The Uninsured and Underinsured in Minnesota[1]

A Summary of Data to Support Outreach and Enrollment Efforts

INTRODUCTION

The Affordable Care Act (ACA) requires states to provide free, impartial enrollment assistance, in the form of Navigators, In-Person-Assisters, and Certified Application Counselors. Many states, including Minnesota, have also invested additional resources in outreach efforts and enrollment assistance to connect people to state exchanges. This report provides a summary of existing data[2] concerning the uninsured and underinsured in Minnesota. The summary will support outreach and enrollment efforts in reaching those most in need of new or improved coverage.

From October 2013 to March 2014, MNsure was launched and started its first round of open enrollment. Effective January 1, 2014, Medical Assistance was expanded, and MinnesotaCare eligibility barriers were decreased. These changes helped more than 180,500 formerly uninsured Minnesotans gain new coverage between September 2013 and May 2014, which was a 40% reduction in the number of uninsured. Yet 264,000 Minnesotans were still uninsured at the end of May 2014, and many *insured* people still face a financial risk due to inadequate coverage.

This report summarizes three areas of information:

- Uninsured Minnesotans in 2013, their eligibility for coverage under the ACA, and reasons for being uninsured, as well as reductions in uninsurance during the first open enrollment
- Underinsured Minnesotans and the negative impacts of underinsurance on financial protection and access to needed care
- Snapshot of the distribution of MNsure outreach grantees by population of focus and geographic area served.

PART I. The Uninsured in Minnesota

With so many Minnesotans newly insured in the past year, stakeholders engaging in outreach and enrollment activities are eager to know the updated profile of the remaining uninsured and whether demographic and geographic distribution has changed substantially. Unfortunately, that data is not yet available. But data on the 2013 uninsured Minnesotans and reasons for being uninsured, as well as their eligibility for coverage under the ACA, can inform efforts to reach the remaining uninsured.

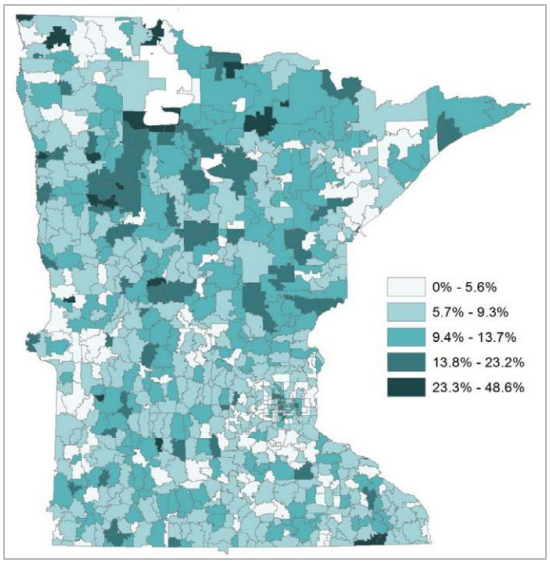
[1] We wish to acknowledge XinXin Han for her invaluable contributions in research and writing for this project

[2] Data sources are mainly from prior reports released by the State Health Data Assistance Center (SHADAC), a health policy research and technical assistance center within the University of Minnesota School of Public Health, whose faculty and staff are recognized as national experts on access to health insurance and health services.

Profile of the uninsured in Minnesota in 2013

In 2013, 8.2% (445,000) of Minnesotans were uninsured.[3] But in certain populations, the rate of uninsurance was much higher. For example, among non-elderly Minnesotans, the uninsurance rate was: 13.9% for adults aged 18-25 and 17.3% for adults aged 26-34; approximately 18% for those below 200% FPL; 35.4% for Hispanics; 19.2% for American Indians; and 15% for African Americans.[4] Compared to Minnesota's overall population, the non-elderly uninsured were more likely to be self-employed, work between 11-20 hours per week, work for firms with fewer than 100 employees and hold temporary or seasonal jobs.[3] Figure 1 shows the geographic distribution of the uninsured Minnesotans from 2008-2012.

Figure 1. Geographic Distribution of The Uninsured in Minnesota, SHADAC Analysis of the 2008-2012 American Community Survey



Source: Profile Of Minnesota's Uninsured. State Health Access Data Assistance Center. April 2014.

