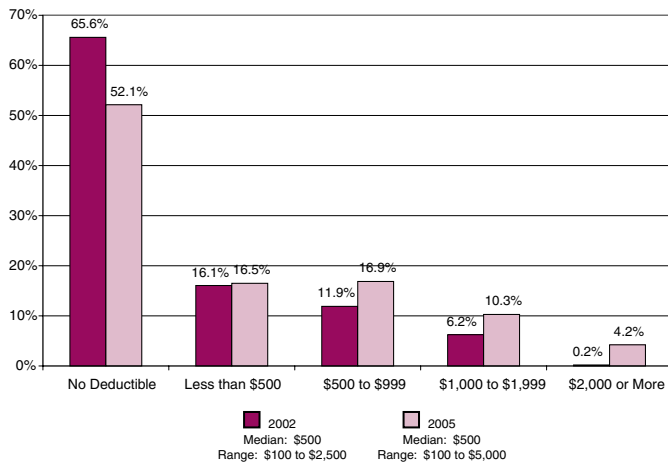
deductibles and coinsurance increased. In general, however, enrollment shifted to plans with higher deductibles and higher cost sharing.

Deductibles

Figures 1 and 2 show the distribution of annual deductibles for individuals and families in the small group market in 2002 and 2005. In 2002, two-thirds (66 percent) of enrollees in Minnesota's small group market were in plans without a deductible. By 2005, that number had decreased to about half (52 percent). Among enrollees with a deductible, the median deductible held constant at \$500 for individuals and \$1,000 for families. The share of enrollees with a deductible of \$2,000 or more increased substantially for both individuals and families.

Figure 1

Per Person Annual Deductibles in the Small Group Market, 2002 to 2005
(by share of enrollment)

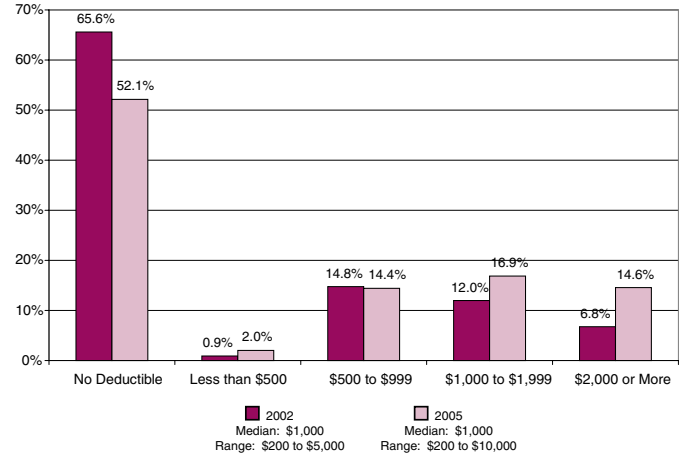


Source: MDH, Health Economics Program

*Median calculation excludes enrollees with no deductible

Figure 2

Family Level Annual Deductibles in the Small Group Market, 2002 to 2005
(by share of enrollment)



Source: MDH, Health Economics Program

*Median calculation excludes enrollees with no deductible

Cost Sharing For Office Visits and Hospitalizations

While roughly half of enrollees in Minnesota's small group market do not have a deductible, almost all enrollees have some type of cost sharing requirement for office visits and hospitalizations. Table 1 shows the variation in cost sharing requirements for office visits in 2002 and 2005. As shown in the table, the share of enrollees with an office visit cost sharing requirement declined slightly and there was a major shift in how office visit cost sharing was structured. In 2002, the majority of enrollees (69 percent) had an office visit copayment (typically \$15) and almost 30 percent had a 20 percent coinsurance for office visits. In 2005, almost 90 percent had a copayment while only 5 percent had a 20 percent coinsurance. This shift was likely related to the fact that one of the largest companies in the market changed its product offerings. For enrollees with office visit copayments, it is also important to note that while the median copayment remained at \$15 between 2002 and 2005, the share that had a copayment of \$25 or more increased by 29 percentage points (see Figure 3).

