MDH Minnesota Department of Health
HEALTH ECONOMICS PROGRAM

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Health Insurance Coverage in Minnesota: Results from the 2015 Minnesota Health Access Survey

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Key Findings:

- In an unprecedented decrease, the MN uninsurance rate fell to 4.3 percent.
- 200,000 more Minnesotans had health insurance in 2015 compared to 2013.
- Group coverage remained steady with increases in public and non-group coverage.
- Despite across-the-board gains in coverage, historical disparities persisted.

As Minnesota and the nation saw increases in health insurance coverage in 2014, the rate of uninsurance coverage fell in the vast majority of states. In the first two years of implementation of the federal health reform legislation under the Patient Protection and Affordable Care Act (ACA), Minnesota experienced an unprecedented decline in the number of people without insurance coverage. Analysis from the first state-based survey reporting on 2015 trends shows uninsurance in Minnesota declining to 4.3 percent, from 8.2 percent in 2013. This is the lowest uninsurance rate recorded for Minnesota since it was first measures in the late 1990s.

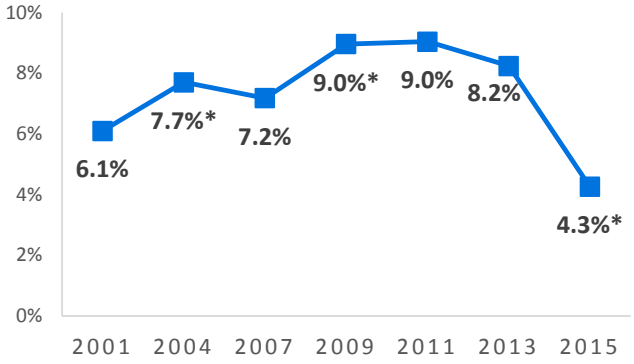
This issue brief summarizes a set of findings from the 2015 Minnesota Health Access Survey (MNHA). The MNHA is a biennial state population telephone survey, conducted in partnership between the Minnesota Department of Health and the State Health Access Data Assistance Center at the University of Minnesota's School of Public Health. It covers trends in uninsurance, changes in sources of health insurance coverage and characteristics of the remaining uninsured in Minnesota. Drawing on responses from 11,178 Minnesotans who participated in the survey, this issue brief aims to broaden understanding about gains in coverage and those who remain uninsured.

Health Insurance Coverage

In national comparisons, Minnesota has always enjoyed relatively high rates of insurance coverage. This was driven in part by significant employer participation in health coverage, but also by a population with higher income and educational attainment. Prior to 2015, coverage rates ranged between 94 and 91 percent of the population, generally placing the state among the top five states with the highest insurance coverage.

In 2015, the rate of health insurance coverage rose to nearly 96 percent, reaching the highest rate ever measured in Minnesota; the uninsured accounted for 4.3 percent of the population that year (Figure 1).[1] MDH estimates that between 2013 (the last MNHA survey) and 2015, 213,000 additional Minnesotans gained coverage, leaving approximately 234,000 Minnesotans lacking health insurance coverage. This large drop is similar to what national surveys indicate – a dramatic decrease in the rate of uninsurance between 2013 and 2014, with a continued drop into 2015.[2]

Figure 1: Uninsurance Rate in Minnesota, 2001 to 2015



Source: Minnesota Health Access Survey
*Indicates statistically significant difference from previous year shown at the 95% level

