

Public and individual health insurance trends in rural Minnesota

ENROLLMENT DURING IMPLEMENTATION OF THE AFFORDABLE CARE ACT

Introduction

Most Minnesotans, including those living in rural areas, obtain their health insurance through an employer. However, coverage through two additional sources - public programs and the individual (or non-group) market – historically have been especially important in rural areas. This brief examines how enrollment in these types of insurance has changed since enactment of the Affordable Care Act (ACA) in 2010.

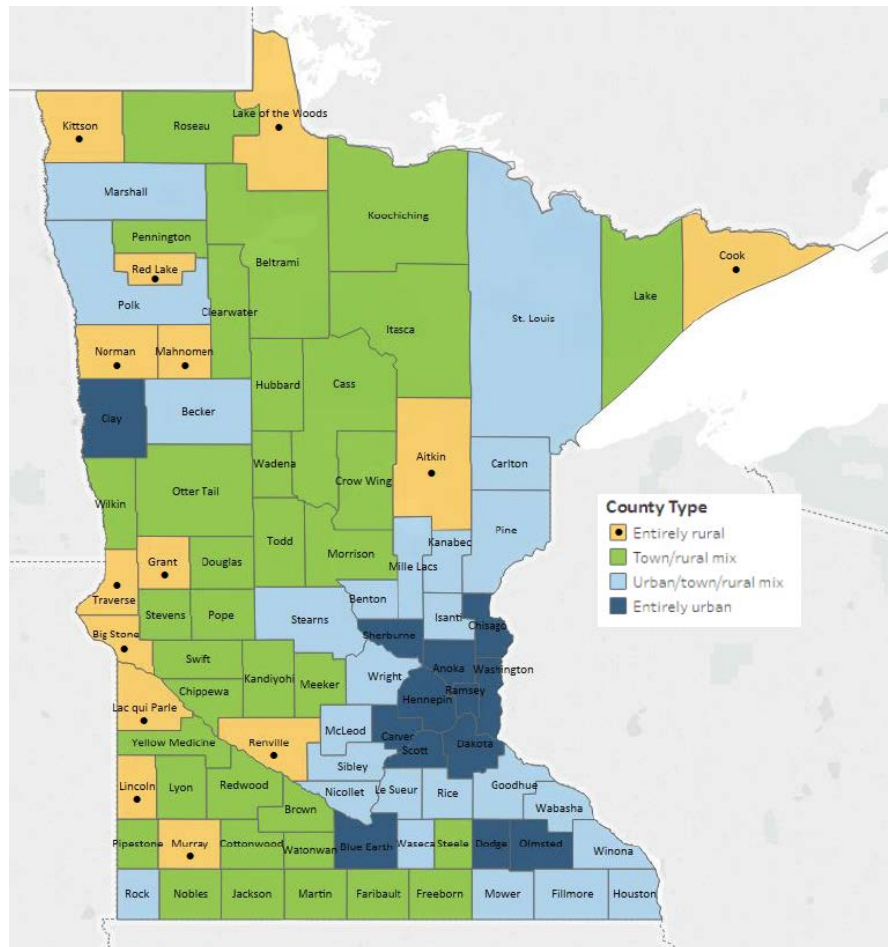
The analysis uses data from the Minnesota Department of Human Services and the Minnesota Department of Commerce.

To understand distribution, it also employs a new urban-rural classification system developed by the state demographer’s office, which categorizes Minnesota’s 87 counties into four groups (Figure 1):

- entirely rural
- small town/rural mix
- urban/small town/rural
- entirely urban.¹

Companion briefs on other rural health access issues and rural hospital finance over the same period are also available.²

Figure 1. Minnesota rural-urban county types



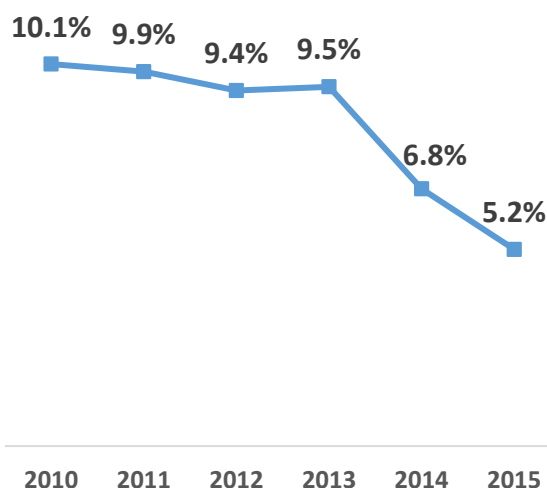
Source: Minnesota State Demographic Center, January 2017

Background

The Affordable Care Act (ACA) affected many aspects of the health care system, with insurance coverage changes among the most visible and dramatic of its impacts.

The number of Minnesotans with health insurance has grown significantly in the seven years since the law's enactment, driving down the state's uninsurance rate among the nonelderly population from 10 percent in 2010 to 5 percent in 2015, an all-time low.

Figure 2: Uninsurance rate in Minnesota, nonelderly population, 2010 to 2015



Source: SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files, State Health Compare, SHADAC, University of Minnesota, statehealthcompare.shadac.org.

Various types of insurance and supports for acquiring it have contributed to this historic shift, including the requirement to hold coverage, the availability of financial help for some to buy coverage and affording health care, resources to help Minnesotans understand their options and the availability of the new state “marketplace” (MNSure) that among other services provides a

“one-stop shop” for finding both public and private health insurance plans.

This brief focuses on trends in coverage through two specific sources of insurance changed by the ACA:

1. The state’s publicly funded health insurance options, also known as Minnesota Health Care Programs, and specifically its two largest programs: Medical Assistance and MinnesotaCare.
2. The individual market, which refers to insurance policies people obtain on their own and not through an employer or other source (which is why it also sometimes referred to as the private “non-group” market).