Table 1

Office Visit Cost Sharing Requirements in the Small Group Market, 2002 and 2005 (by share of total enrollment)

	2002	2005
None	2.0%	4.2%
Copayment	68.9%	89.0%
Tiered Copayment	0.0%	0.3%
20% Coinsurance	27.3%	5.7%
Other Coinsurance	0.1%	0.5%
Copayment and Coinsurance	<u>1.7%</u>	<u>0.4%</u>
	100.0%	100.0%

Source: MDH, Health Economics Program

Table 2

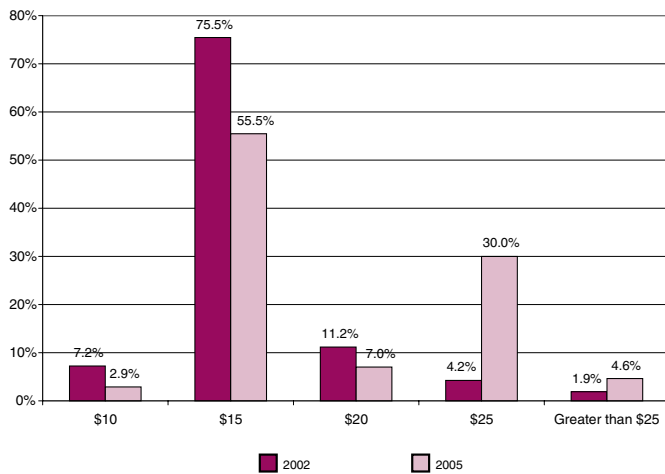
Cost Sharing Requirements for Hospitalizations in the Small Group Market, 2002 and 2005 (by share of total enrollment)

	2002	2005
None	41.4%	30.2%
20% Coinsurance	49.8%	63.2%
Other Coinsurance	2.5%	5.5%
Copayment and Coinsurance	5.3%	1.1%
Other	<u>1.0%</u>	<u>0.1%</u>
	100.0%	100.0%

Source: MDH, Health Economics Program

Figure 3

Distribution of Office Visit Copayments, 2002 and 2005



Source: MDH, Health Economics Program

Includes only enrollees who have an office visit copayment.

Table 2 shows the cost sharing requirements for hospitalizations in 2002 and 2005. In 2005, 30 percent of enrollees did not have a cost sharing requirement for inpatient hospitalizations, a decline of 11 percentage points from 2002. In both years, the majority of enrollees were in plans with a 20 percent coinsurance for inpatient hospitalizations.

Out-of-Pocket Spending Limits

Almost all enrollees in Minnesota's small group market have a per person and per family out-of-pocket (OOP) spending limit. Between 2002 and 2005, the median amount of the OOP limits increased significantly. Table 3 shows the distribution of per person and per family out-of-pocket spending limits for enrollees in the small group market in 2002 and 2005. In 2002, more than half of the enrollees in the small group market had a per person OOP spending limit of less than \$1,500. Between 2002 and 2005, the median increased from \$1,200 to \$1,500, and more than 30 percent of enrollees had a per person OOP spending limit of \$2,000 or more in 2005. Family OOP limits also increased—the median family OOP spending limit rose from \$3,600 in 2002 to \$5,000 in 2005.