ACA eligibility among the 2013 uninsured, applying 2014 eligibility criteria

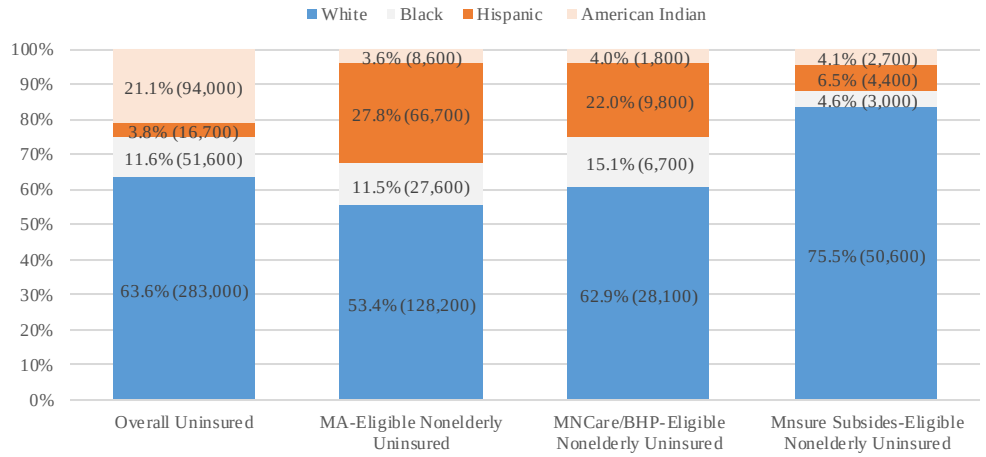
As of January 2014, several significant expansions of public health care eligibility have gone into effect in Minnesota.

- Almost all non-elderly parents and childless adults up to 138% FPL (about $32,900 for a family of four in 2015)[5] and pregnant women and children with family income up to 280-288% FPL (about $66,800-68,700 for a family of four in 2015)[4] are eligible for MA.[6] Certain Legal Permanent Residents who are federally excluded from MA eligibility are instead eligible for MinnesotaCare (MNCare).[7]
- MNCare eligibility was simplified by eliminating asset limits and reducing premiums and some other insurance barriers, while also lowering the income limit to 200% FPL (about $47,700 for a family of four in 2015)[4] and introducing new restrictions based on employer coverage.[5,8] Some of these changes moved people from MNCare to the private market, while other people gained new access.
- Advanced Premium Tax Credit (APTC) eligibility was established for people with income between 200% and 400% FPL when purchasing insurance through MNsure,[5] *if* they are not eligible for affordable employer coverage.[6]

[3] Health Insurance Coverage in Minnesota: Results from the 2013 Minnesota Health Access Survey. Minnesota Department of Health, University of Minnesota School of Public Health, State Health Access Data Assistant Center, Fact Sheet. February 2014.
[4] Call KT, Lukanen E, Pintor JK, Alarcón G. Profile of Minnesota's Uninsured: Summary of Key Findings. State Health Access Data Assistance Center. April 2014.
[5] Calculation was based on the 2015 Federal Poverty Level, a family of 4 with income at 100% FPL. The 2015 Federal Poverty Level is available at https://obamacare.net/2015-federal-poverty-level/.
[6] MNsure: A New World of Opportunities for Affordable Health Insurance Starts in 2014. Minnesota Budget Project. August 2013.
[7] How Will the Uninsured in Minnesota Fare Under the Affordable Care Act? Kaiser Family Foundation, Fact Sheet. January 2014.
[8] Under the ACA, individuals who are offered employer coverage that is considered affordable and meets Minimum Essential Coverage guidelines are not eligible for MNCare or APTCs. If the coverage meets these requirements for the employee, and is also offered to dependents of the employee, those dependents are ineligible for MNCare or APTCs, regardless of whether dependent coverage is affordable. This is known as the "Family Glitch."

