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Session 73PD
The Uninsured

Track: Health

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Summary: The number of uninsured people in the United States has grown to over 40 million. Many possible solutions have been considered at both the federal and state levels to help alleviate the size and growth of the uninsured population.

MR. ANTHONY J. WITTMANN: All of us are aware that there are millions of people in this country who are not covered by a health insurance plan. I'm sure that all of us would agree that it would be a positive public policy goal to get as many people as possible covered, but it's a difficult goal to achieve in reality. We have a panel of experts here who have extensive experience working with issues related to this area, and they're going to share their insights and observations with us.

Our first speaker is a guest, Jeff Fox, who is the managing principal of the Denver office of Reden & Anders, Ltd. Over his 19 years of consulting experience, he has assisted clients in the full spectrum of managed care issues. He's done extensive work in the Medicaid area, and, more recently, he's worked with several communities on implementing programs in response to the Robert Wood Johnson Foundation's initiatives to cover the uninsured population. He will report on some of his experiences working in this area.

Next, is David Bahn, who received his FSA in 1972, and has been with Blue Cross/Blue Shield of Florida since 1984 where he's responsible for the company's over- and under-65 individual products. David's been active on the Academy's

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Note: The chart(s) referred to in the text can be found at the end of the manuscript.

monograph series work groups including the 1996 monograph entitled "Providing Universal Access In A Voluntary Private Sector Market," and the current workgroup addressing actuarial issues involved in the uninsured/underinsured population. Dave will provide an analysis of the uninsured situation in Florida, which has a relatively high uninsured rate.

Then we'll finish up with Harry Sutton. His actuarial career spans over a half a century. Harry's experience in health care, financing, and delivery is vast. It's probably safe to say that over his career he's been involved in every aspect of developing the HMO industry. He is currently at Reden and Anders and he's been a frequent speaker and contributor to the efforts of the Society of Actuaries and the Academy, federal and state government, and health care service associations. Over the past several years, Harry has been involved with the states of Minnesota and Massachusetts in the development of programs for universal health care at the state level. Harry will provide an analysis of the uninsured situation in Minnesota, which has a very low rate of uninsured population.

I'm going to give you a quick overview at the national level and then we'll move on to our experts.

Estimates of the uninsured population are provided each year by the U.S. Census Bureau in the March supplement to the current population survey. There are questions that identify the health insurance coverage of people in the country. In 1998, the estimate of the uninsured population was 44.3 million. In 1999, that number actually reduced for the first time in 12 years to 42.6 million. The driver of that reduction was the increase in private coverage as a result of the strong economy and the early effects of the state Children's Health Insurance Program or CHIP, as it's called, which was enacted by the Balanced Budget Act (BBA) of 1997, and was targeted to increase coverage for low-income children.

Just a couple of months ago, the Census Bureau revised the 1999 number to 39.3 million as a result of a verification question that was introduced into the survey in March 2000 to try to correct for what was thought to be an underestimation in health insurance coverage prior to that. The survey is done in March and then it's released in September. The 2000 number just came out at the end of September, and it was 600,000 lower than the 1999 number. But there's concern that with the weakening economy the number of uninsured may be on the rise again.

Only one percent of the elderly population is uninsured—about 350,000 people, so it really boils down to an under-65 problem. Going back to the 1998 survey, there were 238 million people under 65 in the country. One hundred seventy million or 71 percent were covered by private insurance, 34 million or 14 percent were covered by public insurance, and 44 million or 18 percent were uninsured.

COVERAGE BY INCOME LEVEL

Breaking down the statistics by income level, we see in Table 1 that the private insurance is much less prevalent at the lower income levels than it is at the higher-income levels. The public programs pick up the slack at the lower-income levels to

some degree, but the remaining uninsured rate is much higher at the lower-income levels than it is at the higher-income levels.

Table 1
Coverage By Income Level

Category	Total	% of Federal Poverty Level			
		0-149%	150-199%	200-399%	400+%
Total	100%				
Total Private	71%	31%	60%	79%	90%
Total Public	14%	38%	18%	9%	5%
Uninsured	18%	36%	28%	17%	8%

Source: HIAA - Health Insurance Coverage and the Uninsured 1990-1998
Note: The total for insurance categories may exceed 100% because individuals may have multiple sources of coverage.

UNINSURED CHILDREN
Out of 44 million uninsured people, 25 percent or 11 million are children, 8 million of whom are low-income children. That number is being reduced by the effects of the CHIP program, and over two million children are now enrolled in that program. It's estimated that millions more are eligible for either CHIP or Medicaid, but communication issues and administrative problems may be obstacles to getting those kids enrolled. Ultimately, I think it would be a funding problem, also.

UNINSURED ADULTS BY AGE
Looking at it by age bracket, the rate of uninsured is much higher in the younger age brackets than it is in the older age brackets, and, at the younger ages, it's more prevalent in males than females.

EFFECTS OF LACK OF COVERAGE
Why do we care about this, the effects of lack of coverage? The uninsured are less likely to receive preventive care and care for common conditions and injury. They're more likely to be hospitalized for avoidable conditions like pneumonia and uncontrollable diabetes. And, if they get cancer, they're more likely to be diagnosed in the late stages.

Few uninsured people receive services for free or get the benefit of discounts, and 30 percent report that medical bills have a major impact on their lives.

There's a wealth of information out there if you want to learn more about the uninsured. The U.S. Census Bureau (www.census.gov) puts out a lot of information. The Kaiser Family Foundation (www.kff.org) has done a lot of work in this area. The Health Insurance Association of America (HIAA – www.hiaa.org) has funded a couple of good studies that are available on its web site. The Urban Institute also has some good studies out there to help with those issues. And the January-

February 2001 issue of *Health Affairs* has several good articles also. Now we'll turn it over to Jeff.

MR. JEFFREY D. FOX: Reden & Anders and I have been doing quite a bit of work as part of the Robert Wood Johnson "Communities in Charge" initiative. Briefly, that's 15 communities. It started out as 20. They have grants that try to address the uninsured issue. I have some Medicaid HMO clients that are in states where they've expanded the uninsured beyond the CHIP population, into the adult population. I'm going to talk about the uninsured pricing issues in these communities.

First, in Chart 1, this is quickly just confirming the statistics that Tony alluded to in terms of who the uninsured are, so I'm not going to spend any time on that. Chart 2, By Income, confirms what Tony said. Obviously, the wealthier people are, the less uninsured they are. But there is, surprisingly, 7-10 percent uninsured at the more upper-income levels, so there is a significant push in the uninsured at those levels. In Size of Employer in Chart 3, this is what we all suspected. The uninsured tend to be concentrated in the small employers. Those blue bars are the overall average across all employers. The red is by size of the employer. You can see in companies with less than 25 employees, around 25 percent of those employees who work for those firms have insurance coverage. And when you get up to companies with 1,000 or more employees, about 70 percent of those folks have insurance coverage. The uninsured are concentrated in those small employers who have difficulty in offering that coverage for a variety of reasons—there is a lot of pressure on their margins, etcetera.

