Health Care Access in Minnesota, Baseline Analysis for Assessing the Impact of the Health Reform in the State

The Health Economics Program of the Minnesota Department of Health and SHADAC of the University of Minnesota School of Public Health conduct a biennial population survey to assess trends in access to coverage and costs in Minnesota. The 2013 Minnesota Health Access Survey (MNHA) was conducted as the health care market prepared for implementation of substantial federal health reform provisions in 2014, including:

- Expansion of income eligibility for Medical Assistance (Minnesota's Medicaid program);
- Establishment of MNsure, the state's health insurance marketplace, through which eligible Minnesotans can obtain premium and cost sharing subsidies and comparison-shop for health insurance products;
- Establishment of guaranteed issue, under which pre-existing conditions will not act as a barrier to coverage;
- Reform in standards of available insurance products to include coverage of preventive services free of cost-sharing and remove annual and life-time benefit limits; and
- Requirement that all Minnesotans hold health insurance coverage.[1]

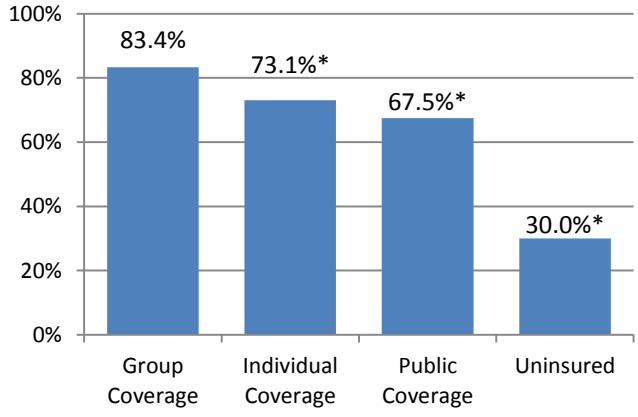
In an effort to establish a baseline against which to measure the effects of federal health reform (also called the Affordable Care Act, or ACA) implementation in Minnesota, this issue brief presents data from the 2013 MNHA on metrics of access to health care.[2] The issue brief also presents information on how well Minnesotans understood the health care market changes planned for 2014, at the time the survey was conducted (between August and November of 2013). Given high rates of coverage among Minnesotans age 65 and older, this brief focuses on the non-elderly population.[3]

Access to Health Care and Providers

While the ultimate goal of health insurance is to protect individuals' financial assets in the event of a health problem, health insurance also facilitates access to health care services. Thus, having health insurance increases confidence in the ability to get needed care, increases access to high-quality treatments and providers, and is associated with improved health outcomes.[4]

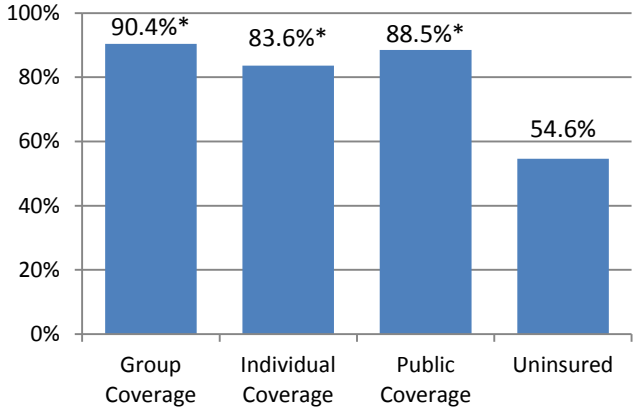
Overall, the majority of Minnesotans in 2013 were very confident in their ability to get needed health care. Specifically, 74.6% of non-elderly Minnesotans said they were very confident in their ability to get needed health care, and 91.1% said they were very or somewhat confident (data not shown). As shown in Figure 1, confidence varied greatly by type of insurance coverage. People with group coverage (coverage through an employer or union) showed higher confidence in their ability to get needed care than those who held other types of insurance coverage.[5] People who were uninsured were less than half as likely as other groups to be very confident they could get the care they needed (30.0%).