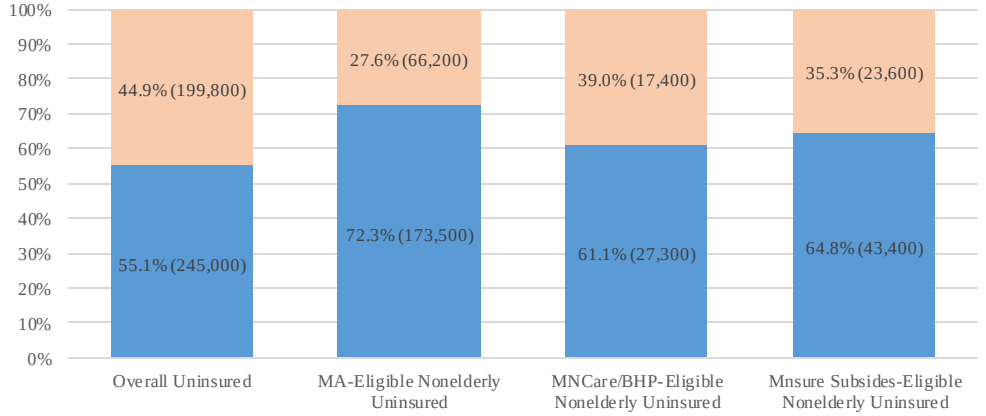
Based on the new ACA income criteria, up to 85% of the 2013 non-elderly uninsured Minnesotans may be eligible for either MA (58%), MNCare (11%) or MNsure health plans with subsidies (16%).[3] However, these estimates include people who may be ineligible for other reasons. For example, those who are offered qualifying coverage by their employer or a household-member's employer are ineligible for MNCare and APTCs, although they may still choose to purchase full-price insurance on MNsure. Undocumented immigrants are denied MA and MNCare and barred from purchasing even full price coverage on MNsure by the ACA, though they may purchase coverage from the non-MNsure individual market or enroll eligible children and other family members in coverage through MNsure. Figures 2 and 3 show the racial and geographic distribution of income-based eligibility.

Figure 2. Race/Ethnicity Distribution among the 2013 Nonelderly Uninsured Minnesotans by ACA Eligibility



Source: Profile of Minnesota's Uninsured. State Health Access Data Assistance Center, April 2014.
Note: The overall uninsured includes both nonelderly and elderly indiviudals, where the elderly uninsured accounted for 0.7% of the 2013 overall Minnesota's u

Figure 3. Geographic Distribution among the 2013 Nonelderly Uninsured Minnesotans by ACA Eligibility



Source: Profile of Minnesota's Uninsured. State Health Access Data Assistance Center, April 2014.
Note: The overall uninsured includes both nonelderly and elderly individuals, where the elderly uninsured accounted for 0.7% of the 2013 overall Minnesota's u

Cost, lack of information, and difficulty enrolling: main reasons for being uninsured in 2013

We cannot assume that these expansions have or will automatically benefit everyone equally. Over half of those who were uninsured in 2013 were potentially eligible for a public health care program under the pre-ACA rules.[2] Yet, barriers to enrollment have resulted in high numbers of those eligible for public program remaining uninsured.

When non-elderly uninsured adults were asked why they had not enrolled in public health care programs, 21.6% said the coverage was too expensive and another 35.7% cited other barriers such as not knowing where to enroll, too much paperwork, or believing they were not eligible.[3] Only 17.8% cited choice-based reasons such as not wanting it, never having looked into it, or believing government should not provide it.[3] Of the 2013 non-elderly uninsured, 11.7% of adults and 20.3% of children applied but were found ineligible for public programs.[3]

Cost was a major reason cited by the uninsured for not enrolling in available private coverage as well. Among 2013 non-elderly uninsured adults, 44.5% of those who refused employer coverage when it was offered said it was too expensive or unaffordable.[3] Over 60% of those who remained uninsured, rather than purchasing individual coverage, named lack of affordability as the barrier.[3] Lack of information on how and where to get health insurance, or the eligibility for a health plan, were also a common reason for being uninsured in 2013. 31% of adults did not take-up employer coverage when offered because, on further inspection, they were ineligible.[3] The uninsured were the least familiar with the ACA provisions, including the availability of Medical Assistance (39.6% not familiar) and tax credits or subsidies to help pay the premium (33.1% not familiar).[1]

The ACA eliminates some challenges that may contribute to these numbers, such as asset limits for public program eligibility. But some barriers persist, such as proof of immigration status, complicated eligibility rules related to income, ineligibility due to access to employer coverage that is unaffordable, or lack of multi-lingual materials. In addition to broad public education about affordable insurance options and how to enroll, continuing one-on-one assistance is a vital complement to help the chronically uninsured obtain and keep coverage.

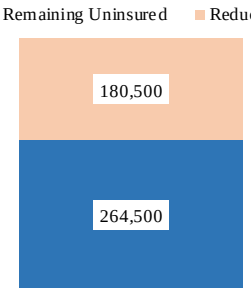
Substantial reduction in the uninsured in Minnesota during September 2013 and May 2014

More than 180,500 uninsured Minnesotans gained insurance from September 2013 to May 2014.[9] That represents a decrease in the percentage of Minnesotans who are uninsured from 8.2% (445,000) in 2013 to 4.9% (264,500) by the end of May (Figure 4).

