Minnesota: A Case Study in Childless Adult Coverage

State Report

by
Heather Sacks and
Stan Dorn
Economic and Social Research Institute

August 2004

INTRODUCTION

For years, Minnesota has been a national leader in state-based health coverage. This leadership extends to childless adults, who are covered through two major programs: General Assistance Medical Care (GAMC) and MinnesotaCare. Most of the following analysis describes these programs before state budget cuts approved in 2003, most of which were implemented by October 1, 2003.

This paper provides an overview of Minnesota's efforts to cover low-income childless adults. It is based interviews with key stakeholders and document reviews, which took place as part of a larger multi-state examination of coverage available to low-income childless adults.

PROGRAM DESIGN

Eligibility, Benefits, and Cost-Sharing

GAMC

GAMC covers adults without children who have incomes at or below 75 percent of the Federal Poverty Level (FPL) and who are not eligible for Medical Assistance (MA), the state's Medicaid program. Before qualifying for GAMC, adults (except migrant workers and individuals with an emergency medical condition) must live in the state for at least 30 days, but they need not have a permanent address.

Generally comparable to Medicaid services, GAMC's benefits include: physician visits; inpatient and outpatient hospital care; emergency room services; prescription drugs; alcohol and drug treatment; chiropractic services; dental care; diagnostic, screening, and other preventive services; family planning; hearing aids; immunizations; medical equipment; transportation; eye exams and glasses; podiatry; and prosthetics. Services not covered include: fertility treatments; hospice care; nursing home services; physical, occupational, and speech therapy; prenatal care; home health care; and cosmetic surgery. While GAMC previously had no premiums or co-payments, this changed on October 1, 2003, as discussed below.

Until the recent budget changes, the program has had a spend-down component, permitting applicants to qualify by deducting from their income costs incurred for health care. The program has also provided retroactive coverage of medical costs incurred during the month before the consumer first applied for coverage.[1]

One important feature of GAMC is that residents with potential disabilities can enroll while they wait for approval of their applications for Supplemental Security Income (SSI) cash assistance. SSI goes to individuals the Social Security Administration (SSA) finds to be so severely disabled that they are incapable of substantial, gainful employment for twelve months or more.

[1] Deborah Chollet and Lori Achman. *Approaching Universal Coverage: Minnesota's Health Insurance Programs.* Mathematica Policy Research, Inc. Prepared for the Commonwealth Fund. February 2003. http://www.cmwf.org/programs/insurance/chollet_universalcoverage_566.pdf.

Approximately 800 individuals per year end up moving from GAMC to SSI.[2] The state also does its own disability determinations, which sometimes issue before SSA's. This lets some certified disabled individuals move from GAMC to MA while awaiting SSI determinations. Approximately 40 percent of GAMC enrollees participate in GAMC for six months or less; there is considerable movement among GAMC, MinnesotaCare, and MA in multiple directions.[3] Approximately 26 percent of GAMC enrollees also receive general assistance cash assistance; 71 percent receive only GAMC coverage; and the remaining 3 percent live in institutions.

MinnesotaCare

MinnesotaCare covers adults without children who have incomes up to 175 percent of the FPL.[4] Before recent budget cuts, childless adults who first enrolled in the program with incomes below that level but whose income later rose above it could retain MinnesotaCare if shifting to the state's high-risk pool would require premium payments that exceed 10 percent of household income. MinnesotaCare also covers children and parents with incomes up to 275 percent of the FPL.

To qualify for MinnesotaCare, childless adults must have six months of state residency and a permanent address. For certain eligibility groups (including childless adults) the program denies eligibility to applicants who had health insurance at any time during the four months before the date of application; who received coverage during the past 18 months from an employer; or who have current access to insurance through an employer who pays at least 50 percent of the premium. The latter requirements are intended to preventing MinnesotaCare from causing losses in employment-based coverage.

There is some overlap of eligible populations with GAMC; consumers with incomes at or below 75 percent of the FPL may choose to enroll in either program, and many select MinnesotaCare. In January 2005, the state plans to implement a new computer system, Health Match, that will more clearly define program options and transitions.