Table 3

Out-of-Pocket Limits for Covered Services in the Small Group Market, 2002 and 2005 (by share of total enrollment)

	2002	2005
Per Person	Median: \$1,200 Range: \$200 to \$3,300	Median: \$1,500 Range: \$500 to \$7,500
No Limit	0.6%	0.2%
Less than \$1,500	56.0%	34.7%
\$1,500 to \$1,999	17.2%	33.9%
\$2,000 to \$2,499	5.3%	13.5%
\$2,500 to \$2,999	20.5%	14.8%
\$3,000 to \$3,999	0.4%	2.4%
\$4,000 or More	<u>0.0%</u>	<u>0.6%</u>
	100.0%	100.0%
Per Family	Median: \$3,600 Range: \$1,000 to \$15,000	Median: \$5,000 Range: \$1,000 to \$15,000
None	0.6%	0.2%
Less than \$2,999	29.3%	10.2%
\$3,000 to \$3,999	16.3%	10.4%
\$4,000 to \$4,999	6.1%	3.1%
\$5,000 to \$5,999	31.3%	63.2%
\$6,000 or More	0.9%	3.2%
Family Size Dependent	<u>15.5%</u>	<u>9.7%</u>
	100.0%	100.0%

Source: MDH, Health Economics Program

*Median calculation excludes enrollees with no OOP limit.

Prescription Drug Benefits

Almost all enrollees in the small group market have some prescription drug coverage and most enrollees are subject to prescription drug coinsurance or copayments (see Table 4). As shown in Table 4, the structure of prescription drug benefits varies substantially and has changed over time. In 2002, most enrollees in Minnesota's small group market (83 percent) had a prescription drug copayment with a range of \$5 to \$37. Of enrollees with a prescription drug copayment in 2002, 57 percent had a fixed copayment and 43 percent had a tiered copayment (a copayment that varies depending on the particular drug prescribed). In 2005, only about half of enrollees had a prescription drug copayment (ranging from \$5 to \$50) and almost all of these enrollees had a tiered copayment. Another common prescription drug benefit structure is a coinsurance of 20 percent with a maximum out-of-pocket payment per prescription tiered between \$10 and \$30. Enrollment in this structure of prescription drug benefits increased significantly from 12 percent in 2002 to nearly 40 percent in 2005.

Table 4

Prescription Drug Benefits in the Small Group Market, 2002 and 2005 (by share of total enrollment)

	2002	2005
Copayments*	83.1%	50.1%
Coinsurance	1.2%	2.8%
Copayment and Coinsurance	1.8%	5.1%
20% Coinsurance with limits per prescription	11.6%	39.1%
100% Coverage After Annual Deductible	0.3%	2.9%
Other	1.8%	0.0%
No Prescription Drug Coverage	<u>0.1%</u>	<u>0.0%</u>
	100.0%	100.0%
*Enrollees with Prescription Drug Copayments:		
Fixed Copayment	56.5%	0.4%
Tiered Copayment	<u>43.5%</u>	<u>99.6%</u>
	100.0%	100.0%

Source: MDH, Health Economics Program

In addition to overall OOP spending limits, many plans in the small group market include separate prescription drug OOP limits. Table 5 shows that the share of enrollees with no separate OOP limit for drugs increased from 40 percent to 60 percent of enrollees between 2002 and 2005.

Table 5

Prescription Drug Out-of-Pocket Limits in the Small Group Market, 2002 and 2005 (by share of total enrollment)

	2002	2005
Per Person		
\$300 or Less	17.3%	9.7%
\$301 to \$500	41.7%	29.6%
\$501 or more	0.3%	0.5%
No Separate Rx Limit	<u>40.7%</u>	<u>60.2%</u>
	100.0%	100.0%
Per Family		
\$500 or Less	1.8%	0.0%
\$501 to \$800	29.4%	0.0%
\$801 to \$1,000	12.2%	29.7%
No Family Level Limit	15.8%	10.1%
No Separate Rx Limit	<u>40.7%</u>	<u>60.2%</u>
	100.0%	100.0%

Source: MDH, Health Economics Program

Among enrollees who have a separate limit, the median prescription drug OOP limits have remained relatively stable for individuals. In 2002 the median OOP limit for prescription drugs was \$500 for

individuals and \$750 for families. By 2005, the median OOP limit for prescription drugs remained at \$500 for individuals, but had increased to \$1,000 for families.