Figure 1
Percent of Non-elderly Minnesotans Very Confident they can get Needed Care



*Indicates statistically different from Group at 95% level

Figure2
Percent of Non-elderly Minnesotans with a Usual Source of Care



*Indicates statistically different from Uninsured at 95% level

Results from actuarial and economic modeling indicate coverage options are most likely to change for the uninsured and people with individual coverage.[6] As such, monitoring the perception of the remaining uninsured and people with individual coverage around access to care will be important. In addition, as the composition of public program enrollees has the potential of changing as well, continued monitoring of that population's sense of their confidence in getting needed care is equally important.

Having a usual source of care increases the likelihood of timely preventive care and health care access.[7] In 2013, the vast majority of Minnesotans had a usual source of health care – a typical place to go when sick, such a physician's office or health care clinic. Overall, 86.3% of non-elderly Minnesotans had a usual source of care (data not shown). Differences in the availability of a usual source of care by insurance coverage are as prevalent as Minnesotans' confidence in getting needed care. While the vast majority of the insured population had a usual source of care (Figure 2), only about half of the uninsured (54.6%) reported having that level of connection to a health care provider.

Although insurance coverage on its own doesn't guarantee access to health care providers, this and other research suggests that there is an association between insurance coverage and connectedness to health care providers. Through future research, MDH will monitor whether increased coverage leads to greater linkages between patients and providers, and to what extent minimum standards around preventive care and other delivery system reforms, such as the Health Care Home effort and movement towards payment systems with greater financial accountability for health care providers, contribute towards that change.

Financial Strain and Health Care

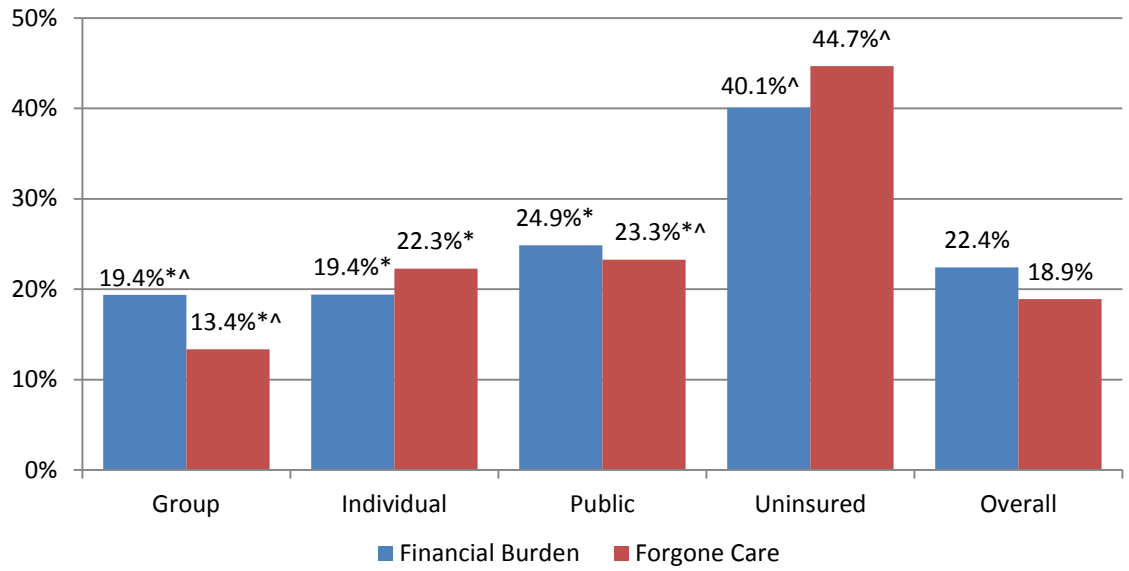
Even with insurance coverage, obtaining health care services can be costly for some. Two indicators were analyzed for this research to understand whether in 2013, prior to federal health reform implementation, Minnesotans experienced financial strain related to health care. One indicator assessed financial burden due to medical bills,[8] a second one determined whether Minnesotans ever felt they had to forgo needed care because of the associated cost.[9]

Using these metrics, nearly one-third of non-elderly Minnesotans (30.8%) experienced some financial strain (financial burden, forgone health care, or both) in 2013 due to health care costs. Specifically, in the past year, 22.4% of non-elderly Minnesotans experienced financial burden associated with health care services they consumed; 18.9% decided to forgo some type care because of the costs.