MinnesotaCare Benefits include: office visits; medical care (including clinic and hospital services); dental care; mental health services, chemical dependency services; prescription drugs; vision care; and laboratory tests and x-rays. Services not covered include: orthodontic services; personal care; nursing home services; non-emergency transportation; fertility treatments; certain mental health services; and case management. MinnesotaCare adult enrollees are subject to a $10,000 annual limit on covered hospital costs. Adults who are not pregnant pay 10 percent coinsurance for hospital care, up to $1,000 per year; $3 copays for prescription drugs and contraceptive supplies; 50 percent coinsurance for non-preventive dental care; and $25 copays for eyeglasses. For the lowest-income beneficiaries, whether they are parents or childless adults, premiums start at $4 per person per month. Premium payments exceed that figure for higher-income enrollees.

Financing and Administration

GAMC is overseen by the State Department of Human Services. While the state pays 100 percent of program costs, GAMC is administered by counties.

---

[2] Along similar lines, a small number shift into MA if they get pregnant or become classified as parents (for example, if their child returns from foster care).
[3] Chollet and Achman, op cit.
[4] The Federal Poverty Level was $15,260 for a family of three in 2003.

MinnesotaCare, on the other hand, is administered by the state and is funded by federal matching funding for parents and children (who are covered by Medicaid and SCHIP waivers under Section 1115 of the Social Security Act); by beneficiary premium payments; and by state dollars raised from provider taxes. Such taxes are now 1.5 percent of gross revenues (excluding Medicare and, for the time being, Medicaid), but are scheduled to rise to 2 percent in January 2004.

Enrollment and Retention

Health Coverage Statistics

In 2001, 5.4 percent of Minnesotans were uninsured – one of the country's lowest rates. About half of uninsured state residents qualified for public programs but were not enrolled.[5] Some 2.7 percent of the population was enrolled in MinnesotaCare, which served 36,336 adults without children, of whom 31.4 percent had incomes at or below 75 percent of the FPL. GAMC covered 46,835 childless adults, or 0.6 percent of the state population.[6]

In MinnesotaCare, coverage of adults without children rose from 11.5 percent of that program's enrollees in 1998 to 20.2 percent in 2002. In the latter year, 47.0 percent of MinnesotaCare enrollees were children, and 32.9 percent were parents.

Procedures

The majority of applicants for GAMC are enrolled in a managed care plan under the "Prepaid Medical Assistance Program," or PMAP, which involves capitated contracts with private health maintenance organizations (HMOs). GAMC consumers not enrolled in managed care obtain care fee-for-service. All MinnesotaCare consumers enroll in managed care. Under Minnesota law, all HMOs are non-profit. The counties, not the state, choose how to implement managed care locally, for both MinnesotaCare and GAMC. Counties have a choice of PMAP or county-based purchasing (CBP), where the county takes on the risk otherwise born by HMOs. Two rural multi-county sites as well as Itasca County, which encompasses Grand Rapids, use the latter option.

Historically, the application for cash assistance and health programs had been combined, but the MinnesotaCare program is no longer tied to cash assistance. GAMC and MinnesotaCare use a single application form but different computer systems to process applications. Like most commercial insurers, MinnesotaCare permits applications by mail, although applicants have the option to apply at county human services offices. For GAMC, by contrast, applicants *must* apply at county human services offices. Before the most recent budget changes, both programs involved annual eligibility reviews and, for MinnesotaCare, annual calculation of appropriate premium amounts.

While counties must provide application opportunities for both GAMC and MA, they have the choice of whether to offer MinnesotaCare through their human services offices. Both programs

---

[5] Health Economics Program. Health Policy and Systems Compliance Division. Minnesota Department of Health. *Final Report to the Secretary: Health Resources and Services Administration, State Planning Grant Program.* October 30, 2001. http://www.health.state.mn.us/divs/hpsc/hep/hrsa/fnlhrs.pdf.

[6] Health Economics Program. Health Policy and Systems Compliance Division. Minnesota Department of Health. *Health Care Coverage and Financing in Minnesota: Public Sector Programs.* (Public Sector Programs) January 2003. http://www.health.state.mn.us/divs/hpsc/hep/miscpubs/hhsrvrpt.pdf.

are available to residents of all counties. In a county not offering MinnesotaCare through its human services offices, individuals can directly enroll in MinnesotaCare through the state.