Lifetime Benefit Limits

Enrollees in the small group market had slightly higher lifetime limits in 2005 compared to 2002 (see Table 6). In 2005, 57 percent of the enrollees in Minnesota's small group market were in plans with unlimited lifetime benefits, compared to about half (51 percent) in 2002. Among enrollees with a lifetime limit, the median remained stable at \$3 million.

Table 6

Lifetime Limit on Benefits in the Small Group Market, 2002 and 2005
(by share of total enrollment)

	2002	2005
Unlimited	51.2%	57.3%
\$5 Million	1.8%	1.2%
\$3 Million	40.8%	40.6%
\$2 Million	5.9%	0.8%
Under \$2 Million	<u>0.3%</u>	<u>0.1%</u>
	100.0%	100.0%

Source: MDH, Health Economics Program

Mandate-Exempt Plans

All states require that health plans include coverage for specific services or health conditions. Because of concern about how much these "mandated benefits" add to premiums, Minnesota law requires all health carriers that participate in Minnesota's small group market to offer two specific plans that do not include these mandated benefits.³ In 1996, an estimated 37,000 people were enrolled in these mandate-exempt plans (slightly less than 8 percent of total enrollment) and by 2002 total enrollment for both mandate-exempt plans had declined to 1,300 people (less than 0.3 percent of total enrollment in the small group market).⁴ Between 2002 and 2005, there was a slight

increase in the number of enrollees in these plans to 2,200 people (0.5 percent of the total enrollment in the small group market). In 2005, the Minnesota Legislature enacted a law allowing the sale of "small employer flexible benefit plans".⁵ These plans are exempt from state mandates with the exception of maternity benefits and other benefits required under federal law. Currently, no health plan companies have filed to sell small employer flexible benefit plans.

Individual Market

In 2004, there were roughly 216,000 people who purchased health insurance in Minnesota's individual market (4 percent of all Minnesotans). Compared with the small group market, enrollees in the individual market typically have less comprehensive benefits. As in the small group market, enrollment in high deductible plans increased between 2002 and 2005 in the individual market. Offsetting this change, however, was an increase in the share of enrollees with no cost sharing for hospitalizations or office visits once their deductible is reached.

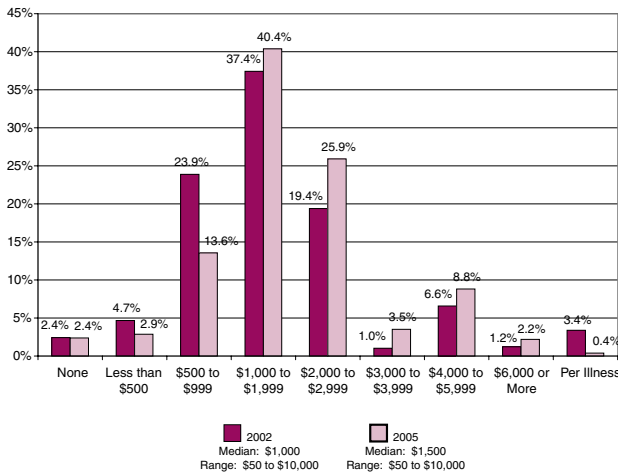
Deductibles

Unlike the small group market, most people in the individual market have an annual deductible. In both 2002 and 2005, less than 3 percent of enrollees in the individual market were in plans without a deductible (see Figures 4 and 5). As shown in the figures, there has been an upward shift in the deductible levels from 2002 to 2005. In 2002, the median per person deductible (among enrollees with a deductible) was \$1,000. By 2005, the median per person deductible had increased to \$1,500. In both years, more than 96 percent of Minnesotans enrolled in the individual market were also in plans whose benefit structure included a family level deductible.⁶ In 2002, most of these enrollees (60 percent) were in plans with a deductible that varied depending on family size, ranging from \$450 to \$30,000 with a median of \$3,000 (all plans limited the deductible amount to

three per family). In 2005, there was little enrollment in plans with a deductible that varied by family size. For plans with a family level deductible the median was \$4,000 in 2005, up from \$2,000 in 2002.