As shown in Figure 3, health insurance remains an important factor in reducing financial strain associated with health care costs –it does not, however, eliminate it. Minnesotans with group coverage were the least likely to experience financial strain associated with using medical care, and of those with group coverage who did experience issues, they appeared more likely to struggle with paying medical bills rather than having to decide to forgo care.

People with individual and public program coverage also experienced financial strain, albeit at levels significantly below those for the uninsured. Overall, nearly six in ten uninsured people (57.8%, data not shown) experienced some health care related financial strain; 40.1% reported struggling with financial burden due to health care bills, 44.7% decided to forgo some care due to cost.

Figure3
Percent of Minnesotans who Experience Financial Strain Due to Health Care by Insurance Coverage



*Indicates statistically different from Uninsured at 95% level
^Indicates statistically different from Overall at 95% level

Previous research indicates that insurance coverage has the potential to decrease the percent of people who experience financial burden, but not to completely eliminate it. For example, a Massachusetts study found significant financial burden among people with unsubsidized plans in the individual market; those with the equivalent of an ACA "bronze" plan, and incomes below 400% of the Federal Poverty Guidelines were more likely to experience financial burden than people with "Gold" or "Silver" plans, or higher incomes.[10] A study in Oregon, which looked at what happened to the uninsured who became eligible for Medicaid, found that Medicaid reduced financial strain after two years on the program.[11]

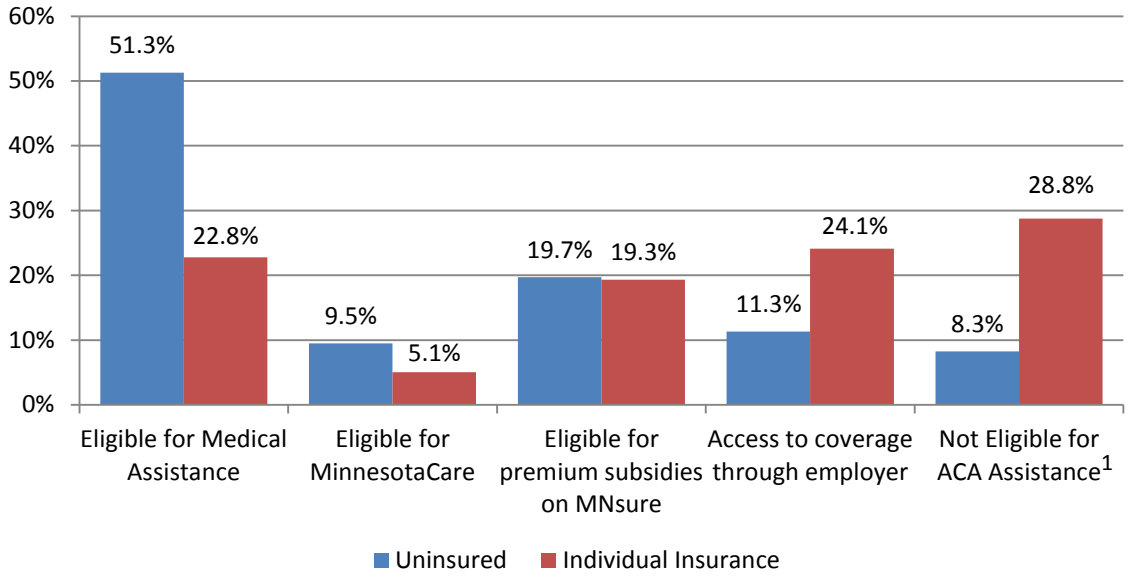
The changes in the health insurance market that extend beyond greater availability of affordable coverage have the potential to decrease financial strain of Minnesotans in the future. The magnitude of the decrease will depend on the mix of metal tiers among enrollees, the volume of care use, the extent to which people qualify for premium subsidies, and the level of health insurance literacy, which would allow enrollees to better understand the available benefits, as well as the implications of service use.