The state, on the other hand, is responsible for administering the MinnesotaCare program, processing MinnesotaCare applications, and contracting with health plans. Some stakeholders believe that more counties *want* to take on increased administrative responsibility for MinnesotaCare, but are unable to do so due to the Department of Human Services' policy of not providing counties with administrative funding for any state health program.

HISTORY AND BACKGROUND

Program Context

Many in the state view GAMC as a welfare-related variant of Medicaid. MinnesotaCare, on the other hand, is viewed as a commercial insurance program that is affordable to low-wage workers.

These very different perceptions of the two programs result, in part, from their history. Traditionally, health care coverage for indigent residents, along with cash welfare assistance, was the responsibility of the state's townships. Within a few years after GAMC was created in 1975, this role shifted to the counties. When GAMC was created, primarily for poor people ineligible for Medical Assistance, counties were responsible for 10 percent of program expenditures. This small share of program spending was phased-out over 10 years ago, as the state took over all funding (except for a small proportion of administrative costs). From the program's beginning, key program features that have generally followed Medicaid's lead include the breadth of most covered benefits, spend-down coverage, the absence of cost-sharing, and some retroactive coverage of medical bills. The upshot of this history is that many view GAMC as part of the state's welfare system.

By contrast, MinnesotaCare was created much more recently, in 1992, as one of the country's first state-based, health insurance programs for working adults. It was the successor program to one of the country's original child health programs going far beyond minimum Medicaid requirements. Some key program features for MinnesotaCare, such as beneficiary cost-sharing, the absence of spend-down and retroactive coverage, application for insurance by mail and the absence of any fee-for-service coverage have the "look and feel" of employer coverage, rather than Medicaid. Thanks in part to these program features and the definition of the program constituency as the working uninsured, MinnesotaCare began and continued with considerable bipartisan and public support.

Phasing-In MinnesotaCare Coverage of Childless Adults

In 1994, childless adults with incomes at or below 125 percent of the FPL were added to MinnesotaCare. This coverage increased to 135 percent of FPL in 1996 and to 175 percent in 1997. Many of the state's health policy leaders planned, in subsequent years, to reach the same eligibility threshold with childless adults as with the rest of the MinnesotaCare population – namely, 275 percent of FPL. However, coverage for childless adults was added slowly to address then-Governor Carlson's concern about keeping spending under control. Continued expansion of childless adult coverage up the income scale stopped after 1997.

GAMC: Encouraging Earlier Receipt of Care

According to a number of stakeholders, GAMC's population resembles Medicaid's. When the program first began, it served men who had a history of seeking care at emergency rooms only when an emergency occurred and there were no other options. Of course, this method of seeking care was quite costly. Many of the key stakeholders believed (and still believe) that if the state did not create a broad and heavily subsidized health coverage program, this population would not commit to health maintenance programs, would not purchase insurance because of insufficient income, and would not seek care until they needed to go to the emergency room, thus making the population vulnerable to deteriorating health in the long run.

Characteristics of Childless Adults Enrolled in GAMC and MinnesotaCare

The state's Department of Human Services developed a comprehensive demographic overview of adults without children in GAMC and MinnesotaCare, with key results displayed in the following tables.[7]

Table 1: Selected characteristics of childless adults covered by GAMC and MinnesotaCare, 2001

	GAMC	MinnesotaCare		
		Under 75% FPL	75-175% FPL	**All MNCare**
Male	**61.9%**	47.4%	41.2%	**43.1%**
Female	**38.1%**	52.6%	58.8%	**56.9%**
Both genders	***100.0%***	*100.0%*	*100.0%*	***100.0%***
White	**60.4%**	75.3%	79.8%	**78.4%**
African-American	**22.6%**	8.0%	4.8%	**5.8%**
Asian-American	**2.9%**	5.2%	3.6%	**4.1%**
American Indian	**6.9%**	1.1%	1.0%	**1.0%**
Hispanic	**3.7%**	1.5%	1.2%	**1.3%**
Unknown or mixed race	**3.6%**	9.0%	9.7%	**9.5%**
All races and ethnicities	***100.0%***	*100.0%*	*100.0%*	***100.0%***
Employed	**36.6%**	49.3%	72.1%	**64.9%**
Not employed	**47.2%**	50.7%	27.9%	**35.1%**
Unknown	**16.2%**	0.0%	0.0%	**0.0%**
Total	***100.0%***	*100.0%*	*100.0%*	***100.0%***
Hennepin County (largest in state)	**34.9%**	22.1%	16.5%	**18.3%**
Other seven large counties	**25.4%**	32.0%	28.2%	**29.4%**
Remaining counties	**39.7%**	45.9%	55.3%	**52.3%**
All counties	***100.0%***	***100.0%***	***100.0%***	***100.00%***