Figure 4

Per Person Annual Deductibles in the Individual Market, 2002 and 2005 (by share of enrollment)

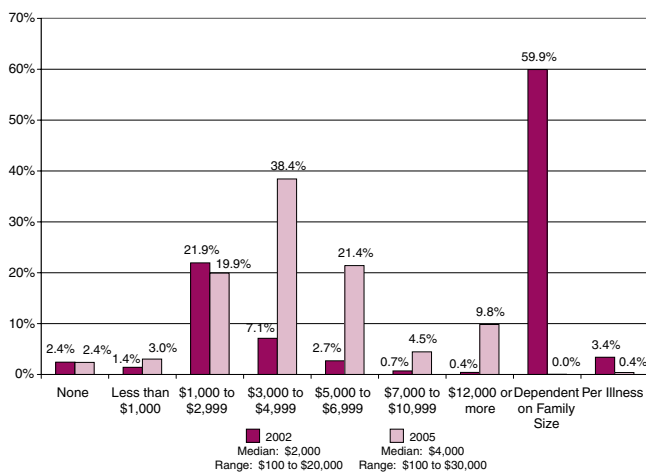


Source: MDH, Health Economics Program

*Median calculation excludes enrollees with no deductible

Figure 5

Per Family Annual Deductibles in the Individual Market, 2002 and 2005 (by share of enrollment)



Source: MDH, Health Economics Program

*Median calculation excludes enrollees with no deductible

Cost Sharing for Office Visits and Hospitalization

Tables 7 and 8 show the distribution of office visit and hospitalization cost sharing requirements in Minnesota's individual market in 2002 and 2005. Unlike the small group market, a sizable share of enrollees in the individual market are in plans without office visit cost sharing. In 2002, more than one quarter (26 percent) of enrollees in the individual market had no cost sharing for office visits, compared to 38 percent in 2005. It is important to note, however, that enrollees without office visit cost sharing tend to have policies with deductibles that are significantly higher than the median. In other words, full coverage for office visits only began after these enrollees had already paid a higher than average amount of money out-of-pocket to satisfy their deductibles. In 2005, the median per person deductible for enrollees without office visit cost sharing was \$2,400, almost \$1,000 greater than the median for all enrollees. Although this was also true in 2002, the difference in deductible levels was smaller. In both 2002 and 2005, the majority of enrollees with office visit cost sharing had a 20% coinsurance requirement.

Table 7

Office Visit Cost Sharing Requirements in the Individual Market, 2002 and 2005 (by share of total enrollment)

	2002	2005
None	25.8%	37.6%
Copayment	5.5%	0.9%
10% Coinsurance	3.4%	3.5%
20% Coinsurance	63.1%	57.2%
Coinsurance Greater than 20%	0.8%	0.8%
Other	1.5%	0.0%
	100.0%	100.0%

Source: MDH, Health Economics Program

Table 8

Cost Sharing Requirements for Hospitalization in the Individual Market, 2002 and 2005 (by share of total enrollment)

	2002	2005
None	8.0%	26.1%
Copayment	0.8%	0.4%
10% Coinsurance	0.0%	1.4%
20% Coinsurance	86.2%	61.6%
Coinsurance Greater than 20%	1.0%	10.1%
Other	4.0%	0.4%
	100.0%	100.0%

Source: MDH, Health Economics Program

As with office visits, there was an increase in the share of enrollees without cost sharing for hospitalizations between 2002 and 2005. In 2002, 8 percent of enrollees in the individual market had no cost sharing requirement for hospitalization, compared with 26 percent in 2005 (see Table 8). Again, enrollees without cost sharing requirements for hospitalization tended to have much higher deductibles than those with cost sharing for hospitalization (median of \$2,600, which was more than \$1,000 higher than the median deductible for all enrollees). For enrollees with hospital cost sharing requirements, most had a 20 percent coinsurance.