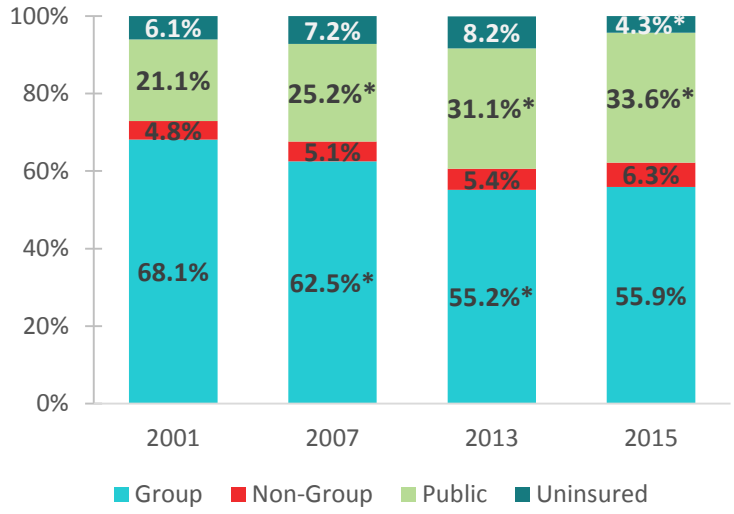
Sources of Health Insurance Coverage

The backbone of the health insurance market in Minnesota is coverage provided by employers to employees and their spouses and dependents in what is called the "group" market. In order to benefit from group coverage, an individual must first be connected to an employer who offers coverage, either through their own employment or that of a family member. Then, they must be eligible for the coverage (based on hours worked, income, tenure, or other factors), and decide to accept, or "take up" that coverage.

While employer-sponsored insurance remains the most common source of coverage in Minnesota, group coverage in Minnesota had fallen steadily since 2001 (Figure 2), consistent with national trends. That trend ended in 2015, with the percent of Minnesotans covered by group coverage holding steady at 55.9 percent. A number of factors likely played a role in stabilizing group coverage between 2013 and 2015, including:

- Economic improvements as represented by lower unemployment and increasing economic growth;
- The 2015 requirement that employers with 100 or more employees offer affordable coverage or face penalties under the Patient Protection and Affordable Care Act (ACA);[3]
- A slight uptick (though not statistically significant) in the percent of Minnesotans connected to an employer who offered coverage (77.1 percent);
- Steady eligibility for group coverage among individuals connected to an employer who offers it (95.8 percent); and
- Unchanged rates in employees accepting health insurance coverage through their employer; the rates of take-up was at 87.3 percent of non-elderly Minnesotans.

Figure 2: Sources of Coverage, Select Years



Source: Minnesota Health Access Survey
* Indicates statistically significant difference from previous year shown at the 95% level

As in 2014, most Americans were required to have health insurance coverage in 2015, or face a penalty. The additional twelve months of exposure to this requirement, in the form of media coverage and tax filings, may have contributed to employees accepting employer coverage.

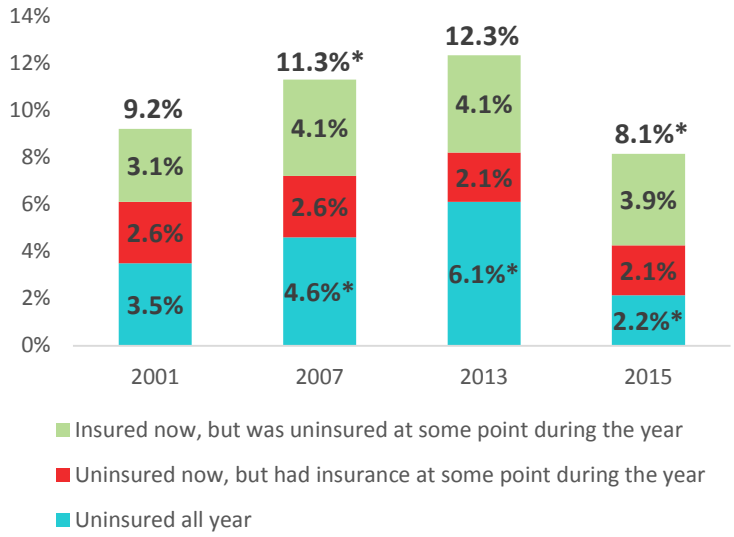
2015 also marked the second consecutive increase in public coverage, from 31.1 percent in 2013 to 33.6 percent in 2015, and continued an overall upward trend in public coverage over the past 15 years. (Figure 2).[4] Over time, a range of factors have contributed to this increase including: (1) The economic downturn of 2007 led to lower incomes, thus increasing the number of people eligible for Medical Assistance; (2) the aging of the state has raised the number and share of Minnesotans eligible for Medicare, and (3) the Medicaid eligibilty expansions under the ACA in 2011 and 2014 brought public program coverage to more Minnesotans. The effort to publicize this opportunity to Minnesotans helped connect people with coverage who had been eligible even under previous coverage rules, including children, who saw the greatest increase in public program coverage.