Potential Sources of Insurance Coverage Under the ACA

The vast majority of Minnesotans will have the option of maintaining their insurance coverage under federal health reform, either through their current employer coverage, Medicare, Medical Assistance (Medicaid) or Minnesota Care.[12] The groups most likely affected by changes in the insurance market are people currently covered under MinnesotaCare with incomes above 200% Federal Poverty Guidelines, those covered by the Minnesota Comprehensive Health Association (MCHA, Minnesota's high-risk pool), people who currently purchase health insurance on the individual market and Minnesotans who lack insurance coverage.

Figure 4 shows projected coverage options available in 2014 for those who were uninsured in 2013 or held individual insurance; these projections are based on estimates of income and current eligibility for employer coverage reported in the MNHA.[13] The coverage estimates are likely somewhat overstated, because the survey does not identify immigration status, thereby removing the possibility to exclude non-documented residents from eligibility estimates.[14]

Figure 4
Potential Sources of Health Insurance in 2014



[1] This category includes those with individual coverage or who are uninsured with incomes greater than 400% of the Federal Poverty Guidelines. While they are not eligible for tax credits, they are still eligible to purchase insurance on MNsure. In addition, they are also subject to the ACA requirement to carry health insurance, or pay a penalty.

Only 8.3% of the uninsured and 28.8% of those who currently have individual coverage will not explicitly be able to benefit from expanded public program eligibility or available premium and cost sharing subsidies available under the ACA. Of the uninsured, over half are likely to be eligible for Medical Assistance, just under 10% might be eligible for MinnesotaCare and another 19.7% likely are eligible for premium subsidies on Minnesota's insurance exchange.

In the individual market, about 30% are likely eligible for public programs (Medical Assistance or MinnesotaCare), an additional 19.3% are potentially eligible for premium subsidies through MNsure, and just under one quarter already have access to coverage through an employer.

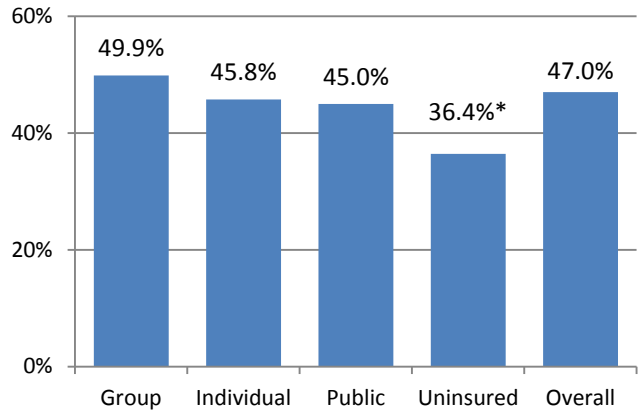
Are Minnesotans knowledgeable about health reform?

Federal health reform aims to improve health care access by providing a range of pathways to affordable health insurance coverage that covers essential health benefits. Opportunities for financial support along the way depend on people's incomes and life circumstances, but most of all, they require Minnesotans to become active decision-makers in purchasing coverage, apply for subsidies and submit information as evidence for eligibility. This means complexities remain and they may present challenges to Minnesotans potentially eligible for premium and/or cost sharing support. A lack of awareness of relevant health reform provisions and opportunities embedded in them may also limit the potential gains in new and more comprehensive insurance coverage.

National studies have shown that around half of adults feel they know enough about federal health reform to understand how it will impact them, and familiarity with provisions of the law vary widely.[15] The 2013 MNHA aimed to assess whether Minnesotans most likely to benefit from reform provisions understand this new landscape.[16]

Slightly fewer than half, 47.0%, of all non-elderly Minnesota adults felt they had enough information about health care reform provisions to understand how they would be impacted by the reforms in 2014. However, as shown in Figure 5, people most likely to be impacted by the ACA – those who lack insurance coverage – were the least likely to say they had enough knowledge to understand how the reforms would impact them (36.4%).