Source: Minnesota Department of Human Services, January 2003 (Calculations by ESRI, July 2003).

[7] These statistics do not include undocumented adults. Minnesota Department of Human Services. *Adults Without Children in GAMC and MinnesotaCare*. January 27, 2003. These numbers reflect calendar year 2001.

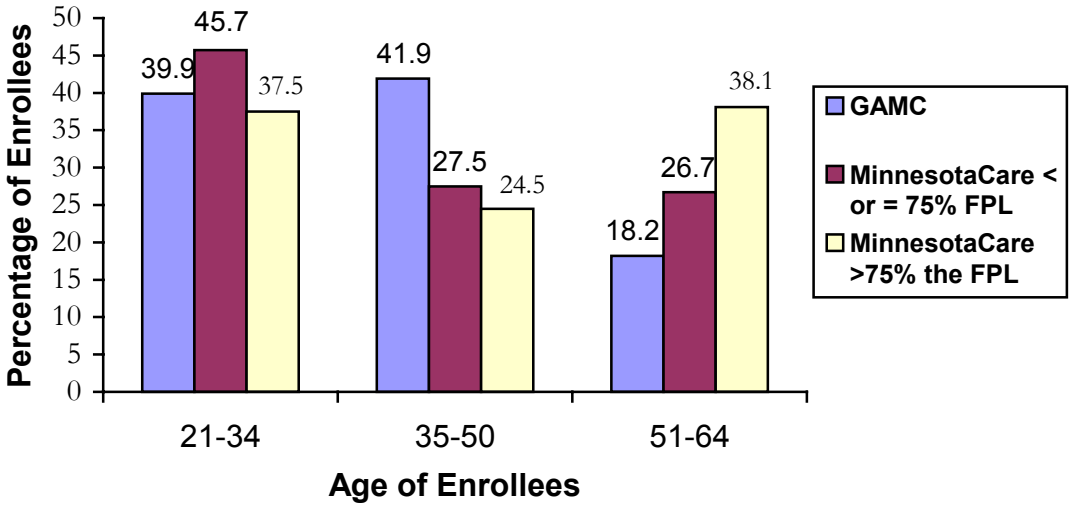
Table 2: The percentage of publicly insured, childless adults with various diagnoses: GAMC vs. MinnesotaCare, 2001

	GAMC	MinnesotaCare		
		Under 75% FPL	75-175% FPL	**All MNCare**
Alcohol/Drugs	**30.5%**	11.6%	10.0%	**10.5%**
Mild Mental Disorder	**21.1%**	17.0%	14.9%	**15.6%**
Severe Mental Disorder	**12.1%**	7.4%	6.5%	**6.8%**
Cold, Flu, etc.	**13.3%**	17.3%	18.4%	**18.1%**
Other Respiratory	**12.8%**	14.2%	15.1%	**14.8%**
Heart/Circulatory	**5.8%**	4.7%	6.5%	**5.9%**
Hypertension	**11.2%**	11.5%	15.1%	**14.0%**
Diabetes	**6.0%**	5.9%	7.4%	**6.9%**
Injury/Poisoning	**27.5%**	25.4%	25.4%	**25.4%**
Neoplasm	**5.0%**	7.6%	8.4%	**8.1%**
No services	**22.2%**	**20.1%**	**18.5%**	**19.0%**

Source: Minnesota Department of Human Services, January 2003 (Calculations by ESRI, July 2003). Notes: (1) This Table includes all diagnoses present for at least 5 percent of enrollees in each program. (2) One individual can be listed in this table with multiple diagnoses.