The 2015 results shows enrollment in the non-group (individual) market[5] rising slightly, to 6.3 percent. While not a statistically significant change, the 0.8 percent increase from 2013 represents the largest increase between surveys. It mirrors administrative data that indicate the non-group market in Minnesota grew by about 70,000 people between the end of 2013 and the middle of 2015.[6] Enrollment changes in the non-group market were precipitated the requirement to carry insurance coverage and other major changes to the market rules of the ACA, most significantly, that premiums could not vary by health status and people with pre-existing health conditions could not be denied coverage. In addition, the creation of MNsure, Minnesota's health insurance marketplace, created a platform for health plan comparison and for obtaining premium and cost sharing subsidies.[7]

Changes in the Distribution of the Uninsured

Health insurance coverage is not static for everyone. Some people experience shifts in the type or source of coverage, while others may experience gaps that are short, for instance because of transitions between jobs. Figure 3 shows that the decline in people who experienced an episode of uninsurance in 2015 – whether short or long – fell from 12.3 percent to 8.1 percent.

Figure 3: Alternate Measures of Uninsurance



Source: Minnesota Health Access Survey
* Indicates statistically significant difference from previous year shown at the 95% level. Estimates were rounded

This drop was nearly exclusively driven by the substantial reduction in the long-term uninsured, people who lacked coverage for a year or longer. In other words, while the share of individuals with a gap in coverage in 2015 stayed unchanged compared to 2013 – 3.9 percent were insured but had a gap in the past and 2.1 percent were uninsured at the time of the survey, but held coverage in the past – 213,000 fewer people in 2015 were without insurance coverage for a year or longer.

The decline in the long-term uninsured is important because it indicates that fewer people may be facing structural barriers to obtaining health coverage. People without coverage for a long time also experience greater barriers to obtaining needed care and greater financial risk associated with catastrophic health care needs. However, past research shows that financial barriers to care exist even for insured people, and concern over the implication of greater cost sharing has been rising. MDH is currently analyzing this question with the newest available data.

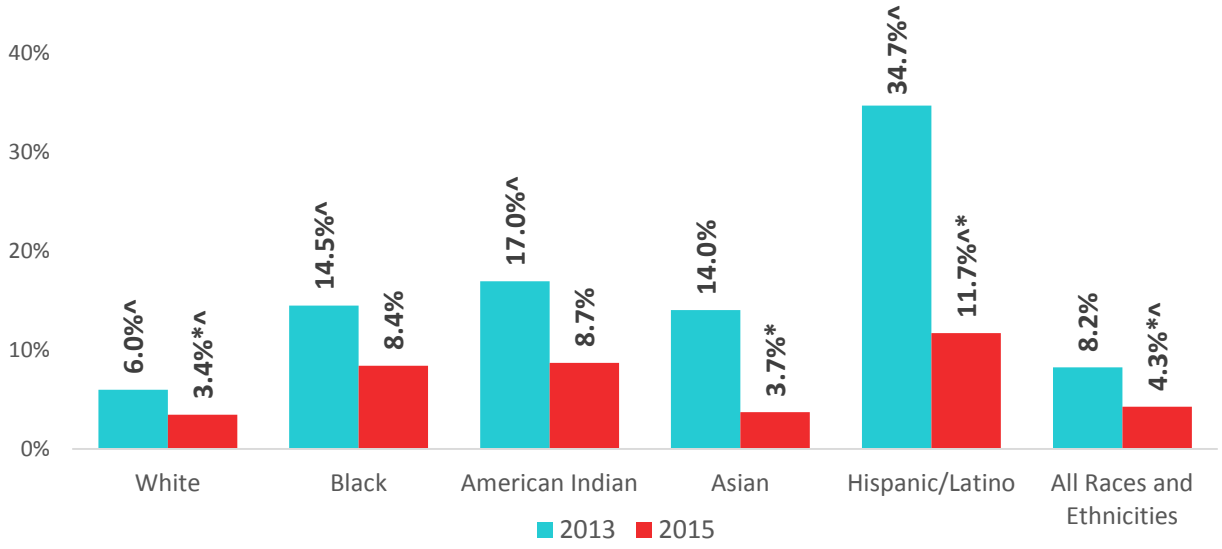
For those who gained coverage – whether they had been uninsured for a shorter or longer time – two reasons stood out: About twenty-four percent (23.7 percent) cited job gains as a reason, with another 22.8 percent reporting coverage through new eligibility for public programs or employer coverage. An additional 22.0 percent cited needing or wanting health insurance, or protection from medical bills. A smaller percentage (11.8 percent) suggested the ACA directly influenced their decision: (1) they responded to the mandate to hold coverage (5.6 percent), (2) they did not want to pay a penalty or fine for not having coverage (4.2 percent), or (3) they referenced the availability of MNsure (2 percent) as their primary reason for gaining coverage.