Out-Of-Pocket Spending Limits

As in the small group market, nearly all enrollees in the individual market are in plans with an individual OOP limit. The range, however, is much wider in the individual market and the limits tend to be significantly higher (see Table 9). In 2002, the per person OOP limits ranged from \$900 to \$28,000, with a median of \$2,000. In 2005, the range was narrower (\$450 to \$20,400, compared with \$500 to \$7,500 in the small group market) but the median increased to \$2,250. Nearly all enrollees were in plans that had separate OOP limits for families. In 2002, over half of enrollees (57 percent) had OOP limits that depended on family size (up to three times the

per person OOP limit). In 2005, this number had decreased to 18 percent. For those enrollees with set family level OOP limits, the median increased from \$4,000 to \$5,400 between 2002 and 2005.

Table 9

Out-of-Pocket Limits in the Individual Market, 2002 and 2005 (by share of enrollment)

	2002 Median: \$2,000 Range: \$900 to \$28,000	2005 Median: \$2,250 Range: \$450 to \$20,400
Per Person		
None	0.0%	3.2%
Less than \$2,000	41.5%	34.1%
\$2,000 to \$2,999	33.5%	38.5%
\$3,000 to \$3,999	10.4%	11.0%
\$4,000 to 5,999	3.9%	6.7%
6,000 to 8,999	3.8%	4.5%
9,000 or greater	1.2%	2.1%
Per Covered Sickness	5.6%	0.0%
	100.0%	100.0%
Per Family	Median: \$4,000 Range: \$1,800 to \$41,600	Median: \$5,400 Range: \$2,400 to \$30,000
None	0.0%	3.2%
Less than \$4,000	13.1%	9.5%
\$4,000 to \$4,999	8.7%	11.7%
\$5,000 to \$5,999	6.5%	22.8%
\$6,000 to \$6,999	3.9%	10.2%
\$7,000 to \$10,999	2.3%	14.9%
\$11,000 or greater	0.6%	9.3%
Per Covered Sickness	5.0%	0.0%
Family Size Dependent	59.8%	18.3%
	100.0%	100.0%

Source: MDH, Health Economics Program

*Median calculation excludes enrollees with no OOP Limit

Prescription Drug Benefits

As in the small group market, the level of prescription drug benefits in the individual market varies widely (see Table 10). In 2002 and 2005, over half of the enrollees in the individual market had a 20 percent coinsurance for prescription drugs (55 percent and 54 percent respectively). Another other popular prescription drug benefit structure was a \$500 deductible and subsequent copayment. The share of enrollees with this type of prescription drug benefit increased by 9 percentage points from 2002 to 2005 (from 11 percent in 2002 to 20 percent in 2005). The share of enrollees with full coverage after the policy deductible is reached declined considerably from 18 percent in 2002 to 4 percent in 2005.

Unlike the small group market, very few enrollees in the individual market have a separate OOP limit for prescription drugs. In 2002 and 2005, less than 3 percent of enrollees had a separate OOP limit for drugs (1.6 percent and 2.2 percent respectively). In both years, the OOP limit for prescription drugs was \$300 for individuals and between \$900 and \$1,000 for families.

Table 10

Prescription Drug Benefits in the Individual Market, 2002 and 2005 (by share of total enrollment)

	2002	2005
20% Coinsurance	54.7%	54.3%
\$500 Rx Deductible with \$10 to \$25 Copayment	10.9%	19.9%
Copayment	11.5%	14.6%
100% Coverage After Deductible	17.9%	3.9%
Fixed Amount of Coverage (\$300 to \$500)	1.2%	2.3%
None	2.6%	3.4%
Other	1.3%	1.5%
	100.0%	100.0%

Source: MDH, Health Economics Program

Lifetime Benefit Limits

Table 11 shows the distribution of lifetime benefit limits in the individual health insurance market in 2002 and 2005. In 2002, about 12 percent of enrollees in the individual market had unlimited benefits. By 2005, this share had decreased to 9 percent. In both years, most enrollees had a lifetime benefit limit of \$3 million.