The following chart shows the age distribution for all GAMC enrollees and for MinnesotaCare childless adults in 2001. Including MinnesotaCare beneficiaries of all income levels, 40.1 percent of the program's childless adults were ages 21-34; 25.4 percent were ages 35-50; and 34.5 percent were ages 51-64.[8]

Figure 1: Age of Childless Adults in GAMC and MinnesotaCare, 2001



Source: Minnesota Department of Human Services, January 2003.

[8] Minnesota Department of Human Services, calculations by ESRI, July 2003.

Recent Program Spending

Spending on GAMC was $182.2 million in fiscal year 2002, averaging roughly $500 per enrollee per month. Program enrollment dropped in eight consecutive years from 1993 through 2000, with particularly sharp declines from 53,000 in 1995 to 23,000 in 2000. From 2000 to 2002, enrollment increased to 30,000. The year 2002 saw a 35.3 percent spike in GAMC spending (the largest on record), resulting from a 21.5 percent increase in enrollment and an 11.3 increase in per capita costs. Notably, per capita costs have more than doubled since 1992, as the healthiest beneficiaries moved off the program during the economic boom of the 1990s, leaving behind the highest-cost individuals.

Total spending on MinnesotaCare for all populations in fiscal year 2002 was $350.8 million, averaging $211.96 per month per enrollee. Spending for the program's childless adults was $109 million, averaging $314 per month per enrollee.

RECENT BUDGET CUTS

Act One: The Governor Proposes

In early 2003, as part of his plan to address Minnesota's budget crisis, Governor Tim Pawlenty proposed eliminating GAMC completely, shifting former GAMC beneficiaries into MinnesotaCare, and capping childless adults' eligibility for MinnesotaCare subsidies at 75 percent of FPL. Under this proposal, childless adults with incomes above that level could obtain coverage only by paying the full premium, which few could afford. This was part of the Governor's broader budget proposal, which included cuts to the Department of Human Services' funding of $1.35 billion.

State analysts projected that, under the Governor's proposal, approximately 63,000 individuals in all categories (not just childless adults) would lose coverage by 2007; that the proportion of state residents without insurance would rise from 5.4 percent in 2001 to 6.6 percent in 2007; and that uncompensated care in hospitals and clinics would increase from $56.9 million in 2004 to $135 million by 2007.[9]

Cuts to childless adult coverage were expected to create serious losses for a number of hospitals and clinics, including the state's major public hospital, inpatient mental health care providers, and hospitals in rural counties, particularly where only one hospital operates county-wide. If enrolled in MinnesotaCare as proposed by the Governor, the former GAMC population could neither obtain retroactive coverage nor "spend down" to qualify. Both retroactive coverage and "spend-down" had the effect of allowing GAMC, like Medicaid, to reimburse inpatient hospital costs incurred by indigent residents who had not previously applied for benefits. In addition, MinnesotaCare's $10,000 annual cap on inpatient hospital reimbursement would have denied reimbursement for the most costly patients formerly covered by GAMC.

---

[9] Scot Leitz. *Estimates of Uncompensated Care Due to Potential Public Insurance Program Changes.* Minnesota Department of Health, Health Economics Program. March 13, 2003. http://www.health.state.mn.us/divs/hpsc/hep/Presentations/uc.pdf. This analysis of the potential impact of program changes took into account changed eligibility rules, not such other potential changes as reduced payment, lower productivity, etc. See also Josephine Marcotty and Maura Lerner. "Pawlenty Plan Could Increase Number of Uninsured." *Star Tribune.* March 10, 2003.

While the level of uncompensated care in Minnesota would have remained well below the national average, even after the proposed cuts, the burden would have been distributed unevenly throughout the state. Hennepin County Medical Center (which alone accounted for 75 percent of all uncompensated care at publicly-funded facilities and treated 25 percent of the population in the state), Fairview University Hospital, St. Mary's and Regions all bore disproportionate burdens. In fact, of the hospital cuts proposed by the Governor, one half of the financial impact would have been experienced by six hospitals.[10] For example, Regions Hospital officials estimated that 6.5 percent of the facility's operating budget would have been cut under the Governor's original proposal. Similarly, analysts at Hennepin County Medical Center projected that their hospital's uncompensated care costs would rise from $4 million to $40 million after 3 years.