Figure 5
Percent of Minnesotans Who Feel They Have Enough Information to Understand How the ACA Will Impact Them



*Indicates statistically different from Overall at 95% level

There were notable differences between the levels of familiarity with specific provisions, including by current insurance coverage (see Table 1). Overall, Minnesotans were most familiar with the requirements that all people hold insurance coverage and that health insurance companies offer coverage to all, independent of their health status and the presence of pre-existing conditions (72.4% and 72.2% respectively).

Also of note:

- In general, people with group coverage exhibited the highest degree of familiarity with most provisions; they are also the population that is least likely to be impacted by insurance market changes.
- People who held individual coverage in 2013 expressed familiarity with the reform provisions comparable to other Minnesotans who held insurance coverage – of potential concern is that fewer than half (46.9%) appeared familiar with the availability of financial support for eligible enrollees in coverage through MNsure.
- Among the publicly insured, only 43.8% expressed familiarity with the availability of health insurance exchanges which also acts as key pathway to coverage for state public programs.
- The uninsured, the group most likely to benefit from a number of reform provisions, were consistently the least familiar with health reform provisions, including the availability of tax credits, through which this disproportionately low-income population could obtain affordable access to coverage.

Table 1: Familiarity with ACA Provisions Among Non-elderly Minnesota Adults by Current Insurance Coverage

How familiar are you with the part of the law that…(% very or somewhat familiar)	Current Insurance Coverage				
	Group	Individual	Public	Uninsured	Overall
Public Health Insurance Coverage: …allows more people to get Medical Assistance or Medicaid	54.8%	56.0%	55.3%	39.6%*	52.9%
Health Insurance Marketplaces: …sets up a new marketplace to shop for health insurance, called MNsure?	61.0%*	60.9%	43.8%*	42.5%*	55.7%
Financial Support for Eligible Enrollees: …allows some people to get tax credits or subsidies to help pay the premium?	45.4%*	46.9%	32.1%*	33.1%*	41.7%
No Pre-Existing Condition Exclusion: …requires insurance companies to offer coverage even if someone has a health problem, called a pre-existing condition?	77.2%*	81.2%*	62.7%*	56.0%*	72.2%
Requirement to Hold Health Insurance: …requires everyone to have insurance, called the individual mandate?	76.4%*	80.9%*	62.2%*	61.8%*	72.4%

* Indicates statistically different from Overall at 95% level

While it is clear that successful implementation of federal health reform in 2014 could be affected by low levels of understanding or familiarity with individual reform provisions, there is strong evidence in Minnesota that media coverage, marketing and education can move the dial. Familiarity with all provisions of federal reform increased with the onset of MNsure marketing in early September 2013 and the opening of MNsure, on October 1, 2013.[17] The greatest increase in familiarity (50%) concerned the existence of MNsure as a new marketplace on which to shop for insurance coverage.

In follow-up research, the Health Economics Program will study differences in familiarity with health reform provisions among socio-demographic characteristics and geographical areas of the state. These analyses may assist with targeting future outreach to populations who disproportionately struggle with navigating health reform options.

Conclusions

In 2013, at the eve of federal health reform implementation, Minnesotans experienced substantial barriers to affordable access to insurance coverage and health care. Even the insured population was not isolated from financial strain related to obtaining needed health care services. Not surprisingly, access barriers for people without coverage were the most pronounced: The uninsured were least confident that they could obtain needed care, least likely to have had a usual place to go for care, they were most likely to experience financial strain related to health care services they obtained, and the uninsured were the most likely group to forgo needed care because of costs.

Yet, among all Minnesotans, the uninsured were least familiar with federal health reform provisions, including those that are specifically designed to support their access to affordable coverage and care. It is encouraging that greater exposure to the topic of health reform, including through MNsure marketing, has had a measurable impact on levels of familiarity among Minnesotans. Future efforts by MNsure, navigators, health care providers, and other stakeholders likely has the potential to further increase literacy with health reform provision in the state and increase the share of Minnesotans who hold protection against financial losses associated with health care needs.

The Health Economics Program aims to continue to contribute to Minnesota's understanding of health reform implementation, through studying successes and ongoing challenges. The next Minnesota Health Access Survey, which is scheduled to be conducted in 2015, will be an important tool in this effort.