[9] Early Impacts of the Affordable Care Act on Health Insurance Coverage in Minnesota. State Health Access Data Assistant Center. June 2014.

- The most growth was in Medical Assistance and MinnesotaCare, which grew by a combined 20.6%.[8]
- Enrollment in private non-group insurance grew by 12.5%.[8]
- Prior to the November 2014 open enrollment period, MNsure reported more than 362,000 individuals enrolled, including 55,593 in Qualified Health Plan (QHP), 228,159 in Medical Assistance, and 78,540 in MinnesotaCare.[10]

Figure 4. Reduction in Numbers of Uninsured Minnesotans after the First Open Enrollement Period



Source: Early Impacts of the Affordable Care Act on Health Insurance Coverage in Minnesota. State Health Data Assistance Center, June 2014.

These numbers may reflect the impact of the expanded income eligibility for public programs as well as what is known as the "welcome mat effect." The "welcome mat effect" is when *already eligible* uninsured enroll only once eligibility is further expanded, perhaps due to awareness, simplicity, or outreach. Expanded eligibility presents renewed opportunities to reach and enroll those already eligible remaining uninsured.

PART II. The Underinsured in Minnesota

Health insurance is expected to protect people from financial risks and reduce their barriers to health care services, but coverage alone may not fully ensure accessible and affordable health care. There is a group of people who are insured but do not have "adequate" insurance coverage, who are referred to as the "*under*insured." Underinsurance is often defined by 1) exposure to out-of-pocket medical costs accounting for a high share the total household income, and 2) being insured but delaying care or failing to obtain needed care due to cost.[11] By definition, this group of people may be at a high risk of facing medical costs that exceed their ability to pay and thus not get the care they need, and should not be ignored in favor of simply expanding coverage.

According to the Commonwealth Fund, in 2012 9% (399,529) of Minnesotans were non-elderly underinsured because their health care costs (*excluding* premiums)[12] exceeded 5% of household income in households below 200% FPL, or 10% of income for all households above 200% FPL.[13] By this definition, 27% (154,992) of non-elderly Minnesotans below 100% FPL, 22% (138,861) of those between 100-199% FPL, and 6% (79,528) of those between 200-399% poverty were underinsured.[12]

Medicaid and MinnesotaCare should now be available to many of these individuals. However, for those who are ineligible, underinsurance is still a significant risk. For those purchasing private coverage, the monthly premium is a frequent focal point when comparing plan options. However, in order to carry a lower monthly premium cost, many

[10] Three Weeks To Go Until MNsure Open Enrollment. MNsure Website. October 2014. Available at: https://www.mnsure.org/news-room/news/news-detail.jsp?id=486-145582.
[11] Schoen C, Collins SR, Kriss JL, Doty MM. How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007. *Health Affairs (Millwood)*. 2008 Jul-Aug; 27(4): w298-309.
[12] Since premiums are a prerequisite to obtaining coverage, most definitions of underinsurance only measure out of pocket spending after the premium.
[13] Schoen C, Hayes SL, Collins SR, Lippa JA, Radley DC. America's Underinsured: A State-by-State Look at Health Insurance Affordability Prior to the New Coverage Expansions. The Commonwealth Fund, March 2014.

low-income individuals may tend to choose those plans with limited benefits but high cost-sharing. Due to their lower incomes, these same individuals may be least able to save and weather sudden medical costs, and are therefore at heightened risk of delaying care or suffering from medical debt.

In 2013, 11% of insured children and 19% of insured non-elderly adults in Minnesota did not get the care they need (e.g., prescription drugs, dental care, routine care, metal health care, and specialist care) due to cost.[3] At the same time, 21% of insured children and 24% of insured non-elderly adults in Minnesota had experienced financial barriers related to health care such as difficulty paying medical bills, having trouble with basic bills due to medical costs, or having to set up a payment plan for medical bills.[3] Outreach and enrollment efforts should include a focus on the underinsured, who may benefit from MA, MNCare or better private plans on MNsure. Once reached, it is important to also educate enrollees about underinsurance and how insurance coverage works so that they can make educated decisions.