Table 11

Lifetime Limit on Benefits in the Individual Market, 2002 and 2005 (by share of total enrollment)

	2002	2005
Less than \$2 Million	4.6%	3.5%
\$2 Million	2.8%	3.2%
\$3 Million	57.2%	65.8%
\$4 Million	0.0%	7.0%
\$5 Million	14.4%	0.3%
\$6 Million	6.0%	10.7%
Unlimited	11.5%	9.1%
Per Illness	3.4%	0.4%
	100.0%	100.0%

Source: MDH, Health Economics Program

Health Savings Accounts

As part of the 2003 Medicare Modernization Act, the Federal government authorized the establishment of tax-advantaged Health Savings Accounts (HSAs). HSAs are paired with high-deductible health insurance policies. Annual contributions to an HSA are limited to the amount of the health plan deductible, and both contributions and eligible withdrawals are tax free. In many ways, HSAs are similar to Archer Medical Savings Accounts (MSAs), which have been available since 1996 to self-employed individuals and small businesses. Many experts expect HSAs to be more popular than MSAs, because of their broader eligibility and greater flexibility.

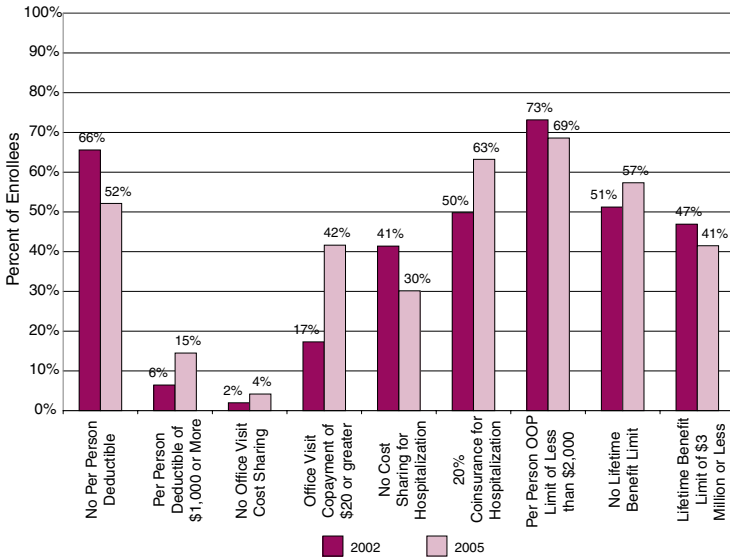
Although HSAs are a very new product, many health carriers participating in Minnesota's small group and individual insurance markets have begun to offer them. In 2005, HSA-compatible plans accounted for about 10 percent of the product offerings in both the small group and individual markets, but their share of enrollment was lower (2 percent and 1 percent in the small group and individual markets, respectively).

Summary and Conclusions

Figures 6 and 7 summarize some of the changes in the level of benefits in Minnesota's small group and individual health insurance markets between 2002 and 2005. Overall, the benefits in the small group market are still more comprehensive than those in the individual market, but for both markets there was a shift toward plans with higher deductibles and OOP limits between 2002 and 2005. In addition, while in some cases the median cost sharing amount did not shift between 2002 and 2005, the range of cost sharing amounts increased.