Endnotes

[1] For a summary of the federal health reform law, see http://kff.org/health-reform/fact-sheet/summary-of-new-health-reform-law/

[2] For initial results from the 2013 MNHA, including an analysis of trends in the uninsurance rate, changes to uninsured population, and more extensive information on survey methods please see: Minnesota Department of Health, Health Economics Program and University of Minnesota, School of Public Health, "Health Insurance Coverage in Minnesota: Results from the 2013 Minnesota Health Access Survey," Fact Sheet, February 2014; www.health.state.mn.us/healtheconomics.

[3] Over 95% of elderly Minnesotans are covered by Medicare, and fewer than 1% of are uninsured. As a group, the elderly are not expected to see substantial changes to their coverage as a result of reforms. Unless otherwise noted, all analyses and comparisons in this issue brief refer to non-elderly Minnesotans.

[4] Institute of Medicine. 2009. America's Uninsured Crisis: Consequences for Health and Health Care. Washington, DC: The National Academies Press

[5] Unless otherwise noted, differences described in this issue brief are statistically significant at the 95% level.

[6] Gruber, J and Gorman, B, 2013 http://archive.leg.state.mn.us/docs/2013/other/130416.pdf

[7] For example, see IOM (Institute of Medicine). 2009. America's Uninsured Crisis: Consequences for Health and Health Care. Washington, DC: The National Academies Press; http://www.commonwealthfund.org/Performance-Snapshots/Financial-and-Structural-Access-to-Care/Usual-Source-of-Care-and-Receipt-of-Preventive-Care.aspx; Blewett, LA, Johnson, PJ, Lee, B and Scal, PB., "When a Usual Source of Care and Usual Provider Matter: Adults Prevention and Screening Services." J. General Internal Medicine. 2008; 23(9): 1354-1360.

[8] A person was considered to experience financial burden due to health care expenses ("financial burden") if they reported having had problems paying medical bills; needed to set up a payment plan with a clinic to cover medical bills; or experienced trouble paying for food, rent and other basic bills due to medical costs. See Galbraith, AA, Sinaiko, AD, Soumerai, SB, Dutta-Linn, M and Lieu TA., "Some Families Who Purchased Health Coverage Through The Massachusetts Connector Wound Up With High Financial Burdens". Health Affairs. 2013; 32(5):974-983

[9] The survey assessed whether respondents ever had to forgo needed care due to cost ("forgone care") in the following categories: prescription drugs, dental care, routine medical care, mental health care and specialist medical care.

[10] Galbraith, AA, et al., 2013.

[11] Baicker, K, Taubman, SL, Allen, HL et al., "The Oregon Experiment – Effects of Medicaid on Clinical Outcomes. New England Journal of Medicine," 2013; 368(18): 1713-1722.

[12] Gruber, J and Gorman, B, 2013 http://archive.leg.state.mn.us/docs/2013/other/130416.pdf

[13] For this analysis, eligibility for public coverage (Medical Assistance) preempted eligibility for employer coverage; therefore a small number of people potentially eligible for coverage through both Medical Assistance and an employer.

[14] The State Health Access Data Assistance Center estimates approximately 3% of non-elderly adults in Minnesota are unauthorized or recent immigrants. For some state programs, there is a waiting period for legal permanent residents before they become eligible. For more information on this issue, see http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/03/state-estimates-of-the-low-income-uninsured-not-eligible-for-the.html.

[15] For example, see http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-january-2014/

[16] For more information about the timing of each or the provisions, see http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html. The questions on the ACA were asked to the adult who responded to the survey for the household. For more information on this methodology, please contact the Health Economics Program at 651-201-3550 or health.mnha@state.mn.us

[17] The MNHA was in the field between August and November 2013.

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) 201-3550 or health.hep@state.mn.us. This issue brief, as well as other Health Economics Program publications, can be found on our website at http://www.health.state.mn.us/healtheconomics

Minnesota Department of Health
Health Economics Program
85 East Seventh Place, PO Box 64882
St. Paul, MN 55164-0882
(651) 201-3550