Persistent Disparities

While the overall uninsurance rate for Minnesota has declined across virtually all demographic categories, significant disparities in health insurance coverage persist in the state, especially by race, ethnicity, age and income.[8] These disparities may be impacting health-related inequities in Minnesota such as higher infant mortality and higher rates of chronic diseases as insurance coverage plays an important role in enabling access to health care services.[9]

As shown in Figure 4, Minnesota saw major decreases in uninsurance across all racial and ethnic groups. For American Indians and Black Minnesotans, the decline was not statistically

Figure 4: Uninsurance Rates by Race and Ethnicity, 2013 and 2015



Source: Minnesota Health Access Survey
* Indicates statistically significant difference from 2013 at the 95% level
^ Indicates statistically significant difference from All Races and Ethnicities rate at the 95% level

significant, in part because of smaller sample sizes in the study. For most groups, uninsurance rates were cut in half; for Hispanic/Latino Minnesotans, the rate of uninsurance decreased by nearly 200 percent.

Seeing decreases in all groups indicates that policies to reduce uninsurance rates were working for Minnesotans, on average. But while the overall rate of uninsurance dropped, the two to three-fold gap in coverage between people of color, American Indians and Whites remained. For the Black community the gap in coverage compared to Whites (the group with the lowest rates) actually widened in 2015 (from 2.4 times the white rate in 2013 to 2.5 times the white rate in 2015).

A similar pattern of improved across-the-board coverage, paired with persistent historical inequities, emerged across other demographic characteristics.

- **Household Income:** Although Minnesotans with incomes at or below 400 percent of the Federal Poverty Guidelines (FPG)[10] saw significant reductions in uninsurance in 2015, the lowest-income residents (those under 200 percent FPG) continued to experience rates significantly higher than people with higher incomes (see Appendix Table 1). Despite their potential access to Medicaid coverage, people in poverty (incomes at 100 percent of FPG) had a rate of uninsurance nearly three times the state average (11.5 percent).[11]
- **Education:** Uninsurance rates were halved between 2013 and 2015 for those who had completed at least some college, with the uninsurance rate falling to 1.1 percent for those with postgraduate education (from 2.6 percent). While rates for Minnesotans who had completed high school fell from 11.0 percent to 6.5 percent, they, along with people who had not completed high school, continued to experience higher rates of

uninsurance (from 20.0 percent to 12.0 percent, respectively), and both groups experienced a widening gap compared to the statewide rate for both groups.[12]