While the most common type of health insurance in Minnesota – including in rural areas – remains employer-based coverage (covering 56 percent of the state in 2015),³ this analysis focuses on public program and non-group coverage because historically, rural residents of the state have been more likely than their urban counterparts to rely on these types of coverage.^{4 5 6}

Public programs

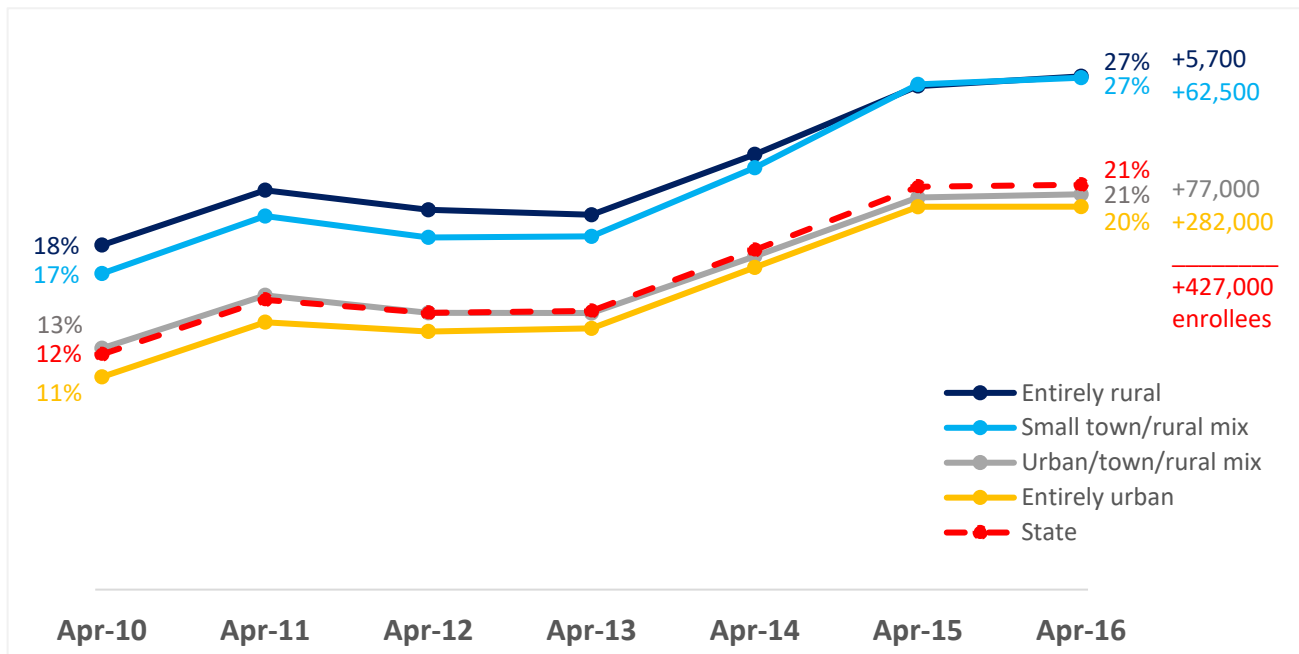
As states implemented portions of the ACA under their jurisdiction, Minnesota made some of the earliest and most significant changes to its public insurance programs. It expanded eligibility for Medical Assistance (MA, Minnesota’s version of Medicaid), first in early 2011 and again in early 2014. It was also the first state to establish a “Basic Health Plan,” an option under the ACA to provide affordable coverage to those who are low-income (138-200 percent of Federal Poverty Guidelines, or FPG) but not eligible for MA. It did so by adapting the long-standing MinnesotaCare program to meet the ACA’s standards.⁷

MA and MinnesotaCare combined enrollment trends

Key ACA implementation milestones saw shifts in the combined enrollment of MA and MinnesotaCare, with notable jumps occurring in 2011 (after the first expansion of MA) and 2014 (when multiple components of the ACA took effect, including the second expansion of MA and the launch of MNsure). See Appendix 1 for more detail on these and other ACA milestones, and Appendix 2 for how eligibility changes reshaped Minnesota’s public insurance coverage continuum.

Combined, the two programs saw a net statewide increase of 427,000 enrollees between 2010 and 2016, and by early 2016 insured 21 percent of the state’s nonelderly population (Figure 3). The state’s population also grew during this period, but only by 63,000.

Figure 3: Combined MinnesotaCare and MA enrollment as percent of population, <65 nondisabled adults and children, by rural-urban county group, 2010-2016



Notes: Does not include disabled adults enrolled in that portion of MA. Enrollment as of April of each year, with totals rounded.

Source: MDH analysis of Minnesota Health Care Programs enrollment data, Minnesota Department of Human Services; Population data from U.S. Census annual estimates, 2010-2015.

Looking at enrollment by county type reveals notable rural-urban differences.