In Chart 4, the uninsured are broken down by race and ethnicity. This is just to demonstrate some of the communities we've been working with. One of the things we've been trying to do is grapple with how costs vary by race and ethnicity, and I'm going to talk briefly about some of the models that they're all looking at. In fact, we just finished—and I don't have the statistics—an analysis of primary care costs per community where we were able to get data by race and ethnicity. The only population who had a statistically higher per-member per-month (PMPM) cost was the Hispanic population. The other populations basically were similar in terms of their primary care costs. This is a community that's just putting in a model around primary care services.

PRIMARY CARE/SAFETY NET MODEL

Basically, in the communities we've been working with, we looked at three different kinds of models. The primary care/safety net model is a model where the community tries to expand coverage, taking the safety net providers that exist in that community. There's a whole array of providers that do exist to serve the uninsured and the poor, and they try to expand the coverage using those providers and others. There's a solid primary care network that provides the uninsured with access to good primary care services. Once they get outside of primary care, they really don't have much access to specialists and they end up in the hospitals on the charity side.

INSURANCE LOOK-ALIKE MODEL
An insurance look-alike model is really just offering quasi-insurance coverage. For example, it's an insurance look-alike, but it doesn't pay the hospital. So, to the members, they have a whole array of coverage and services. But how the insurance look-alikes reimburse is such that the hospitals get paid nothing because they don't get paid anything now. And, yet, the hospitals benefit financially because there's a significant reduction in admissions, length of stays, etcetera, so their costs come down, yet they're not receiving any payment from this insurance look-alike. For the person that's uninsured, it looks like a full array of coverage.

PRESCRIPTION DRUG MODEL
The other area that tends to get looked at hard in these models is prescription drugs. It's a hard-dollar cost. It's not as if providers can get together and say, "We'll just pay ourselves less," so it's an area that tends to get whittled away at in terms of the coverage.

KEY COST ISSUES
The key issue is provider reimbursement, in terms of trying to come up with a program in which to pay providers. Your cost is directly proportional to what you pay providers. Again, one of the models is not to pay hospitals for those that are typically going to be uninsured anyhow. And, yet, we have done some modeling and projections and sat down with hospital CFOs and convinced them that they save a significant amount of money by participating just by the reduction in admissions and length of stays as well as the severity of the types of illnesses. Also, emergency room encounters drop.

A couple of issues that enter into any kind of program like this are adverse selection and pent-up demand. We have found that when you offer coverage to a population that hasn't had it in a long time, there's demand that's been pent up. For example, I'll show you later a New Jersey experience where dental costs soared initially because the folks hadn't gotten dental benefits and they were suddenly exposed to them. Adverse selection is an issue because a lot of these communities and folks that are doing programs aren't doing any kind of underwriting.

We have found that you have to look at several unique populations when you price this. You can't just look at the uninsured as the uninsured. First, you have to break out the uninsured between indigent and working poor. The indigent have several issues that are unique to them: homelessness, substance abuse, etcetera. And even within the indigent, the poorer the indigent are, the more prevalent those issues are, and the costs could vary dramatically by these categories. The "richer" a population gets, the more it starts to look like a normal commercial population.

One of the things we've been grappling with is race and ethnicity. We don't have yet a lot of good data, but it's one of the things that, at least anecdotally, clients we work with talk about. I have a client in El Paso that talks about how the high prevalence of the Hispanic population fundamentally changes its cost. We aren't able to confirm it.

In the communities we work with, the populations are going to be disproportionately male and adult because of the CHIP program, because of Medicaid. When you're looking at, let's say, under 150 percent of poverty, a lot of women will be covered by the Medicaid program, at least partially—under a 100 percent almost completely, if they have children. Disproportionately fewer women are uninsured, and I think that was inherent in Tony's statistics. Also, where you can, you're going to move these children into the CHIP program. These communities that have these programs are saying, "When we find kids, we'll just pay the CHIP premium for them." So when we're looking at pricing, we're eliminating children and have far fewer women in our population. Now, depending on where you are, illegal children are a big issue because you cannot enroll them in the CHIP program. If they're illegal aliens, it would change your mix.

I talked earlier about the impact of social problems on especially the indigent population and it's significant in terms of its impact on cost and your ability to manage them.

Here are some actual experiences. Remember I talked about how you have to differentiate between the working poor and the indigent, and this is why. This is actual experience, and you can see in Chart 5 that the PMPM costs are significantly different between the two. Again, this is all working poor, so let's say up to 250 percent of poverty. This is how the distribution of expenses differs for the working poor and the indigent. The distribution you can see is weighted in the indigent more toward hospital services. There are proportionally more outpatient and inpatient hospital services with the indigent than there are with the working poor. It's interesting that prescription drugs have a higher proportion in the working poor than in the indigent.

In Chart 6, this is how the two compare, and this is the experience I was referring to with a state that's expanded into the uninsured adults, and this is by income. The green bar is the indigent population 0 to 50 percent. The blue bar is 0 to 133 percent. This is not indigent. And the other is 134 to 200 percent. This is about six months worth of credible experience. But the biggest surprise that we found in this is we're not seeing a major difference between the 0 to 133 and the 134 to 200. Remember, I said, as they get richer, theoretically they look more like a normal commercial population. Well, that is not being proved in this preliminary experience, but it's confirming everything we believed prior in terms of the cost of the indigent, and it's primarily being driven by a $100 PMPM difference in inpatient. That's the demographic distribution in Chart 7, and you can see it's CIC, which is communities in charge, which is what Robert Wood Johnson calls its initiative, and you can see it tends to be older because we pulled the kids out.
Chart 8 shows the adverse selection issue. This is our crude attempt to try to model for one of these communities the potential effect of adverse selection because these communities are offering this, but who is likely to come into the program even though it's free? It's likely to be the sicker individuals. They're likely to find them when they come into the emergency room or are hospitalized. This is an issue we're still struggling with to get enough data to build a mathematically better model.

MR. DAVID J. BAHN: I'm going to take a look at the state of Florida. And who are the uninsured in Florida? They're probably very much like the uninsured in your own state. Then I'm going to talk about the wages, hours, and medical services. I'm also going to talk about insuring the kids. This was an early success in the state of Florida, an ongoing success. The medically uninsurable present a problem for those of us who are interested in addressing the issue. These are the folks that are sick. How do we provide care for the sick folks? And I'll talk about expanding access. Florida has taken an approach of using a private sector response and trying to maintain affordability for these. Finally, I'll address some remaining gaps and possible closure of those gaps.

FLORIDA UNINSURED

Florida's uninsured are very consistent with the numbers that Tony gave: 18 percent nationwide, 16.8 percent in Florida. By the way, the most current population survey showed a decline in the percentage of uninsured nationwide, but not Florida. Our percentage of uninsured stayed very close to that 16.8 percent.

Now we start talking about who are "they." Fifty-eight percent of the uninsured earn less than 200 percent of the federal poverty level (FPL). Sixty-five percent of those uninsured work for employers who do not offer health insurance. Smaller firms have much higher uninsured rates. Hispanics are nearly 25 percent of Florida's uninsured. It's a matter of affordability. The uninsured say they just can't afford the coverage even though it's offered. This is consistent with Jeff's indication that 10 percent of the people with $50,000 to $55,000 annual income do not have insurance. Even among the larger employers, five percent don't have insurance.