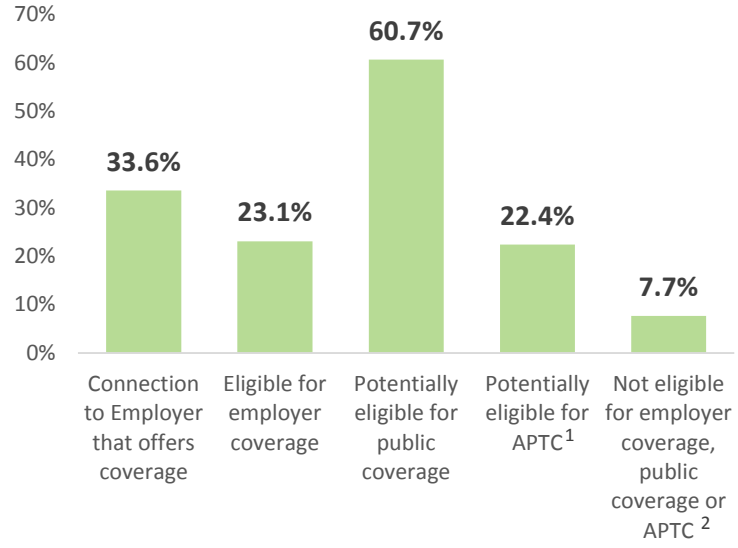
- **Age:** Young adults, aged 18-34, have traditionally had the highest rates of uninsurance, with children and the near-elderly (age 55-64) having the lowest rates. While that pattern held steady, all age groups saw dramatic gains in insurance coverage. Of note, the uninsurance rate for young adults aged 18 to 34 was halved between 2013 and 2015 (from 15.3 percent to 7.3 percent) and the rate for the near-elderly also saw a significant decrease (from 6.2 percent to 2.8 percent). Both groups saw significant increases in coverage in the non-group market.

The gains in coverage by the near-elderly are particularly striking. Given the relationship between age and the likelihood of experiencing chronic conditions, this population may have been most affected by not being able to get coverage because of pre-existing health conditions. The impact of the ACA in 2014 and 2015 may have been most impactful for the near-elderly and the young adults, who benefited from the expansion of dependent coverage.[13]

Pathways to Coverage for the Remaining Uninsured

Dating back to 2001, MDH has estimated that typically between 70 and 80 percent of the uninsured potentially have had access to group coverage or were income-eligible for public coverage. As shown in Figure 5, with the addition of federal premium assistance (advanced premium tax credits, or APTC) and the increase in the income limits for Medical Assistance, an estimated 92.3 percent of the uninsured in 2015 had a potential pathway to some form of subsidized health insurance coverage. Some had multiple pathways to coverage, such as being income eligible for Medical Assistance, and also eligible for coverage through their employer, while others may work for an employer who offers coverage, but are not eligible for that coverage, and instead have access to APTC.

Figure 5: Potential Sources of Coverage for the Uninsured



Source: Minnesota Health Access Survey
[1] APTC is Advanced Premium Tax Credits
[2] Categories may overlap. For example, a person could be eligible for coverage through an employer and also potentially eligible for Medical Assistance based on their income.

Despite a lowering of income limits for adults on MinnesotaCare (from 275 percent to 200 percent FPG), three in five uninsured Minnesotans, or 60 percent, may have been eligible for state public programs in 2015. Although we do not have a full understanding of the extent to which immigration

status may affect this estimate, our data show that the vast majority of these individuals over two years of age (87.8 percent) were U.S. citizens in 2015 and therefore eligible for public programs and public subsidies.

As part of our aim to understand the potential coverage options available to the remaining uninsured, we wanted to assess what share of this population might be eligible for premium tax subsidies for coverage purchased through MNsure, Minnesota's health insurance exchange. Figure 5 shows that approximately 22 percent of the uninsured, or 51,000 people, could have potentially taken advantage of this subsidy based on their income as reported via the MNHA.

While the survey did not ask about awareness of premium supports such as the APTC, it is possible that some Minnesotans are still not aware that they may be eligible for tax credits. Earlier research conducted in late 2013 indicated that only 33.1 percent of uninsured adults under 65 were familiar with APTC.[14] MDH estimates that 82,000 Minnesotans who held non-group coverage in 2015 had incomes that would make them eligible for premium tax subsidies, yet data from MNsure indicates only 26,500 people received these subsidies. Other potential interpretations of the lower take-up of the subsidy could be related to:

- The complexity associated with assessing the value of the subsidy and the net coverage cost for many families. Eligibility is based on income and the premium cost for a given insurance policy.
- Concern about sharing information on family income with MNsure or other facilitators of gaining coverage.
- Feeling that health insurance coverage is not worth the cost compared to other expenses, especially with high cost sharing.