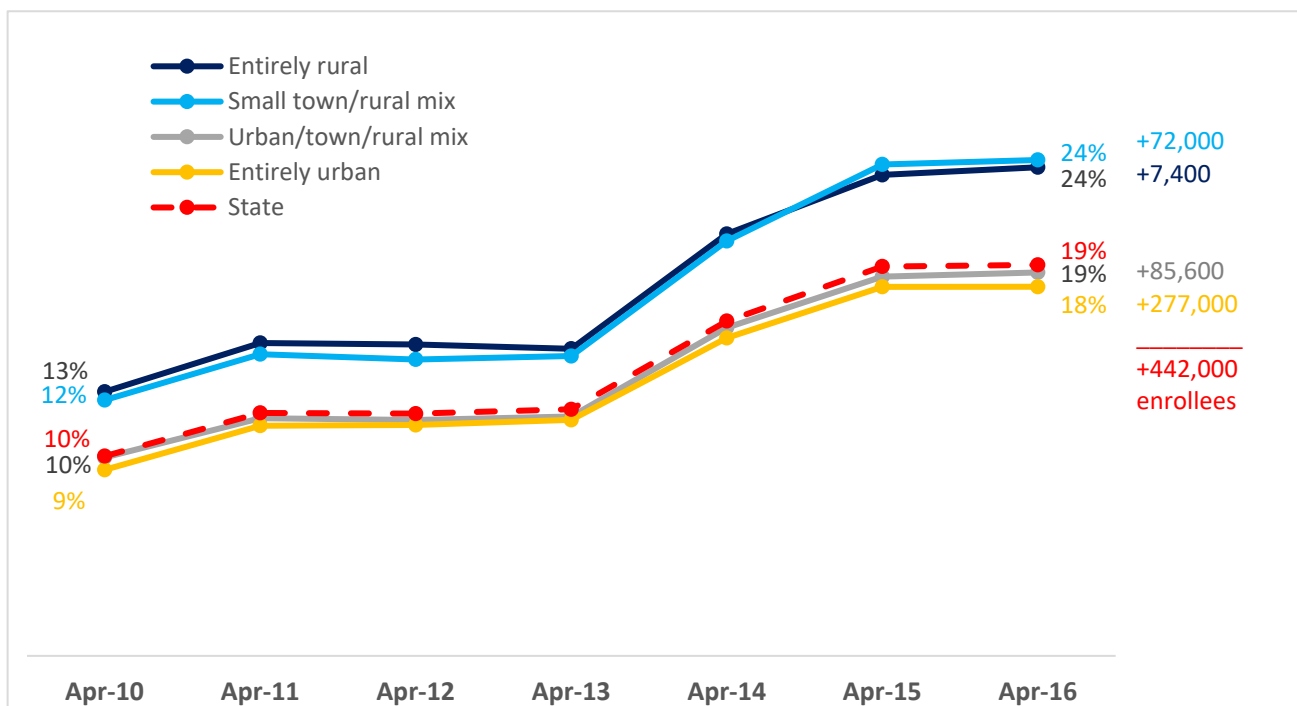
- Both pre- and post-ACA changes, rural Minnesota had a greater share of its population enrolled in the two public programs than more urban areas (27 percent compared to about 20 percent).
- Rural enrollment grew even as population decreased, with entirely rural counties adding 5,700 enrollees by 2015, while their population decreased by 4,000. Similarly, small town/rural mix counties added 62,500 enrollees even as they lost 15,500 residents. In contrast, entirely urban counties gained 282,000 enrollees alongside a population increase of 94,000.
- By early 2016, over 1 in 4 rural Minnesotans were enrolled in either MA or MinnesotaCare, compared to 1 in 5 in urban areas.

MA enrollment trends

With Medical Assistance enrollment specifically (and again focusing on nonelderly, nondisabled participants), the jumps after 2011 and 2013 appear even more substantial than when combined with MinnesotaCare. Overall, MA enrollment nearly doubled between 2010 and 2016: from 449,000 to 891,000 Minnesotans. By 2016, MA insured 19 percent of the state’s population, compared to 10 percent in 2010 (Figure 4).

It is important to note that a significant portion – approximately 100,000 – of the new MA enrollees as of April 2014 were former MinnesotaCare enrollees.⁸ The ACA required that any MinnesotaCare enrollees who were now eligible under the MA expansion be shifted from MinnesotaCare to MA.⁹

Figure 4: MA enrollment as percent of population, <65 nondisabled adults and children, by rural-urban county group, 2010-2016



Notes: Does not include disabled enrollees in that portion of MA. Enrollment as of April of each year, with totals rounded.

Source: MDH analysis of Minnesota Health Care Programs enrollment data, Minnesota Department of Human Services; Population data from U.S. Census annual estimates, 2010-2015.

Rural-urban differences appear here too.

- Both pre- and post-ACA, rural counties had a higher share of residents enrolled in MA than urban counties, and experienced a slightly greater increase in that share between 2010 and 2016.
- Of the 100,000 enrollees who moved from MinnesotaCare to MA in early 2014, a disproportionate share lived in rural Minnesota: 22 percent were residents of entirely rural and small town/rural mix counties (home to 15 percent of the state’s population) and 78 percent were from more urban counties (home to 85 percent of the population).
- By early 2016, 1 in 4 rural Minnesotans was enrolled in MA, compared to 1 in 5 in urban areas.

Interestingly, even though the expansion of MA to childless adults garnered more public attention, the growth in parents and children enrolled in the program was significantly higher. Between 2010 and 2016 there were an additional of 195,000 adults without children enrolled in the program, compared to 247,000 additional parents and children (Figures 4 and 5).

Figure 4. MA enrollment as percent of population, childless adults <65, by rural-urban county group, 2010-2016