In Table 2, the geographic "pockets" vary significantly. Where are the insured located in Florida? I call this urban. That might be something like my own county, Duval County. Then we have suburban as slightly higher. Urban, suburban, and rural have the upper range. The highest range is urban—some of the zip codes in Dade County, for instance—and also, what I call, "deep rural." There are some counties in Florida where the major employer is the state prison. And if you're not working for the state prison, you probably don't have insurance coverage.

Table 2

Adult Non-Elderly Uninsured
Geographic "Pockets" Vary Significantly

	Percentage	Geographic Type
Lowest	12%	Urban
Midrange	13-15%	Urban-suburban
Upper Range	16-20%	Urban-suburban-rural
Highest	25%	Urban and "Deep Rural"

- Highest is rural area in South Florida
- Second highest is Dade County
- Percentage is percentage of population without insurance

NONELDERLY FLORIDIANS UNINSURED

The uninsured percentages of non-elderly Floridians are as follows: white, non-Hispanic, very low, 13 percent; Hispanic, 29 percent; black, 20 percent; others, 27 percent.

FEDERAL POVERTY LEVEL

Tables 3 and 4 detail the FPL. What is it? For a family of three, it's $14,630 a year. If you're working at the current minimum wage of $5.15 hour, how many hours a week do you have to work? Fifty-five. You can also have two workers, each at, say, 27, 28 hours per week. Or, if you only want to work the typical 40 hours per week, what do you have to get paid? For a family of four, $8.49 per hour, and that's just to make $17,650 per year. 200 percent of the FPL is a typical eligibility level for many of the programs.

Table 3

FEDERAL POVERTY LEVELS 2001

		HOURS WORKED PER WEEK	HOURLY WAGE REQUIRED
	ANNUAL DOLLAR AMOUNTS	52 WEEKS PER YEAR	52 WEEKS
FAMILY SIZE	PERCENT OF FPL 100.0%	AT MIN WAGE OF $5.15 100.0%	40 HOURS/WEEK 100.0%
2	$11,610	43	$5.58
3	$14,630	55	$7.03
4	$17,650	66	$8.49

NOTES: THE HOURS AND WAGES ARE TOTAL. THEY ARE PRE-TAX

THE HOURS WORKED OR DOLLARS EARNED MAY BE BY ONE OR MORE FAMILY MEMBERS.

FEDERAL POVERTY LEVELS ARE FOR 48 CONTIGUOUS UNITED STATES.

Table 4

FEDERAL POVERTY LEVELS 2001

		HOURS WORKED PER WEEK	HOURLY WAGE REQUIRED
	ANNUAL DOLLAR AMOUNTS	52 WEEKS PER YEAR	52 WEEKS
FAMILY SIZE	PERCENT OF FPL 200.0%	AT MIN WAGE OF $5.15 200.0%	40 HOURS/WEEK 200.0%
2	$23,220	87	$11.16
3	$29,260	109	$14.07
4	$35,300	132	$16.97

NOTES: THE HOURS AND WAGES ARE TOTAL. THEY ARE PRE-TAX

THE HOURS WORKED OR DOLLARS EARNED MAY BE BY ONE OR MORE FAMILY MEMBERS.

FEDERAL POVERTY LEVELS ARE FOR 48 CONTIGUOUS UNITED STATES.

Let's try to relate that to some medical costs. Table 5 shows the average medical costs in Florida. For instance, an inpatient stay looks to be around three or four days. The first day was medical, the second day surgical, third day maternity, fourth day a little psychiatric care. How many hours do you have to work to pay for those services? For routine physician service, if you're getting paid minimum wage, then you need to work eight hours. And another thing to keep in mind for those who are insured right now. Instead of looking at it as an inpatient day of $975 to pay your average calendar year deductible of $1,000, if that's what your employer goes up to these days, you're going to have to work 189 hours at that minimum wage, and these are all pre-tax.

Table 5

HOURS OF WORK REQUIRED FOR AVERAGE COST OF MEDICAL SERVICES

MEDICAL SERVICE	AVERAGE COST	HOURS REQUIRED AT WAGE SHOWN $5.15	$7.03	$16.97
INPATIENT DAY	$975	189	139	58
INPATIENT STAY	$4,584	890	652	270
OUTPATIENT VISIT	$370	72	53	22
PHYSICIAN VISIT	$110	21	16	7
PHYSICIAN SERVICE	$42	8	6	3

NOTES: MEDICAL COSTS ARE FLORIDA STATEWIDE AVERAGES FOR INSURED PATIENTS.
MEDICAL COSTS ARE MIX OF PRODUCT TYPES, REIMBURSEMENT METHODS.
THE ABOVE ARE ALL PRE-TAX.

FLORIDA HEALTHY KIDS PROGRAM

As I said, the Florida Healthy Kids Program was a precursor to the CHIP program. We started in 1990, the first plan/location began in 1991-92. In enrolling the kids, Florida followed the old Willie Sutton advice. Remember, he's the one, when they asked him why he robbed the bank, he said, "That's where the money is." We went to the schools because that's where the kids were. And it has grown: 47,000 in 1997, 62,000 in 1998. We hope to have 250,000 kids.

PARTNERS

It's a state, local family partnership for funding. Private health plans provide coverage. There are about 10 different private health plans providing coverage in different counties. The kids are ages 5 to 19 and in school. They have a full-pay option. If you're working above the 200 percent FPL, you can pay and enroll your child in the program. Coverage is a comprehensive benefits package with

preventive, well child care focus. Nominal co-pays are $3. That's maybe worth less than an hour for someone at minimum wage. We are starting to add dental coverage beginning in the year 2000.

FUNDING FOR THE HEALTHY KIDS PROGRAM
Where is all this money coming from? In the year 2000-01, funding will total $266 million. The CHIP money is $138.3 million, or 52 percent of the total. Local participation is 4.4 percent, or $11.6 million. Tobacco funds, 21.7 percent. This is how we're funding this Healthy Kids Program.

SUCCESSES AND GOALS OF THE HEALTHY KIDS PROGRAM
Current enrollment is 182,000 children. Dental benefits were added in 2000. We want to go to statewide expansion. As I mentioned, there are some counties in the state of Florida that are very rural, very poor. Those have been the last ones to be added. We're using an HMO as a primary model for delivery, an exclusive provider organization (EPO) for those rural counties.

MEDICALLY UNINSURABLE
Some 10 percent of the uninsured report themselves to be in fair or poor health. There are some 27 high-risk pools operating. They covered, however, only a 112,000 people at the end of 1999. Our own high-risk pool has been closed to new members since 1991 due to funding limitations. But Florida has encouraged private-sector solutions: active monitoring of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) coverage after COBRA is exhausted, including finding some companies that did not fulfill their requirements. HIPAA, as you remember, provided that coverage for someone who basically lost his or her group insurance, lost his or her job, quit, etcetera. If that person went through a continuation without his or her group program, then within the COBRA extension, at the end of that time, that person was entitled to purchase individual insurance.