Summary and Conclusions

In the second year of implementing major federal coverage provisions, Minnesota saw broad gains in health insurance that led to a reduction of uninsured Minnesotans by over 200,000 compared to 2013 and the lowest-ever rate of uninsurance in the state (4.3 percent). This reduction was fueled by steady levels of employer coverage, modest gains in non-group coverage and substantial improvements in take up of public health insurance coverage.

Among the uninsured, the most substantial improvement in 2015 occurred for people who were uninsured one year or longer. This population fell by an unprecedented 213,000. Other promising gains were seen for children, young adults and the Hispanic/Latino community (declines of 36,000, 99,000, and 59,000, respectively).

The data used in the preparation of this report does not lend itself to making easy, causal inferences about the primary reason for the gain in coverage – data that track study participants over time would be better suited to that task. However, there are a number of empirical observations that demonstrate the distinct effect the ACA had on Minnesota's coverage trends, even if they are somewhat bolstered by economic gains:

- National surveys suggest that post-ACA coverage gains continued in most states, even when economic improvements were not as strong as in Minnesota;
- In response to expansions of public program eligibility and outreach to the community, coverage in Minnesota's Medicaid program, Medical Assistance, rose substantially. In part, this reduced the number of people who in the past were uninsured but appeared eligible for public program coverage;
- Many Minnesotans also obtained coverage in the non-group market, including through Minnesota's health insurance marketplace, MNsure, where they were able to obtain premium and cost-sharing subsidies;
- For the first time, people who were long-term uninsured and presumably experienced the most entrenched structural barriers to obtaining coverage, accounted for less than 2.5 percent of the population; and
- Among people who obtained coverage, about 12 percent reported doing so because they understood it was a requirement, sought to avoid a fine associated with not having coverage and/or realized they were eligible for more easily available coverage and subsidies.

Our initial research suggests there are two primary areas of opportunities to make additional improvements in coverage in Minnesota:

(1) Nearly all of the uninsured in 2015 appear to have some existing pathway to coverage, either through an employer offer, public program eligibility or premium subsidies for private coverage, though not all of them may be aware of these options.

(2) The continuing variation in coverage rates in Minnesota that has led to inequities by race, ethnicity, age, and income provide a benchmark for what is achievable for populations of color, American Indians and others with the greatest disparities, if the right tools are put in place.

To make further gains in coverage, it will be essential that the remaining uninsured have the tools and necessary support to overcome challenges associated with health insurance literacy, life event transitions and costs of coverage. Yet, not all Minnesotans will likely be able to take advantage of coverage options. At some point, policy-makers and others may wish to look for models outside of the health insurance framework to ensure access to needed health care services for individuals who remain without coverage. Data on rates of insurance coverage from some other states suggest that point is somewhat in the future; Minnesota still has opportunities to make progress.

In closing, Minnesota has made great strides in expanding health insurance coverage and is poised to continue this work. For those who now have coverage, this is a critical step towards reducing financial strain and emotional stress, and obtaining needed health care services that can contribute to improving quality of life and health.

However, insurance coverage is necessary but not sufficient for ensuring access to care or better health. As coverage evolves and benefits change with rising health care costs, it will be important to ensure that the state is taking appropriate actions to control the costs borne by patients, and align patients with the right kind of subsidized health care programs, as well as understanding how successful individuals are at using their coverage, including accessing services preventively and taking advantage of services that support better health. There are opportunities outside of the medical system and services funded through insurance coverage. As noted, our work in this area will continue to provide empirical evidence along the way.

Ongoing Research using the Minnesota Health Access Survey

- Trends in financial and other barriers to using health care services;
- Differences in health care use and service providers, by coverage type;
- Dynamics of employer coverage changes;
- Estimates of coverage "churn" or transitions;
- Resources used to successfully obtain health coverage;
- Use of tax credits by Minnesotans potentially eligible for them;
- Availability of paid sick leave by demographic categories; and
- Trends and challenges with health insurance literacy.