Figure 6

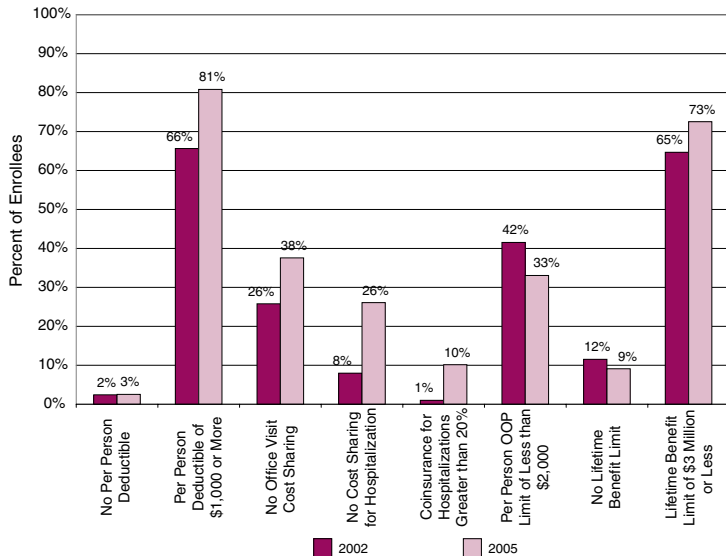
Summary of Benefits in the Small Group Market, 2002 and 2005



Source: MDH, Health Economics Program

Figure 7

Summary of Benefits in the Individual Market, 2002 and 2005



Source: MDH, Health Economics Program

In the small group market specifically, enrollment in high deductible plans increased, as did enrollment in plans with high OOP maximums. Enrollment decreased, however, for plans where cost sharing requirements were based on a percentage of cost rather than a fixed amount. In addition, there were modest increases in enrollment in mandate-exempt plans.

In the individual market, there was a large increase in the median deductible between 2002 and 2005, an increase in OOP maximums, and a reduction in the share of enrollees with unlimited lifetime benefits; enrollment increased in plans without cost sharing for hospitalizations and office visits after the deductible has been reached.

Despite being offered for a short time, HSAs make up roughly 10 percent of the product offerings in both the small group and individual market. Their share of enrollment, however, was much lower.

As cost sharing levels increase, there is concern among policy makers about how this will affect enrollees. While, high deductible plans are usually associated with cost savings in the form of a lower premium, they may also discourage people from seeking health care when they need it.⁷ Similarly, while cost sharing is intended to deter misuse and overuse of services by making enrollees responsible for a portion of the cost of care, there is also concern that cost sharing can create a barrier to the appropriate use of services. This can have a disproportionate impact on high users of health care (the elderly and chronically ill).⁸ The Health Economics Program will continue to monitor these trends to determine their impact on health care access and cost.

Endnotes

- ¹ The Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2005 Annual Survey," September 2005.
- ² Minnesota Department of Health, Health Economics Program, "The Structure of Cost Sharing and Benefit Levels in The Structure of Cost Sharing and Benefit Levels in Minnesota's Small Group and Individual Insurance Markets," Issue Brief 2003-11, October 2003.
- ³ Minnesota Statutes Section 62L.05.
- ⁴ Minnesota Department of Health, Health Economics Program, Minnesota Small Employer Health Insurance Survey, 1997. This decline was related to the fact that in 1996 a company that held more than half of the enrollment in these plans ceased to do business in Minnesota. Other companies with a sizable enrollment in these plans in 1996 also had significantly less enrollment in 2002.
- ⁵ Minnesota Statutes Section 62L.056.
- ⁶ Based on the data collected, it is not possible to determine how many enrollees purchase family policies.
- ⁷ Newhouse, Joseph P., "Free for All? Lessons from the RAND Health Insurance Experiment", Harvard University Press, Cambridge, Mass. (1993).
- ⁸ Ibid.

The Health Economics Program conducts research and applied policy analysis to monitor changes in the health care marketplace; to understand factors influencing health care cost, quality and access; and to provide technical assistance in the development of state health care policy.

For more information, contact the Health Economics Program at (651) 282-6367. This issue brief, as well as other Health Economics Program publications, can be found on our website at: <http://www.health.state.mn.us/divs/hpsc/hep/index.html>

Minnesota Department of Health
Health Economics Program
85 East Seventh Place, P.O. Box 64882
St. Paul, MN 55164-0882
(651) 282-6367