There are various state options providing that coverage. Some states provide coverage in the state high-risk pool. Florida provides that if your individual product terminates—if it exits the market, for instance—you're entitled to purchase an individual product from one of the remaining carriers. This is actually a way of maintaining insurability for people and reducing the number of medically uninsured.

There is also the issue of assigning HMO members with individual coverage when their HMOs fail. There are some HMOs in Florida that are very shaky financially. We're concerned that if they go belly-up, the surviving HMOs are going to have to pick up a large number of people. But it is a state solution to try to help maintain continuity of coverage.

You can "rate up" the HIPAA eligible up to your approved rate limit, but this is done on an individual basis (Table 6). You cannot say just because you are eligible, "I'm going to rate you 200 percent." We can look at an application and say, "My goodness! You have cancer, so I'm going to rate you up to what our approved rating limit is." And even with those, our standard percentage of applicants at the

rating was seven percent. Up to 88 percent received the 100 percent rate up. This closely mirrors our regular underwritten business.

Table 6
The HIPAA Experience of One Company

Year 1999-2000 Applicants for Coverage:

- Percentage of Applicants at ratings below:
  - Standard 7%
  - 25% 2%
  - 50% 2%
  - 75% 1%
  - 100% 88%

100% rate ups would normally be declined in most cases.
The average percentages are the mirror of regular underwritten applicants

What does this mean financially? In Table 7, this was the HIPAA experience of one company: enrolled months, 48,000; revenue, $13.9 million; medical costs, $18.5 million—what the loss ratio against one of our reasonable target loss ratio for those products and durations would have been. By the way, this sounds like a lot. We did some estimates when we made our most recent rate filings with the Department of Insurance, and this information, I found out after I put these slides together, that the HIPAA experience added four percent to our rate increase. In other words, what would have been a 10 percent rate increase, was a 14 percent increase. The four percent may sound like a lot, but it is in line with the projections made by both the Academy and the Rand Corporation when the HIPAA bill was being discussed in 1996. It does cost money, but, so far, the HIPAA costs are in line with what the estimates were as far as the cost to the individual market.

Table 7
The HIPAA Experience of One Company

1998-2001	To Date Financial Results
Enrolled Months	48,000
Income ($ Millions)	$13.9
Medical Costs	$18.5
Loss Ratio	133%
Target Loss Ratio	75%

PRIVATE SECTOR SOLUTIONS IN FLORIDA

Access to insurance is an issue of concern. One life groups were permitted on a year-round basis. That since has been restricted to one month during the year of August. All the carriers were receiving on a year round basis pretty much all of the sick people who could, in some way, demonstrate that they were self-employed.

Affordability is another issue of concern. For years we have had modified community rating by area, gender, family status, smoker status, no experience rating, no health status. We have since added the NAIC model of limited experience

adjustments of plus or minus 15 percent. That's to try to maintain affordability for everyone. There are some additional costs for the sicker groups, but standard rates and, perhaps, slightly lower rates, apply for those with no current health history.

CLOSING THE UNINSURED GAPS—ADDITIONAL SOLUTIONS

Some public sector proposals would include: expanding CHIP (call it "Florida Healthy Parents"), supporting community-based nonprofits to arrange for health insurance, and expanding the capacity of the safety net providers. However, the real difficulty is that even before the September 11th attacks, the Florida economy was soft. It is even softer now. As we speak, our legislature is discussing reducing our state budget significantly to meet a projected shortfall in excess of $1.4 billion. One of the topics they are considering is reducing the support to the safety-net providers, the hospitals who provide assistance. It used to be called charity care. If you want to help provide insurance or health care coverage to Florida's uninsured, please visit Disney World and spend a lot of money. We need the sales tax.

We're also considering some public-private sector partnerships, targeting insurance products, entry level benefits. Some states have tried this in the past. Remove some of the mandates to reduce the cost, insure provider partnerships where we may arrange for the care, but not necessarily pay for it, and then offer limited enrollment pilots to minimize the entitlement aspects of it. Unfortunately, where we are today, the economy in general is adding to the uninsured layoffs, the tourist business is declining, and it is putting restrictions on the private and public funding.

MR. HARRY L. SUTTON, Jr.: Recently the uninsured population in Minnesota has been estimated at about five percent of the total. First, I'll give you a little background. Minnesota was settled originally by farmers, then people in the lumber business, then grain processing. We were a heavily agricultural community. Over the years, we've become more high tech. We have people with Nordic and European backgrounds, with German being the largest single subset. Consequently, we have a very socialist outlook in our state. We have high median wages. There's a more even wage level. New York City has much higher average wages because people make millions of dollars there, but we have a lower level of poor people and probably a lower level of very high-income people.

We are very different from the state of Florida. I'll explain briefly how we get to the five percent uninsured rate. The national numbers include everybody who is uninsured for any month during the year. We've done a lot of very lengthy surveys, Robert Wood Johnson financing some of them, and we can make a point estimate. In other words, there can be a whole bunch of people that are not insured during part of the year—they're changing jobs, or they get laid off this week, and so on. So if we counted everybody who was uninsured a month, it might be seven, eight, nine percent, which comes out of the annual surveys. But, at any given time, in our point estimates, it's around five percent. If we were to compare with Florida's numbers like the national numbers, we might be seven or eight percent versus Florida's 16.8 percent.

MINNESOTA POPULATION

The population is very different from Florida, but it's changing. Essentially, we're 90 percent Caucasian from our Nordic, European, and north European backgrounds. We have a relatively small Black population. The American Indian population is about one percent. Hispanic and Asian populations are each about three percent and growing. Recently, large numbers of Hmong and Somali immigrants have moved into the metro areas.

DISTRIBUTION OF INSURANCE COVERAGE

In Table 8, you can see that we have a very high ratio of employer-based private coverage. We're losing some of our *Fortune* 500 companies. They're being merged or moving out. We have stable industries like 3M, who have very good coverage. Coverage is not quite as good as it used to be, however. We have been heavily covered by HMOs. Our largest HMOs, Medica and Health Partners, provide services to nearly two million members, with over half the members self-insured by employers.

Table 8
Distribution of Insurance Coverage in Minnesota, 1999

Total Population 4.8 million	**100%**
Private Coverage	**72%**
Large Group	58%
Small Group (2-50)	10%
Individual	4%
Public Programs	**23%**
Medicare	14%
Medical Assistance	6%
GAMC	0.5%
MinnesotaCare	2%
MCHA	0.5%
Uninsured	**5%**

Source: Minnesota Department of Health

Public programs in Minnesota are extremely liberal. We use the most liberal limits for Medicaid and we cover everything but the kitchen sink under our Medicaid program. We have among the most liberal benefits, and it's consistent with the social objective that our state wishes every one to be covered and have good benefits. Private coverage is 72 percent, public programs are 23 percent, including Medicare. And the uninsured population is about five percent, probably a little higher than that, and it's probably gone up a little recently.