Methodological Notes

The Minnesota Health Access (MNHA) surveys are stratified random digit dial telephone surveys, designed to produce stable estimates for regions of the state and the most population demographic groups. In 2015 landline and cell phone interviews were completed with 11,178 respondents (cell phones have been part of our sample since 2009). In 2015, prepaid cell phones were oversampled to ensure appropriate generalizability of our findings.

Consistent with national trends, the MNHA response and cooperation rates have decreased over time, with the response rate at 34.6 percent and the cooperation rate at 36.2 percent in 2015. Each year, interviews were conducted in English and Spanish; in addition, interviews were conducted in Hmong in 2001 and 2004, and Somali in 2001.

As in previous years, statistical weights were used to ensure that survey results are representative of the state's population. The 2015 data were weighted to be representative of the state's population distribution based on age, race/ethnicity, education, region, home-ownership, nativity and household size. Additionally, the data were weighted to represent what is known to date about the prevalence of cell phone households and the distribution of usage by service type. Estimates presented here for 2004, 2007, 2009, 2011 and 2013 may differ slightly from previously published results, as historical data may have been reweighted to ensure comparability over time.

Endnotes

[1] Unless otherwise noted, all differences referenced in the text are statistically significant at the 95% level.

[2] For example, the National Health Interview Survey (NHIS) estimates an uninsurance rate of 14.4% in 2013, 11.5% in 2014 and 9.1% through September of 2015. See Martinez ME, Cohen RA, Zammitti EP. Health insurance coverage: Early release of estimates from the National Health Interview Survey, January – September2015. National Center for Health Statistics. February 2016. Available from: http://www.cdc.gov/nchs/nhis/releases.htm.

[3] See http://healthaffairs.org/blog/2015/09/29/implementing-health-reform-pace-and-each-acts-pass-house-cms-addresses-consumers-enrolled-in-multiple-plans/

[4] Public coverage includes federal programs, such as Medicare and Veterans Affairs (VA) and TRICARE for veterans and members of the military; and state public programs Medical Assistance (Medicaid) and MinnesotaCare. Both administrative and national survey data from the American Community Survey confirm the upward trend in public coverage.

[5] Previously, the non-group market was referred to as the "individual" market. To avoid confusion between an insurance policy for one individual, and self-purchased insurance, we now refer to it as the non-group market.

[6] MDH analysis of data from the National Association of Insurance Commissioners (NAIC).

[7] Two types of subsidies are available: Advance Premium Tax Credits (APTC) are available to people with family incomes between 200 percent and 400 percent of the Federal Poverty Guidelines (FPG) who do not have access to affordable coverage through an employer. Cost Sharing Reduction (CSR) is available to people with family incomes between 200 percent and 250 percent FPG who purchase a qualifying silver level plan. Both APTC and CSR are only available for coverage purchased through MNsure.

[8] Minnesota Department of Health, Health Economics Program. Health Insurance Coverage in Minnesota: Results from the 2013 Minnesota Health Access Survey. May 2014. Available from: http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2013primary.pdf

[9] Minnesota Department of Health. Advancing Health Equity in Minnesota. February 2014. Available from: http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf

[10] Income is 2014 household income, reported as a percentage of the Federal Poverty Guidelines (FPG), https://aspe.hhs.gov/2014-poverty-guidelines, Volume 79 Federal Register, January 22, 2014, pp 3593-3594.

[11] A share of this population likely includes undocumented immigrant populations, who are not eligible for subsidized coverage on the health insurance exchange or public program benefits.

[12] For children under 18, educational attainment is that of the parent or primary wage earner in the household.

[13] Additional detail, including rates of uninsurance for a number of demographic groups are available in online: www.health.state.mn/healtheconomics and www.health.state.mn.us/healtheconomics/chartbook.

[14] Minnesota Department of Health, Health Economics Program. Health Care Access in Minnesota, Baseline Analysis for Assessing the Impact of Health Reform in the State. February 2014. Available from: http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/acaissuebrief0214.pdf

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