PART III. 2014 Outreach and Enrollment Resources

In 2014, MNsure awarded $4.6 million in Outreach and Infrastructure grants to 28 organizations across Minnesota to support outreach and enrollment efforts through mid-2015. The goals for the grant program include assisting populations with barriers to coverage, building regional navigator resource and referral networks, and educating Minnesotans about the importance of health insurance and how they can enroll through MNsure. Figures 5 and 6 on the following pages draw from the grantee profiles released by MNsure to show the areas of the state and focus populations served by 2014 MNsure outreach grantees.[14] Grantees may only be offering services to a portion of each region or population, and these figures do not include the many MNsure assisters who are not outreach grantees. For a full searchable list of navigators and other assisters across the state, see the assister directory at MNsure.org.

CONCLUSION

Through the ACA and MNsure, many people who were previously uninsured have obtained coverage. Covering the remaining uninsured depends on sustained investment in outreach and enrollment efforts, as well as continued focus on affordability and access. Continued attention to who gains coverage, who is left out, and the quality of coverage can help inform future outreach and enrollment efforts. These efforts could be even more successful in the future if:

- More real time population specific data is collected and available about who is getting covered and how;
- Sustainable funding is available for supporting outreach and enrollment by, of, and for specific communities
- Collaboration and networking continues among local organizations to share strategies and innovative approaches to reach persistently uninsured and underinsured populations.

[14] Outreach Enrollment Grant Program Summary. MNsure. September 2014. Available at: https://www.mnsure.org/images/2014-Outreach-Enrollment-Program-Grantees.pdf.

Figure 5. Distribution of Geographic Areas Served by MNsure Grantees

Area 7:
1. National Association on Mental Illness (NAMI Minnesota), St. Paul
2. Community Resource Connections, Bemidji
3. Minnesota Chippewa Tribe, Cass Lake
4. Arrowhead Economic Opportunity Agency, Inc. (AEOA), Virginia
5. Arrowhead Economic Opportunity Agency, Inc. (AEOA), Virginia
6. Mid-Minnesota Legal Aid, St. Cloud
7. Minnesota AIDS Project (MAP), Minneapolis
8. Planned Parenthood Minnesota North Dakota South Dakota, St. Paul
9. The Arc Greater Twin Cities, St. Paul

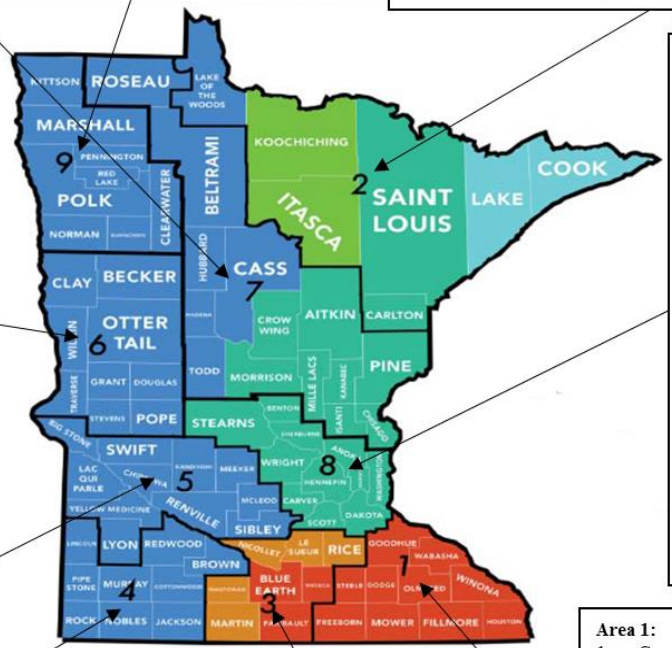
Area 9:
1. St. Cloud Area Somali Salvation Organization (SASSO), St. Cloud
2. National Association on Mental Illness (NAMI Minnesota), St. Paul
3. Community Resource Connections, Bemidji
4. Planned Parenthood Minnesota North Dakota South Dakota, St. Paul

Area 2:
1. National Association on Mental Illness (NAMI Minnesota), St. Paul
2. Generations Health Care Initiatives (insureDuluth), Duluth
3. Minnesota Chippewa Tribe, Cass Lake
4. Arrowhead Economic Opportunity Agency, Inc. (AEOA), Virginia
5. Arrowhead Economic Opportunity Agency, Inc. (AEOA), Virginia
6. Minnesota AIDS Project (MAP), Minneapolis