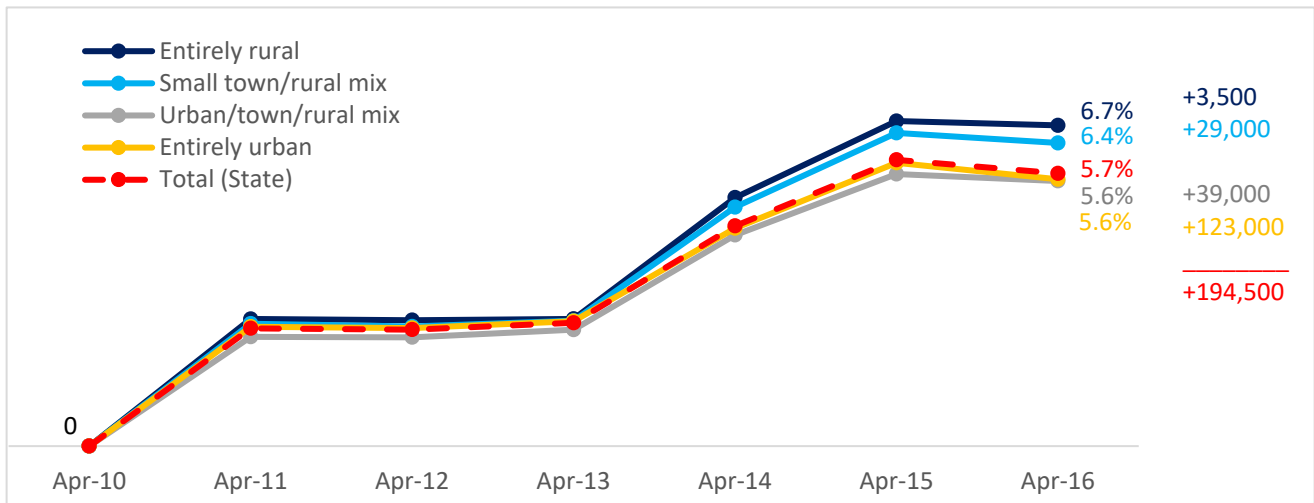
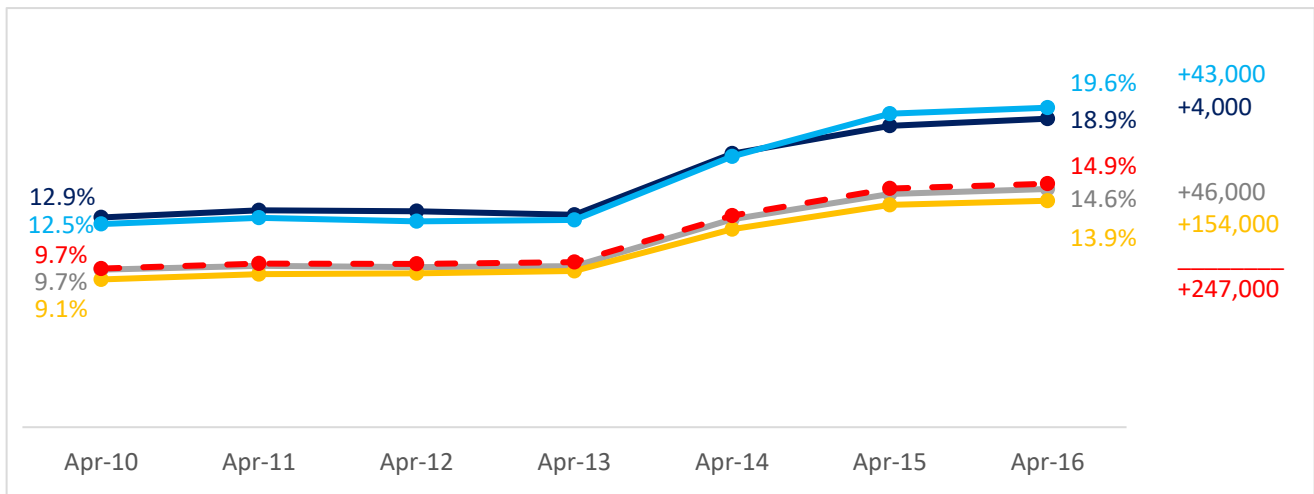


Figure 5. MA enrollment as percent of population, parents and children, by rural-urban county group, 2010-2016



Notes: Does not include disabled enrollees in that portion of MA. Enrollment as of April of each year, with totals rounded.

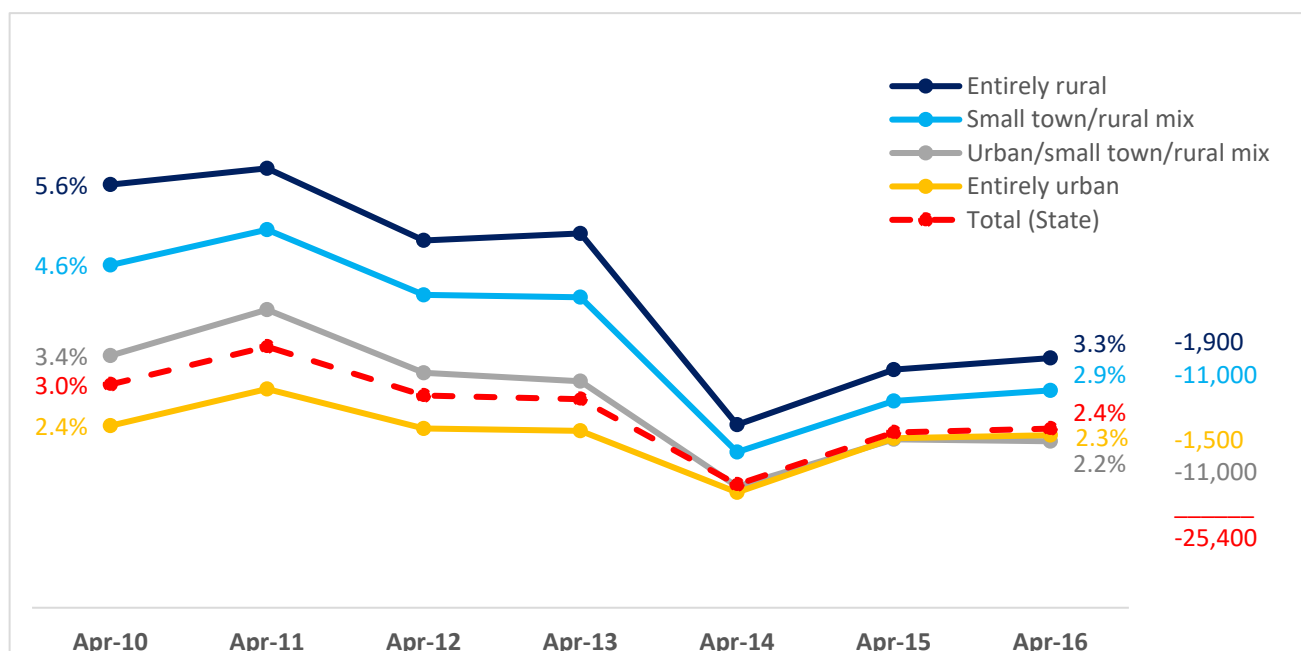
Source: MDH analysis of Minnesota Health Care Programs enrollment data, Minnesota Department of Human Services; Population data from U.S. Census annual estimates, 2010-2015.