Act Two: The Legislature Disposes

Ultimately, the Governor and the Legislature agreed to a compromise, aided by a $195 million federal Medicaid payment in June 2003. This compromise featured the following elements:[11]

- GAMC was neither repealed nor folded into MinnesotaCare. Starting October 1, 2003, it was changed, however, to eliminate retroactive and spend-down coverage. To defray resulting hospital losses, a special category in GAMC was created solely for inpatient hospital coverage for individuals with incomes between 75 and 175 percent of FPL and with assets valued at or below $10,000. For this somewhat higher-income group, GAMC will not pay the first $1,000 of costs incurred during a hospital stay.
- Added to GAMC were 50 percent dental care coinsurance, $25 copays for non-emergency use of emergency rooms and adult eyeglasses, and nominal co-payments for office visits and prescription drugs.
- In the past, certain undocumented immigrants and non-residents received GAMC coverage of emergency services. As of July 1, 2003, this coverage was repealed, affecting an estimated 2,000 people, including childless adults, children, seniors, and people with disabilities. However, some of these former GAMC beneficiaries may qualify for Emergency Medical Assistance, if they have an emergency medical condition.
- Policymakers adopted a number of across-the-board cutbacks to MinnesotaCare, affecting all beneficiary groups. Many of these cutbacks also applied to Medicaid and GAMC. Such cuts reduced provider payments; eliminated coverage of weight-loss products; capped adult dental services; increased verification of eligibility and requirements for prompt submission of beneficiary forms; increased the frequency of eligibility reviews; increased the restrictiveness of eligibility rules related to assets; and increased premium payments on a sliding scale from beneficiaries with incomes above 100 percent of FPL.
- Several MinnesotaCare cutbacks targeted childless adults: for individuals with incomes between 75-175 percent of the FPL, coverage is limited to physician outpatient services, prescription drugs, chiropractic services, and lab and diagnostic services, all of which are capped at $5,000 per year, effective 10/1/03. Also, these childless adults will have $50

[10] Regions Hospital Press Release. *GAMC Shift to MinnesotaCare Assumptions and Impacts.* 2003.
[11] The following analysis comes from *Summary of Legislation Affecting the Department Of Human Services – FY 2004-05*. June 2003. http://edocs.dhs.state.mn.us/live/DM-0165-ENG.pdf; and Minnesota Council of Nonprofits/Minnesota Budget Project. *Impact of the Final FY 2004-05 Budget*. June 30, 2003. www.mncn.org/doc/fy200405.pdf

copays for all ER visits, 10% co-insurance for inpatient hospital care, and $5 copays for non-preventive physician visits. Individuals with incomes that rose above 175 percent of the FPL after they first enrolled in MinnesotaCare, who previously received MinnesotaCare because purchasing coverage through the state's high-risk pool would have consumed more than 10 percent of household income, will now be denied MinnesotaCare when their income rises.

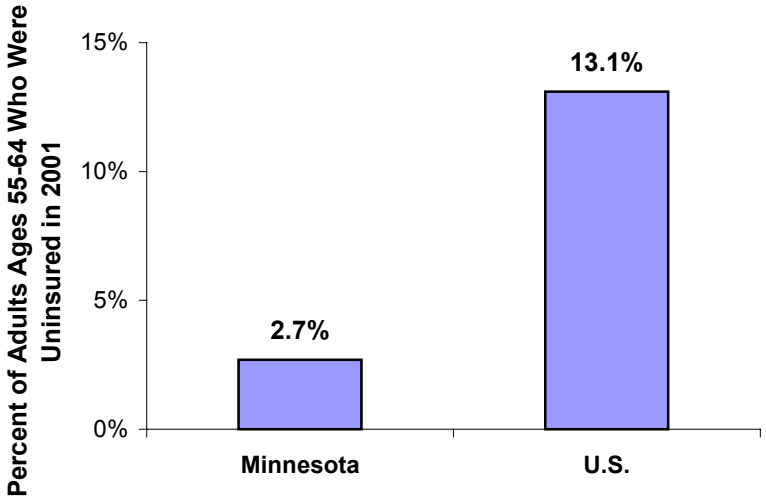
By 2007, this year's cutbacks to MA, MinnesotaCare, and GAMC are projected to deny coverage to 37,000 individuals who would have been insured under prior law. This includes between 13,500 and 15,000 childless adults.[12] These projections take into account both flat denials of eligibility and reduced enrollment expected to result from premium increases, administrative changes, and benefit reductions.