FACTORS AFFECTING INSURANCE RATES

There is an interesting article in *Inquiry* (Vol.38, No. I), which is a Blue Cross publication that listed some of the factors that account for Minnesota's low uninsurance rate. The main factor is that we have a white high-income population, so we have very low uninsured rate. The other positive things are that we have a very high social value society, a very coordinated society, and we want all of our

people to have insurance coverage. We were down as low as two percent unemployment during the peak of the boom years, and we're still only at 3.9 percent, while the federal rate was up to around five percent. We've enjoyed a very high rate of employment. Minnesota has also high education standards. During the 10 years prior to the year 2000, our population grew from immigration and other things about 10 percent. While we're not in a booming area, we grew rather rapidly.

TRENDS
We have growing minority populations. We still have the farming business and we have a lot of migrant farm workers. Some coverage exists, but mobility may make coverage or access difficult.

I think Hawaii has the longest life span because if you're in Hawaii you don't care about dying. In Minnesota, I think you're frozen half the time so you can't tell if you're alive or dead. But you live longer and this accounts for the bulk of our Medicaid cost. We have more nursing homes per capita than any other state except South Dakota, and we spend $600-$700 million dollars a year paying for long-term care. Data on that population shows that many people move south, but when they get older and they need to go in a nursing home, they come back to where they were born. So even though a lot of our people retire and go to Florida, Arizona, or wherever, they frequently come back to go in a nursing home.

PERCENT OF UNINSURED POPULATION
The white population uninsured rate for adults is 4.8 percent, and for children, 3.5 percent. I'll explain why that's so low. We started our children's program back in the 1980s. The uninsured percentage of blacks is 15.7 percent, for Hispanics it's 15.6 percent, and for Asians, typically low, 7.2 percent more like the white background. Native Americans have a problem because when they move off the reservation, they don't have the availability of the Indian Health Service. About 16 percent are without insurance coverage. So about five percent uninsured is the state average. This is the most recent survey done by the Robert Wood Johnson Foundation as part of its program.

SHIFTING COMPOSITION OF UNINSURED
In Table 9, we have an age breakdown in our state. We have changed dramatically by both age and income level, because of our programs that I'll get into in a minute, which are different from Florida. The second largest subset of our population without coverage is people over 300 percent of federal poverty guideline (FPG). The lowest income groups (<100% of FPG) make up only 10 percent of our uninsured population.

Now, since we've covered many more children, our structure by age level has changed due to our social programs. In 1990, 25 percent of our uninsured were children, and with our children's program, which began in the late '80s, it's down to 16 percent. We reduced that problem and some of the uninsured population has shifted to the teenagers, mostly male ages 18 to 24. If they don't work, they'd rather spend the money for health insurance premiums on a new motorcycle.

Table 9
The composition of Minnesota's uninsured population has shifted: fewer children

	1990	1999
0-17	25.0%	16.5%
18-24	19.9%	23.1%
25-44	36.4%	42.4%
45-64	18.8%	17.8%
Total	100.0%	100.0%

Source: MDH Analysis of University of Minnesota Health Access Surveys, 1990 and 1999.

SOURCES OF PRIVATE HEALTH INSURANCE COVERAGE

The extent of private coverage in Minnesota is higher than many states, but similar in distributions. Since insurance reform in 1991, the percent covered has increased to 72 percent in 1999 from 70 percent in 1993. Large employer growth has increased moderately from 56 percent to 58 percent of the population. The reform affected small employers the most, showing an increase from six percent to 10 percent, a startling success rate of increased penetration of 65 percent. Tightened underwriting rules and loss ratio requirements reduced private individual insurance shares by 50 percent, from eight percent to four percent of the total.

PUBLIC HEALTH INSURANCE COVERAGE

Interestingly, Table 10 shows that the Medicare population as a percentage of the total, due to immigration offsetting aging, has remained almost constant even though the population is aging during the 1990s. Medicaid coverage has dropped with high rates of employment. MinnesotaCare, which I will go into separately, has risen sharply, offsetting some of the drop in General Assistance and the Minnesota Comprehensive Health Association (MCHA), which is our uninsurable pool.

Table 10
Sources of Public Health Insurance Coverage for Minnesotans as Percent of Population

Source of Coverage	1993	1999
Medicare	13.6%	13.6%
Medicaid	7.7%	6.1%
MinnesotaCare	1.1%	2.3%
General Assistance	1.2%	0.5%
MCHA	0.7%	0.4%
TOTAL	**24.3%**	**22.9%**

Source: MDH, Health Economics Program

REDUCING THE UNINSURED

We have two programs that have been the backbone for cutting down our uninsured population. And I see Bill Bluhm here. He worked with our governor's commission back in '89-'90 in trying to price out the various subsets of the

uninsured population as to the nature of the risks involved. No one yet has figured it out exactly.

In Minnesota, a bill was introduced in the state legislature in 1991 to mandate universal health care, and there was a lot of discussion about it. They were going to catch you. When you applied for a driver's license, they'd make sure you were covered for health insurance or you couldn't renew your driver's license. More critical would be a fishing license and a hunting license! Then they had second thoughts and decided they were biting off more than they could chew so they aggressively addressed small group reform and set up MinnesotaCare, which evolved from a children's program set up by the Children's Defense Fund. The Minnesota Comprehensive Health Association had started fifteen years earlier.

MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION (MCHA)

The MCHA is an uninsurable pool. It has two basic plans: a $500 and $1000 deductible, both with coinsurance and a maximum out-of-pocket of $3,000. A Medicare supplement is also available. The base plans are supposed to be priced at roughly 125 percent of the premiums of the prevailing private individual rates. There's no direct subsidy to the premium payor. The individual just pays the premium.

Interestingly, about 17 percent of the premium notices go to an employer. Some of the small employers figured a way around the small group indemnity rules. I don't think the state tried to interfere with this too much. If the employer could put an uninsurable person into this pool, then everybody else would be insurable resulting in a lower group rate for the rest of the employees. Actually, I think that's a good approach.

Originally, the MCHA started in 1976. It was one of the early plans. Now such plans exist in 27 states. The Traveler's started a plan in Connecticut, which got up to 2,000 enrollees. We hit a top of about 36,000 members. But that's not indicative of the strong effect of this program. Forty to fifty percent of these people leave this pool within two years. They're employed and they get regular coverage. They get over their illness or they were pregnant and had the baby, and, consequently, their coverage was postponed. It's a fail-safe for a lot of people. And it's much more significant than the enrollment numbers in Table 11 below.

The MCHA operating deficit is funded by a premium tax on all health carrier risk premiums: reinsurance premiums, health insurance premiums, HMO premiums. HMOs for a while paid more than half the taxes. As mentioned above, the premiums were supposed to be 125 percent of the prevailing individual rates and rates by age. The board of directors of this plan, which is now managed by Blue Cross and at one time was managed by Northwestern National Life, dislike rate increases, so maybe the MCHA premiums are more like 115 percent of the standard premium rate. The largest company writing individual insurance is Blue Cross, so essentially it's 115 percent of the Blue Cross rate. It varies by age, and you can go to any doctor you choose. You can even go to the Mayo Clinic, or any hospital in the state. Blue Cross has tried to control reimbursement rates to providers.

Table 11

Minnesota Comprehensive Health Association
Enrollment Trends

1984	10,000
1990	25,000
1993	35,000
2000	26,000

Recent financial result 1997 (enrollment 26,314) Premiums $47.5 million; claims $90 million; deficit $47.7 million
Total Expenses $95.2 million
Note: Minnesota is the largest such pool in the U.S.
Enrollment is 23% of total U.S.