In both of these MA populations, rural counties again had higher proportions of enrollees compared to more urban counties and the state overall. This difference was most pronounced in the case of families and children enrolled in the program.

MinnesotaCare

Unlike MA but related to changes to it, MinnesotaCare enrollment declined statewide after 2011, with the biggest drop corresponding with the size of eligibility changes in 2014 (Figure 6). Early that year, as MA eligibility was further expanded, MinnesotaCare was converted to a Basic Health Plan under the ACA. These changes affected MinnesotaCare enrollment in two ways: those individuals with incomes now eligible for MA moved out of MinnesotaCare and into MA, and those with incomes over 200 percent FPG were no longer eligible for MinnesotaCare (which up till then had an income ceiling of 275 percent FPG).¹⁰

Figure 6: MinnesotaCare enrollment as percent of population, by rural-urban county group, 2010-2016



Note: Enrollment as of April of each year, with totals rounded.

Data source: Minnesota Department Human Services enrollment data, October 2010-April 2016, U.S. Census data for 2010-2015.

Rural-urban differences are notable here, too:

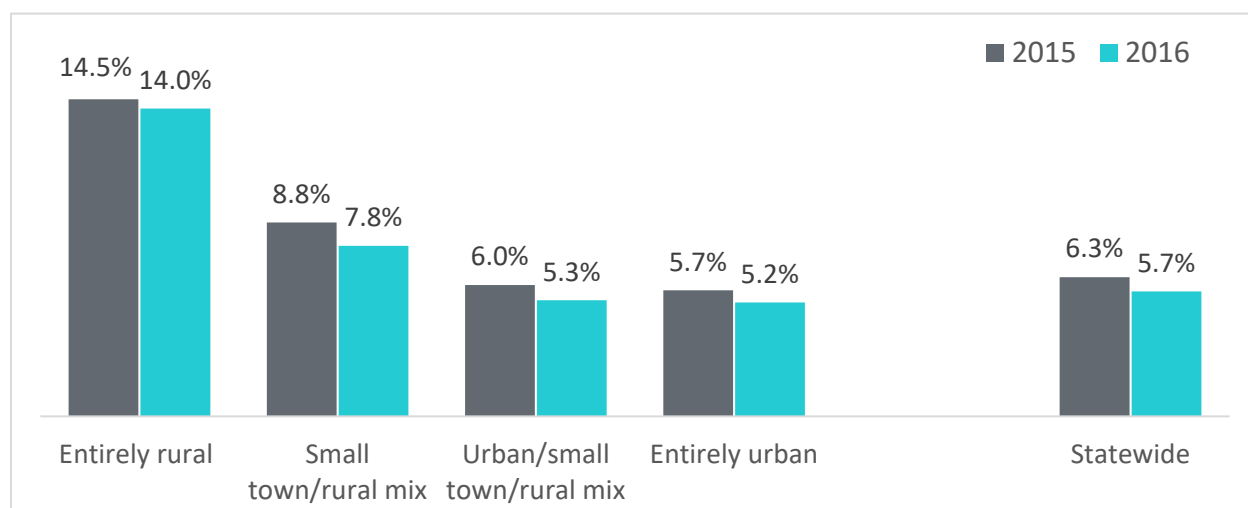
- As in the case of MA, rural counties had a higher share of MinnesotaCare enrollment than urban counties both pre- and post-ACA, though the gap narrowed after 2014.
- Following the eligibility shifts in early 2014, MinnesotaCare enrollment shrank in all 87 counties, but to the greatest degree in rural Minnesota: Of the 26,000 enrollees who left MinnesotaCare by 2016, half were from entirely rural or small town/rural mix counties.
- Entirely rural counties collectively saw their MinnesotaCare enrollment halved by 2016, compared to a much smaller percentage decrease (23 percent) in entirely urban counties. This translated to a greater absolute change in those rural counties as well. Despite being much smaller in population size (73,000 vs 963,000), entirely rural counties had 1,900 fewer MinnesotaCare enrollees by 2016, compared to 1,500 fewer in entirely urban counties.

Individual market

The individual market, sometimes referred to as the market for non-group insurance, is a place where people buy health insurance on their own, rather than receiving insurance through an employer or public program. In Minnesota, this type of health insurance covers a relatively small percentage of the state's population – about six to seven percent between 2010 and 2015¹¹ - but historically has been used more extensively in rural parts of the state, in part because more people tend to be self-employed, work part-time, or work for employers that do not offer comprehensive benefits.^{12 13 14}

Enrollment data at finer levels of rurality is available only for 2015 and 2016, but show that the proportion of Minnesotans covered by individual policies decreased statewide and across rural-urban county groups (Figure 7). Overall, the number of Minnesotans covered with individual coverage decreased by 10 percent between 2015 and 2016, from 297,000 to 267,000. The ACA likely played a role here as well: The availability of more affordable public program coverage meant fewer people needed coverage through the individual market.

Figure 7. Total individual market enrollment as percent of population, by rural-urban county group, 2015-2016



Data source: Minnesota Department of Commerce; U.S. Census data for 2015 population under age 65.