LESSONS LEARNED

Many Near-Elderly Beneficiaries

As noted above, fully 34.5 percent of childless adults in MinnesotaCare are over age 50. This is one important reason why, in Minnesota, uninsurance among the near elderly is only one-fifth the rate in the country as a whole, as shown by the following chart.

Figure 2. Uninsurance Among the Near-Elderly is Far Lower in Minnesota Than in the U.S. as a Whole



Sources: Kaiser Commission on Medicaid and the Uninsured, 2003;[13] Minnesota Department of Public Health, 2002.[14]

[12] 2003 Legislative Eligibility Reductions in Minnesota Health Care Programs. DHS Health Care Administration. June 25, 2003.
[13] Catherine Hoffman and Marie Wang. *Health Insurance Coverage in America: 2001 Data Update*. Kaiser Commission on Medicaid and the Uninsured. January 2003. http://www.kff.org/content/2003/4070/4070.pdf.
[14] Stefan Gildemeister, Julie Sonier, and April Todd-Malmlov. *Minnesota's Uninsured: Findings From the 2001 Health Access Survey.* Health Economics Program, Minnesota Department of Health, in collaboration with School of Public Health, University of Minnesota. April 2002. http://www.health.state.mn.us/divs/hpsc/hep/miscpubs/hhsrvrpt.pdf.

Public coverage is only part of the explanation for this striking disparity. In Minnesota, private coverage among adults ages 55-64 is 10.5 percent higher than in the country as a whole; 81.3 percent of such adults are privately insured in Minnesota, compared to 73.6 percent nationally. Public coverage also plays an important role, however. Such coverage is 20.1 percent higher for near-elderly adults in Minnesota than in the entire U.S. (16.1 vs. 13.4 percent).[15] Minnesota's experience suggests that giving states increased capacity to cover low-income adults without children may be a strategy worth considering in addressing the increasing loss of health coverage among near-elderly adults.

Two Programs For Two Populations

These two relatively longstanding programs use different approaches to covering two groups of childless adults who tend to have different characteristics. The following table displays salient facts from the above discussion.

Table 3: Selected program and enrollee characteristics: GAMC vs. MinnesotaCare childless adults, before 2003 budget cuts

	GAMC	MinnesotaCare
Program features	No enrollee premium payments	Enrollee premium payments of $4 a month or more, on a sliding fee scale
	No out-of-pocket cost-sharing	Limited coinsurance and copays
	Retroactive coverage of prior medical bills	No retroactive coverage
	Apply at county welfare office	Apply to state via mail
Enrollee characteristics	37 percent employed	65 percent employed
	31 percent diagnosed with substance abuse	11 percent diagnosed with substance abuse
	35 percent live in Hennepin County (Minneapolis)	18 percent live in Hennepin County
	40 percent non-white	12 percent non-white

Such differences persist at a slightly reduced level when GAMC is compared to MinnesotaCare enrollees with incomes at or below 75 percent FPL – the same income level served by GAMC. Among such very-low-income MinnesotaCare consumers:

- 12 percent are diagnosed with substance abuse, compared to 31 percent among GAMC enrollees;
- 22 percent live in urban Hennepin County, compared to 35 percent of GAMC consumers;
- 25 percent are nonwhite, compared to 40 percent of GAMC enrollees; and
- 49 percent are employed, compared with 37 percent of GAMC consumers.

Put succinctly, before the 2003 cutbacks, GAMC was a very comprehensive program serving a very poor group of childless adults; and MinnesotaCare served low-wage workers through a more mainstream health insurance model (albeit with important program features, like reduced cost-sharing, that took into account most enrollees' lack of discretionary income, compared to

[15] Hoffman and Wang, op cit.; Gildemeister, et al., op cit.

higher-income workers with employer-based coverage). The two programs complemented each other well, according to a number of state officials.