ENROLLMENT TRENDS

Table 11 shows the enrollment. It hit a peak in 1993 at about 35,000, now it's down around 25,000 or 26,000. It's got roughly $100 million of claims and $50 million of premium, and it's been running that way for several years even though the enrollment has dropped. But the latest year is a deficit of $58 million.

The taxes on risk premiums ran for many years about one percent, and for a while they were deductible from state premium taxes if you were a carrier who paid premium taxes. HMOs don't pay premium taxes. Now the tax on risk premiums exceeds two percent as HMOs administer more self-insured employer plans. Recently, the Minnesota state employees converted from risk premiums to a self-insured benefit program, saving $15 million in MCHA taxes. The state has used some general funds to reduce the deficit in the last two years.

This program has worked well. It's a wonderful fail-safe to have a $500 deductible policy, where you can go anywhere you want. It's not a bad deal. Raising enrollee premiums in other states has resulted in sharp drops in enrollment, defeating the objectives of the program.

MINNESOTACARE

When the MinnesotaCare law passed, we had a children's health plan already in place, which started in the late '80s. MinnesotaCare started in the early '90s and merged with the existing children's program. The original people eligible were children from low-income families. Then eligibility extended to siblings of these low-income children who got enrolled. Later single parents were added. Some individuals could have been on Medicaid. Recently, rules added full family, even some single adults.

In Minnesota, the state estimates that of all of the people that are still uninsured, between 70 and 80 percent, are eligible to enroll in either Medicaid or MinnesotaCare. Of course, anyone is eligible to enroll in the MCHA if they're

uninsurable. And MCHA will take dependents, even though they are not uninsurable. Possibly, this may lower MCHA deficits.

In Table 12, there are some examples of enrollee premium contributions for MinnesotaCare. I happen to think that the premiums they have to pay based on income levels are pretty low. There was a family of four with an income of $30,000 and all they had to pay was $12 a month for family coverage ten years ago. I thought that was stretching a bit, but it got front-page coverage about how great the program is in the local newspapers. Everybody pays a premium, and the population thinks this is a private program. It's not Medicaid. It's a big deal. People don't like to be on welfare. They don't want to accept donations, but $4 a month isn't enough to pay for much.

The employees may think their $25 a month deduction is the total cost as well. There's poor understanding of how much medical care premiums cost. In MinnesotaCare for a family of three with a $12,000 income, which is about the federal poverty level, it costs $18 a month. There's always at least a minimal premium to pay, so enrollees think they're buying private insurance, and they don't understand what goes on underneath. They don't have to register for Medicaid. They just have to prove what their income is.

Table 12
MinnesotaCare
Benefits (1988-93) outpatient medical; added hospital inpatient (1993)*
1997 – all beneficiaries enrolled in managed care health plans

Sample income premiums (2001). All eligibles pay some premium!

- Low income/premiums: $4 per month per child
- Family of three; $1000/month gross income: $18/month
- Family of three; $3000/month gross income: $264/month

*Children unlimited hospital benefits; adults $10,000 (excess covered by Medicaid)
Minnesota Department of Human Services

As shown in Table 13 below, the enrollment on this plan is now up to 136,000, which is two or three percent of Minnesota population.

Table 13 shows the distribution by type of eligibility and the 1998 funding sources. The growth was partially offset by drops in other welfare programs, and voluntary shifts from MCHA.

Table 13
MinnesotaCare

Enrollment Patterns Approximate

	Children <21	Adults with Children	Adults Only	Total
1990	12,000	-0-	-0-	12,000
1993	39,000	16,000	-0-	55,000
1995	42,000	35,000	3,000	80,000
2000	60,000	40,000	20,000	120,000
2001	66,000	45,000	25,000	136,000

Funding: Enrollee premiums; 2% provider tax; $0.05/pack cigarettes (thru 1993)
1998 Funding (in millions): Expenditures $108; Premiums $22; State Tax $73; Federal $14 (adults)

The MCHA Program has shrunk because some enrollees could get better coverage with a lower premium by switching to the MinnesotaCare program. In fact, Minnesota had 500 people who were covered under the MCHA program with Medicaid, paying the premium. Usually Medicaid is about 50 percent funded by the federal government, but by paying MCHA premiums, the state saved over $500,000.

In the early years of CHIP, Minnesota could not use federal funds because children were already covered above the income limits. Now Minnesota will receive $30 or $40 million to expand eligibility along with two of three other states including New York.

Minnesota is a very different environment from Florida. Our state will be under budget, not the $1.2 billion that David was talking about, but our state employees

just went on strike one week after September 11th, 2001.The state budget balance was reported at $77 million below last year, which hopefully is not going to put us in a big deficit position.