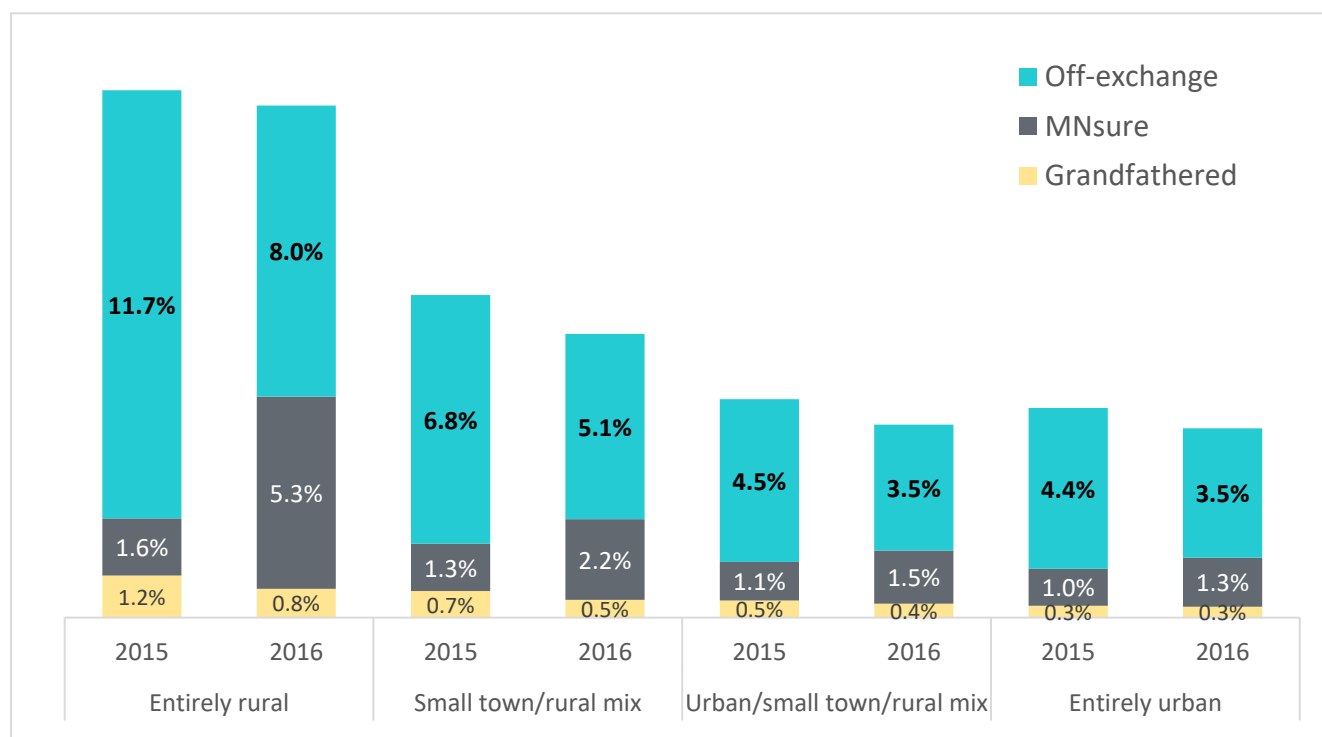
It also reveals important rural-urban differences:

- Rural counties had a higher proportion of residents in the individual market in both years, with these proportions increasing with rurality.
- Entirely rural counties had a much higher proportion of individual enrollees than other county types, with 14 percent of their population covered by individual policies compared to 6 percent of the state overall and 5 percent of entirely urban county residents in 2016 – a nearly three-fold difference.

The data also provides a glimpse of where Minnesotans obtained individual coverage post-ACA, across three categories: MNsure, or Minnesota’s insurance exchange; an “off-exchange” (the traditional non-group market) health insurance product; or a “grandfathered” product (pre-ACA coverage that was not compliant with the ACA but was grandfathered in post-implementation).¹⁵

Statewide, off-exchange sources remained the most common route for individual enrollment between 2015 and 2016. However, the number of people enrolling through MNsure increased 44 percent (from 50,000 to 72,000) and those using an off-exchange source decreased 22 percent (from 227,500 to 178,200). This was likely driven by increases in insurance premiums in 2016 and the greater value of subsidized coverage to Minnesotans that year. The number of grandfathered policies decreased 17 percent, from nearly 20,000 to just over 16,000.

Figure 8. Individual enrollment as percent of population, MNsure vs off-exchange by rural-urban county group, 2015-2016



Data source: Minnesota Department of Commerce; U.S. Census data for 2015 population under age 65.

Once again, significant rural-urban differences emerge (Figure 8).

- While individual enrollment via MNsure increased across county types, it did so most substantially in entirely rural counties (from 1,000 to 4,000 enrollees) and in small town/rural mix counties, where enrollment increased by 70 percent (from 8,000 to 14,000).
- Similarly, off-exchange enrollment decreased to the greatest degree in these counties: Entirely rural counties by 32 percent and small town/rural mix counties by 26 percent, compared to 20-23 percent decreases in more urban counties.

Appendix 1. Key milestones in ACA implementation in Minnesota

March 2010

- Patient Protection and Affordable Care Act (ACA) signed.

March 2011

- **Minnesota expands eligibility for its Medicaid program - known as Medical Assistance (MA)** - opening the program to childless adults with incomes at 75% of Federal Poverty Guidelines (FPG).¹⁶

November 2013-March 2014

- 1st open enrollment period through the state's new health insurance marketplace, MNsure.
- **Tax credits and cost-sharing reductions now available** for those with income between 200% and 400% FPG who enroll in private coverage through MNsure.

January 2014

- **MA eligibility further expanded**, now to childless adults up to 133% FPG. The income limit for children ages 2-18 was also increased from 150% to 275% FPG. The ACA requires that all income-eligible MinnesotaCare populations be shifted into Medical Assistance.^{17 18 19}
- **MinnesotaCare converted to an ACA "Basic Health Plan,"** which brings expanded benefits but reduces the maximum income allowed; eligibility now limited to those with more than 133% FPG (the new income maximum for MA) but not more than 200% FPG.²⁰ Exceptions to the income floor are made for certain children under age 19 and legal noncitizens, who are not eligible for MA.
- Federal "individual mandate" kicks in, requiring all Americans to have health insurance coverage or pay a penalty.