Other Lessons

Minnesota's long history of innovative health coverage expansions can inform policy development nationally and in other states by providing lessons that include the following:

- The absence of federal matching funding for childless adults increases their vulnerability to cutbacks during times of fiscal difficulty. While it was not the sole factor, 100 percent state funding contributed to the singling out of childless adult programs for disproportionately heavy cuts. This disproportionate impact was quite severe in the Governor's original proposal but still present, albeit at a greatly reduced level, in the final budget passed by the Legislature.
- Despite this vulnerability, the Legislature greatly reduced the singling out of childless adults for heavier cuts, relying much more than did the Governor on across-the-board cuts to achieve savings. This suggests the political viability of covering childless adults as part of broader health coverage programs. Such viability reflects, in part, many policymakers' belief that the presence or absence of children living at home should have no bearing on whether uninsured workers deserve help purchasing health coverage.
- From the start, proponents relied on bipartisan Legislative champions and a broad-based coalition to pass and expand MinnesotaCare. Such broad-based support was important to resisting cutbacks. Crucially, the Legislature's substantial revision of the Governor's proposed cuts this year was bipartisan. Almost certainly, bipartisan support would be essential to any future program restorations or expansions.
- Rural areas benefit from coverage of childless adults. As noted above, more than half of MinnesotaCare beneficiaries live outside the large, urban counties, and sole community hospitals in rural areas faced some of the greatest potential losses from the Governor's proposed cuts to childless adult coverage. In part, this reflects the fact that rural employers are less likely to provide their workers with health coverage. In the Twin Cities Metropolitan Statistical Area (MSA), 69 percent of employers offer health coverage to their workers. Outside that MSA, only 53 percent offer such coverage.[16]
- A related lesson suggests the importance of childless adult coverage to certain health care providers, who helped rescue the program by opposing the Governor's proposed cutbacks. In addition to rural hospitals, providers with a large financial stake in childless adult coverage include public hospitals in urban areas, mental health care providers (particularly inpatient facilities), and community health centers.
- Many studies have examined whether MinnesotaCare caused the contraction of employer-based coverage in the state. These studies have come to different conclusions, some finding limited "crowding out" of employer coverage, and others finding none.[17] However, two conclusions seem hard to dispute: there have been only modest reductions in employer coverage, if any, during a time of large expansions of public coverage in Minnesota; and concerns about crowd-out has not stopped Minnesota from coming closer than almost any other state to health coverage for all residents. In fact, if uninsured individuals eligible for

[16] Health Economics Program, *Final Report to the Secretary*, op cit.
[17] See studies cited in Health Economics Program, *Public Sector Programs,* op cit.

public coverage were all enrolled, the state's already low uninsurance rate would be cut in half.[18]

- Compelling individual examples show how important this coverage is to childless adults. One case involved a diabetic man whose leg needed amputation. His income was below 175 percent of the FPL and he spent down to qualify for GAMC. However, the amputation itself could have been avoided if he had been in the system all along and received preventive care and treatment much earlier in the course of the disease. The Fremont Community Health Services Clinic in north Minneapolis provided yet another example. Half of the clinic's 9,000 patients are enrolled in state-subsidized health programs. Many are former laborers whose disability insurance payments provide their entire income, which ranges from $7,000 to $16,000 a year. Without MinnesotaCare, many of these workers with chronic health care needs would defer seeking care until their health problems degenerate into emergencies, placing their well-being at serious risk and increasing the state's total costs.[19]
- This year's budget crisis was neither unique to Minnesota nor the first time the state faced a shortage of funding. When Minnesota experienced an earlier budget crisis in the 1980s, policymakers decreased some Medicaid benefits. Eventually, most of the benefits were restored. Only time will tell whether similar results follow this year's round of health coverage cutbacks.

ADDITIONAL SOURCES:

Interviews with Mary Kennedy, Medicaid Director, Minnesota Department of Human Services.

Interview with Lee Greenfield, Hennepin County, Health and Community Initiatives Department. Former chair of HHS Finance Committee from 1979-2000.

Interview with Maureen O'Connell, Advocacy Director, and Kathy McDonough, Attorney, Legal Services Advocacy Project.

[18] Health Economics Program, *Final Report to the Secretary*, op cit.
[19] Jean Hopfensperger. "Deficit Tugs at State's Safety Net."*Star Tribune.* February 21, 2003.