Chart 1

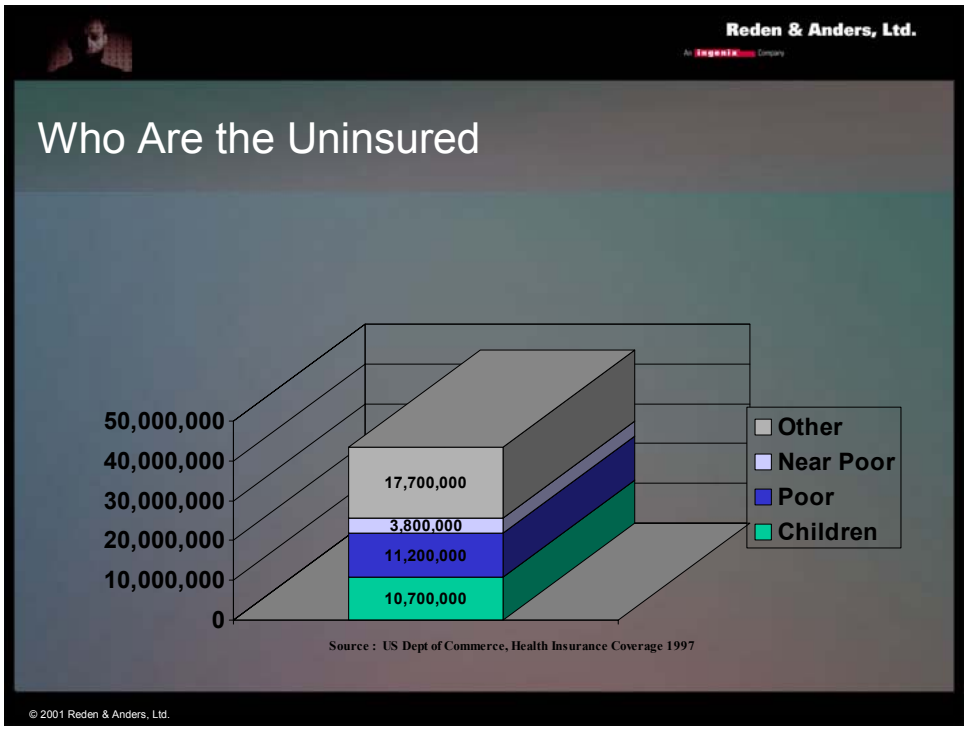
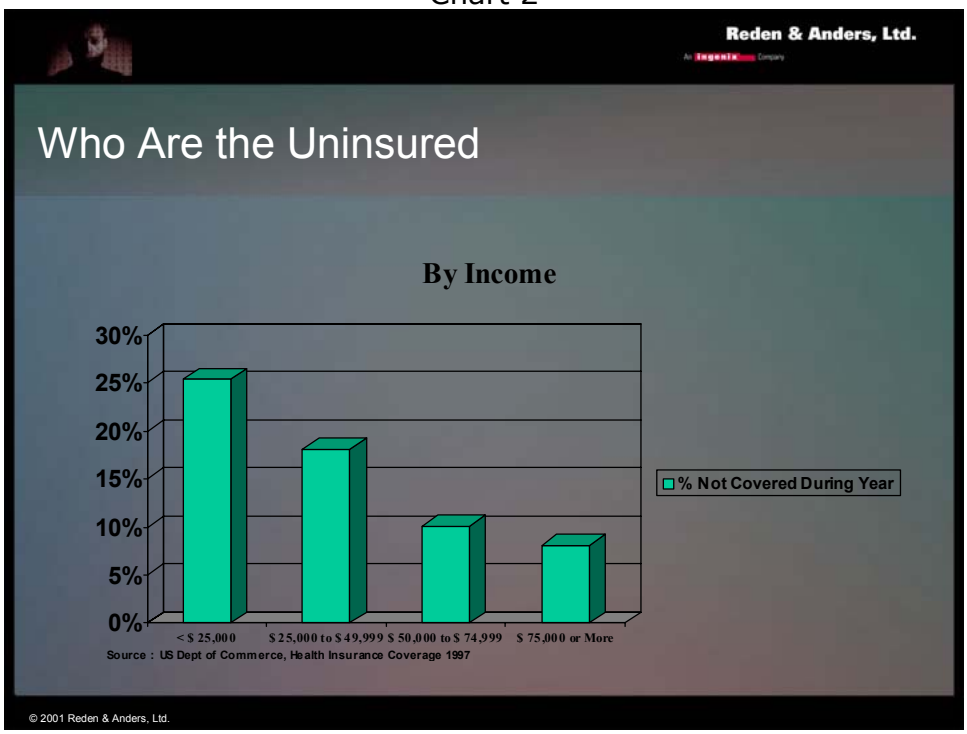


Chart 2



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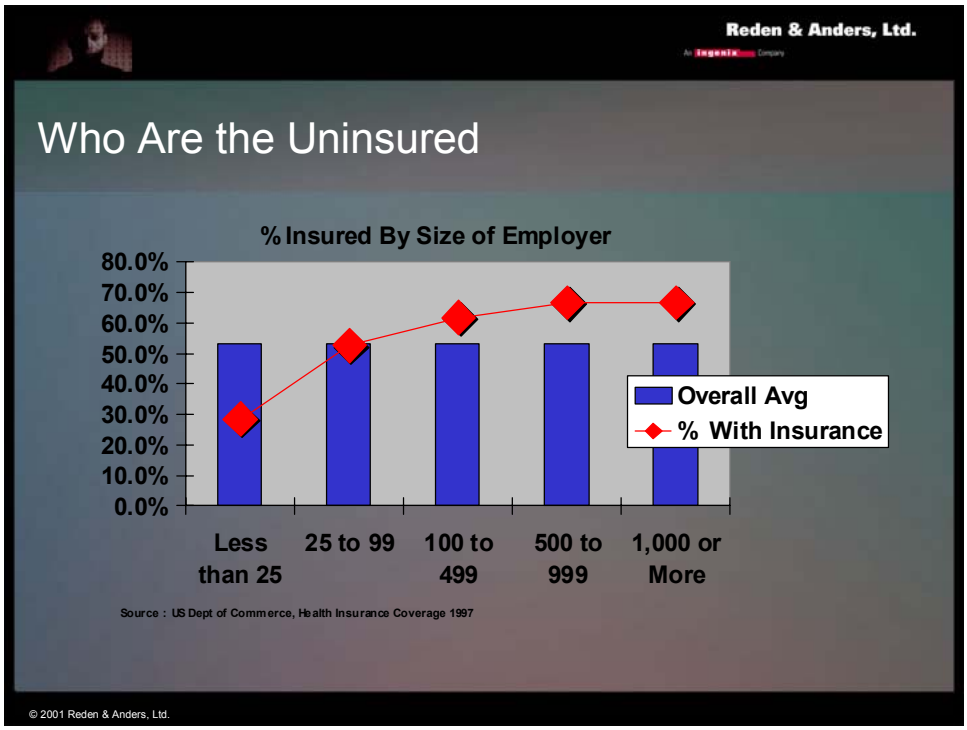

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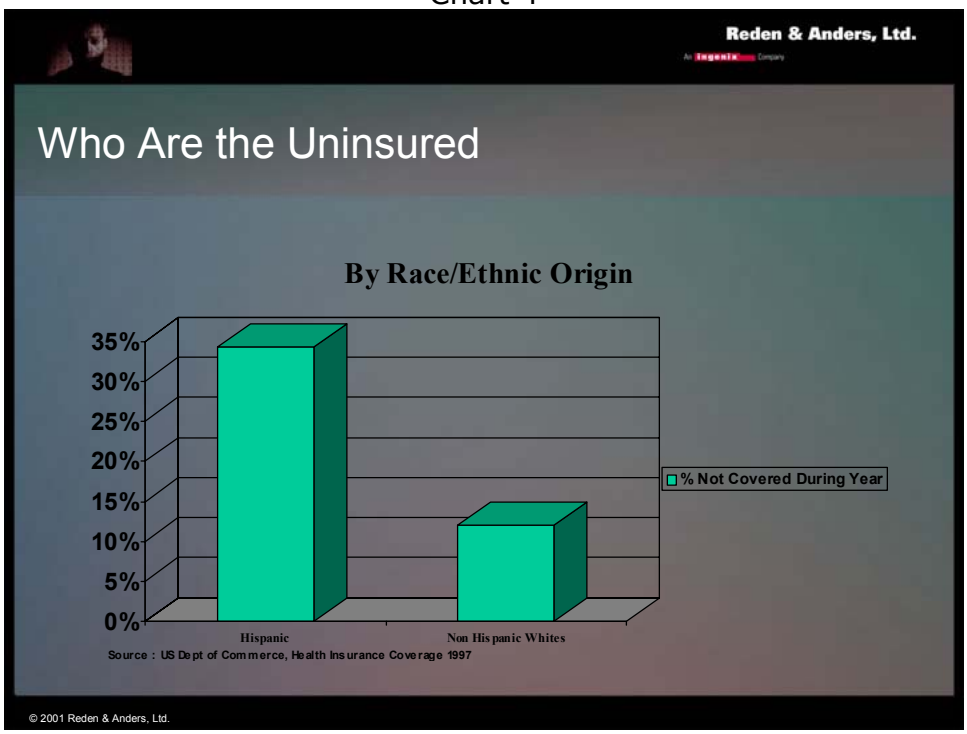