November 2014-March 2015

- 2nd open enrollment period through MNsure.

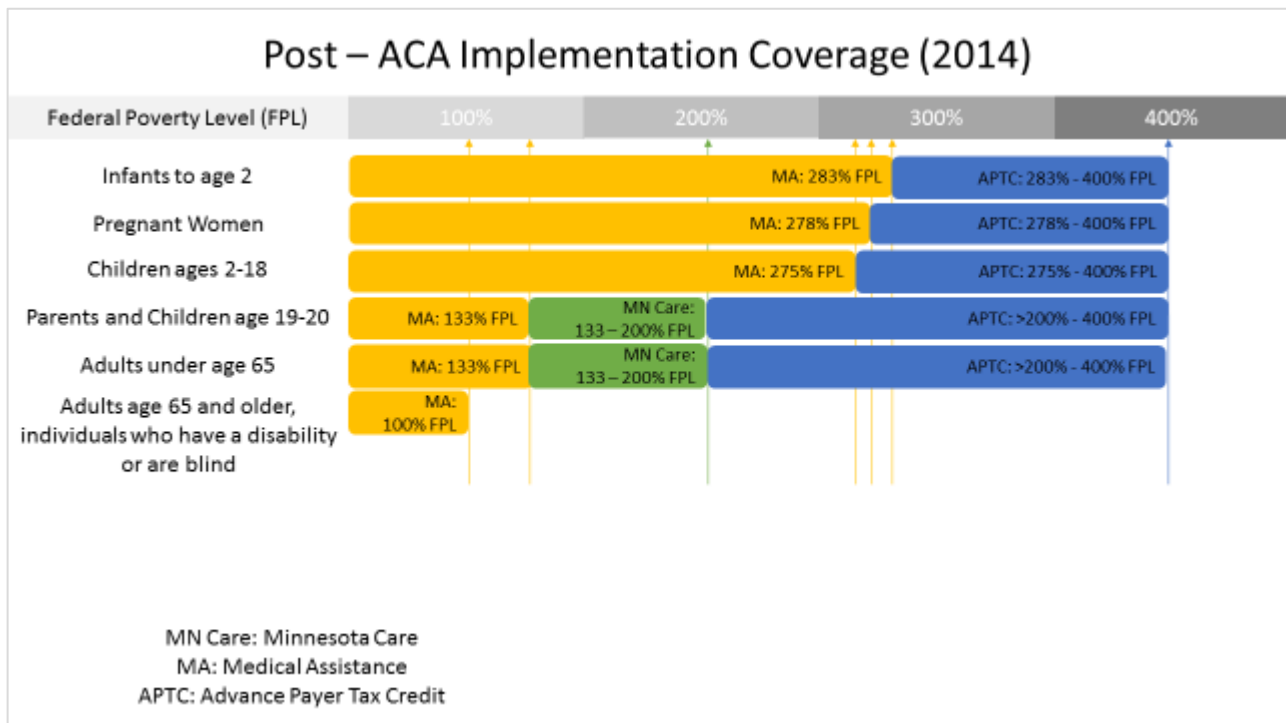
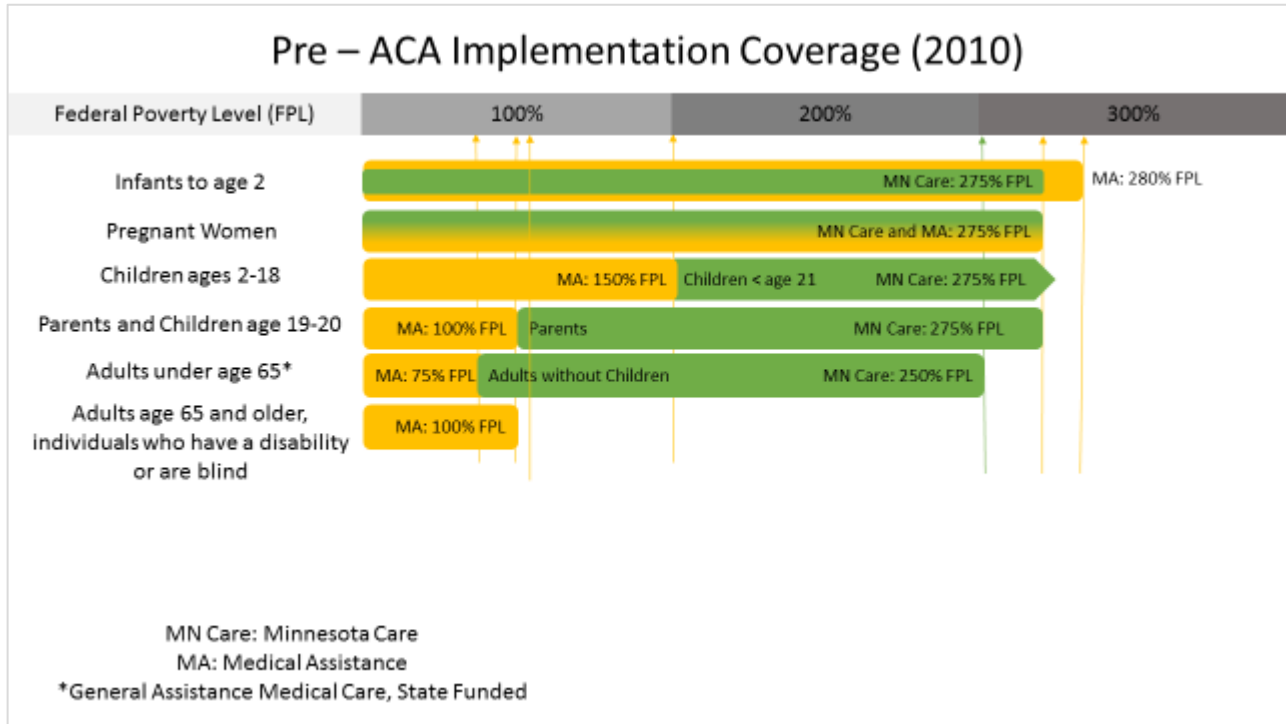
November 2015-January 2016

- 3rd open enrollment period.

November 2016-January 2017

- 4th open enrollment period.

Appendix 2. Minnesota Health Care Programs coverage continuums, pre-ACA and post-ACA



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Endnotes

¹This is a new classification system developed by the Minnesota State Demographic Center in January 2017. [add full citation] http://mn.gov/admin/assets/greater-mn-refined-and-revisited-msdc-jan2017_tcm36-273216.pdf

² Link to, if available [delete if not].

³ HEP, <http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2015.pdf>

⁴ Yawn B, Krein, S. Rural Enrollment in State Health Insurance Programs: the Minnesota Experience. UMN RHRC Working Paper #14. March 1996. Available at: <http://rhrc.umn.edu/1996/03/rural-enrollment-in-state-health-insurance-programs-the-minnesota-experience-umn-rhrc-working-paper-14/>

⁵ Call and Ziegenfuss, [add rest of cite]. Available at: <http://www.ruralmn.org/wp-content/uploads/2011/03/Health-Insurance-Coverage.pdf>

⁶ Sonier J, Lukanen E, Blewett L. Minneapolis, MN: State Health Access Data Assistance Center, University of Minnesota; 2014. Early impacts of the Affordable Care Act on health insurance coverage in Minnesota. Available at: <http://www.shadac.org/MinnesotaCoverageReport>

⁷ [paraphrase this] “The BHP is an optional program under the ACA through which states can offer more affordable coverage to individuals who are ineligible for Medicaid and are between 139 and 200 percent of the FPL. Since Minnesota had already covered this population under the MinnesotaCare program, the state submitted a Blueprint Plan to the Centers for Medicare & Medicaid Services (CMS) to transition MinnesotaCare into a BHP. MinnesotaCare adjusted its eligibility criteria to meet the ACA standards and became an ACA-defined BHP on January 1, 2015.” [Minnesota Individual State Report: State-Level Field Network Study of the Implementation of the Affordable Care Act](#). Brookings Institute; Nelson A. Rockefeller Institute of Government. August 2015. RA395.A4 M5673 2015.

⁸ Data provided by DHS for counts of MA enrollees as of April 2014 who had been eligible for MinnesotaCare in December 2013.

⁹ [Minnesota Individual State Report: State-Level Field Network Study of the Implementation of the Affordable Care Act](#). Brookings Institute; Nelson A. Rockefeller Institute of Government. August 2015. RA395.A4 M5673 2015

¹⁰ [Minnesota Individual State Report: State-Level Field Network Study of the Implementation of the Affordable Care Act](#). Brookings Institute; Nelson A. Rockefeller Institute of Government. August 2015. RA395.A4 M5673 2015.

¹¹ SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files, State Health Compare, SHADAC, University of Minnesota. Available at: www.statehealthcompare.shadac.org.

¹² Yawn B, Krein, S. Rural Enrollment in State Health Insurance Programs: the Minnesota Experience. UMN RHRC Working Paper #14. March 1996. Available at: <http://rhrc.umn.edu/1996/03/rural-enrollment-in-state-health-insurance-programs-the-minnesota-experience-umn-rhrc-working-paper-14/>

13 Call KT and Ziegenfuss J. "Health Insurance Coverage and Access to Care Among Rural and Urban Minnesotans." Rural Minnesota Journal 2(1):11-36; 2007. Available at: <http://www.ruraimn.org/wp-content/uploads/2011/03/Health-Insurance-Coverage.pdf>.

14 Sonier J, Lukanen E, Blewett L. Minneapolis, MN: State Health Access Data Assistance Center, University of Minnesota; 2014. Early impacts of the Affordable Care Act on health insurance coverage in Minnesota. Available at: <http://www.shadac.org/MinnesotaCoverageReport>

15 These plans are still guaranteed renewable, but are slowly disappearing over time due to rising premiums and a dwindling pool of people. No one can newly buy these plans since March of 2010. These plans are often missing essential health benefits, such as pharmacy, maternity, and behavioral health coverage. Per email correspondence with Dept of Commerce [check if need to cite and if so, how]

16 Before the ACA, adults without children were ineligible for MA. The only public options were a state-funded program (General Assistance Medical Care, or GAMC) for childless adults ineligible for MA and <75% FPG and MinnesotaCare for individuals up to 250% FPG. GAMC ended in February 2011 and those enrollees were automatically enrolled in MA.

17 The law expanding Medicaid a second time was enacted in February 2013, but enrollment began in early 2014. [Minnesota Individual State Report: State-Level Field Network Study of the Implementation of the Affordable Care Act](#). Brookings Institute; Nelson A. Rockefeller Institute of Government. August 2015. RA395.A4 M5673 2015.

18 Sonier J, Lukanen E, Blewett L. Minneapolis, MN: State Health Access Data Assistance Center, University of Minnesota; 2014. Early impacts of the Affordable Care Act on health insurance coverage in Minnesota. Available at: <http://www.shadac.org/MinnesotaCoverageReport>.

19 [Minnesota Individual State Report: State-Level Field Network Study of the Implementation of the Affordable Care Act](#). Brookings Institute; Nelson A. Rockefeller Institute of Government. August 2015. RA395.A4 M5673 2015.

20 Pre-ACA, the income maximum for MinnesotaCare was 275% FPG for children and families, and 250% for childless adults.