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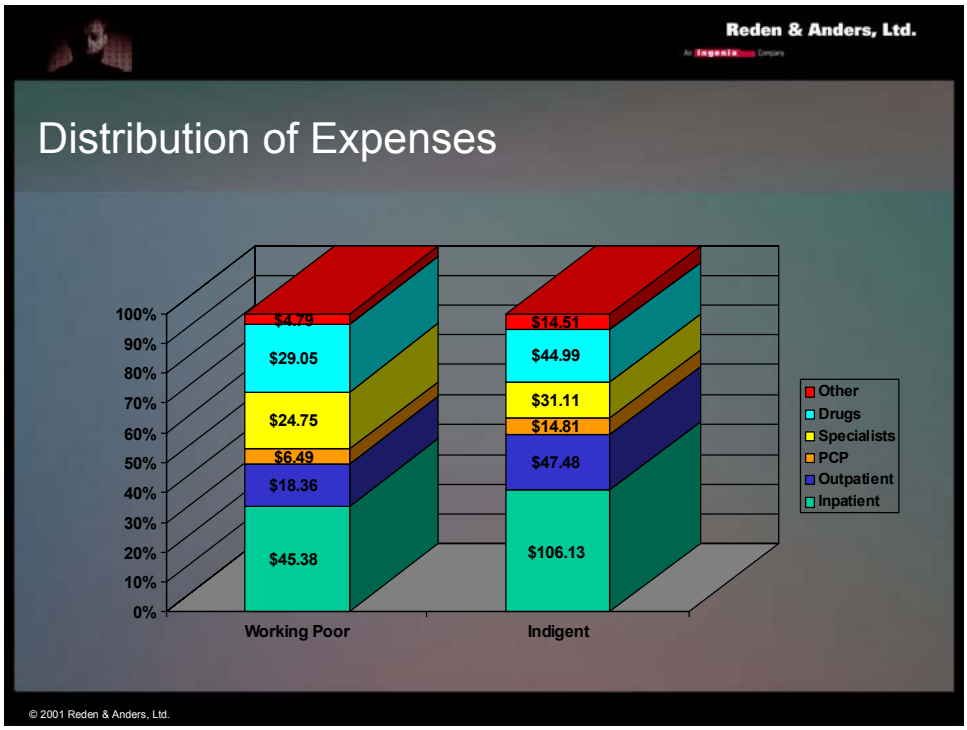

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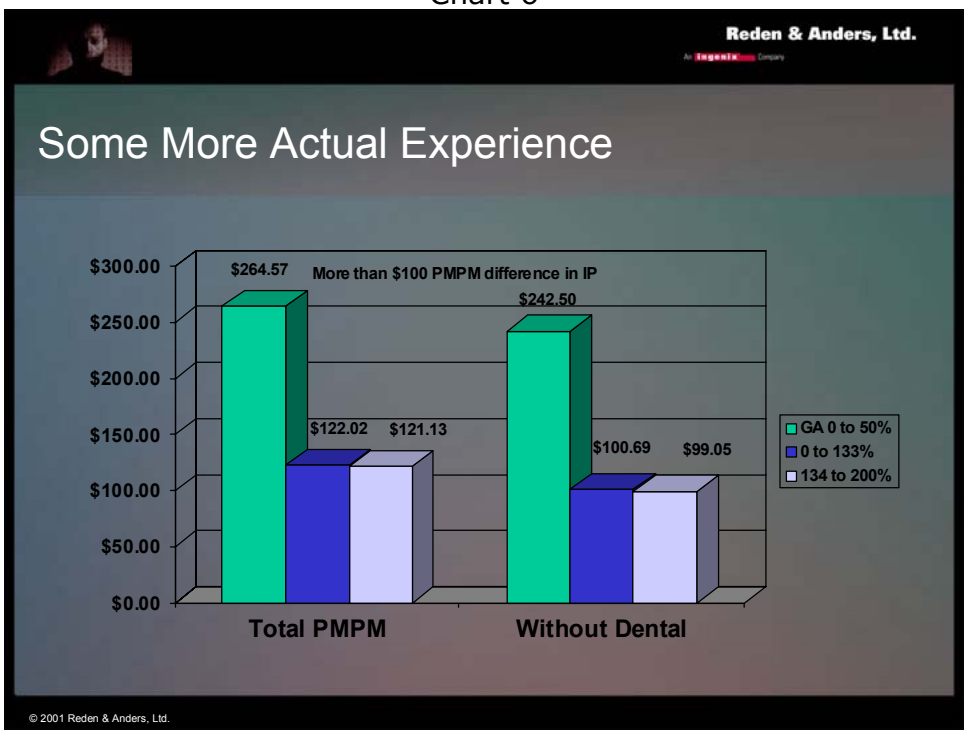

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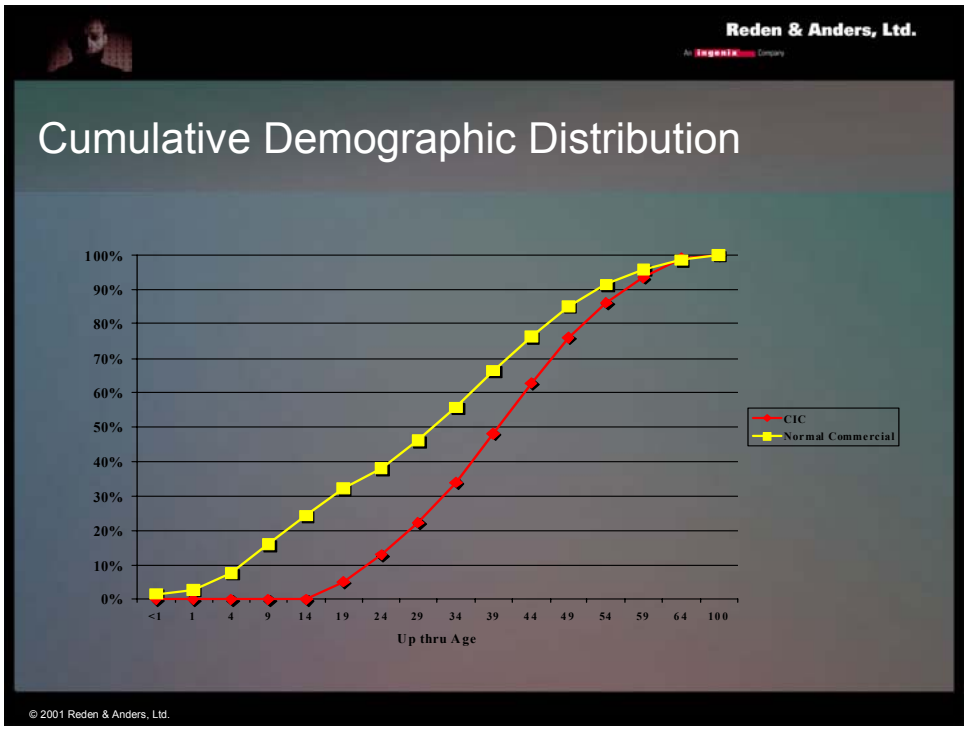

Chart 8