Area 8:
1. Portico Healthnet, St. Paul
2. Asian Economic Development Association (AEDA), St. Paul
3. Hmong American Partnership (HAP), St. Paul
4. Communidades Latinas Unidas En Servicio (CLUES), St. Paul
5. Centro Cultural Chicano, Minneapolis
6. Minneapolis Urban League, Minneapolis
7. Stairstep Foundation, Minneapolis
8. United Family Medicine, St. Paul
9. Native American Community Clinic, Minneapolis
10. NorthPoint Health and Wellness Center, Inc., Minneapolis
11. Pillsbury United Communities (PUC), Minneapolis
12. Somali Health Solutions, Minneapolis
13. National Association on Mental Illness (NAMI Minnesota), St. Paul
14. Health Access MN, Inc., St. Paul
15. Southside Community Health Services, Inc., Minneapolis
16. West Side Community Health Services, Inc., St. Paul
17. Minnesota Chippewa Tribe, Cass Lake
18. The Arc Greater Twin Cities, St. Paul
19. Mid-Minnesota Legal Aid, St. Cloud
20. Minnesota AIDS Project (MAP), Minneapolis
21. Planned Parenthood Minnesota North Dakota South Dakota, St. Paul
22. Western Community Action, Inc., Marshall

Area 6:
1. National Association on Mental Illness (NAMI Minnesota), St. Paul
2. Communicating for America, Inc., Fergus Falls
3. Minnesota AIDS Project (MAP), Minneapolis
4. Planned Parenthood Minnesota North Dakota South Dakota, St. Paul
5. Western Community Action, Inc., Marshall

Area 5:
1. National Association on Mental Illness (NAMI Minnesota), St. Paul
2. Mid-Minnesota Legal Aid, St. Cloud
3. Minnesota AIDS Project (MAP), Minneapolis
4. Planned Parenthood Minnesota North Dakota South Dakota, St. Paul
5. Western Community Action, Inc., Marshall



Area 4:
1. Communidades Latinas Unidas En Servicio (CLUES), St. Paul
2. National Association on Mental Illness (NAMI Minnesota), St. Paul
3. Health Access MN, Inc., St. Paul
4. Western Community Action, Inc., Marshall

Area 3:
1. Communidades Latinas Unidas En Servicio (CLUES), St. Paul
2. National Association on Mental Illness (NAMI Minnesota), St. Paul
3. The Arc Greater Twin Cities, St. Paul
4. Minnesota AIDS Project (MAP), Minneapolis

Area 1:
1. Communidades Latinas Unidas En Servicio (CLUES), St. Paul
2. Somali Health Solutions, Minneapolis
3. National Association on Mental Illness (NAMI Minnesota), St. Paul
4. Intercultural Mutual Assistance Association (IMAA), Rochester
5. The Arc Greater Twin Cities, St. Paul
6. Minnesota AIDS Project (MAP), Minneapolis
7. Health Access MN, Inc., St. Paul
8. Planned Parenthood Minnesota North Dakota South Dakota, St. Paul

Figure 6. Selected Focused Populations and List of MNsure Grantees Who Serve Them

Low-income individuals	People who were unfamiliar with health insurance and the health care system	Young adults	People with mental illness or physical disabilities	People with complex immigration statuses	East African and Somali	Latinos	African Americans	Hmong	American Indians
Pillsbury United Communities (PUC), Minneapolis	Generations Health Care Initiatives (insureDuluth), Duluth	Pillsbury United Communities (PUC), Minneapolis	Portico Healthnet, St. Paul	Portico Healthnet, St. Paul	Portico Healthnet, St. Paul	Portico Healthnet, St. Paul	Portico Healthnet, St. Paul	Portico Healthnet, St. Paul	Portico Healthnet, St. Paul
Communidades Latinas Unidas En Servicio (CLUES), St. Paul	Planned Parenthood Minnesota North Dakota South Dakota, St. Paul	Intercultural Mutual Assistance Association (IMAA), Rochester	Intercultural Mutual Assistance Association (IMAA), Rochester	Intercultural Mutual Assistance Association (IMAA), Rochester	Pillsbury United Communities (PUC), Minneapolis	Pillsbury United Communities (PUC), Minneapolis	Pillsbury United Communities (PUC), Minneapolis	Pillsbury United Communities (PUC), Minneapolis	Pillsbury United Communities (PUC), Minneapolis
Planned Parenthood Minnesota North Dakota South Dakota, St. Paul	Southside Community Health Services, Inc., Minneapolis	Communicating for America, Inc., Fergus Falls	Communicating for America, Inc., Fergus Falls	Mid-Minnesota Legal Aid, St. Cloud	Mid-Minnesota Legal Aid, St. Cloud	Asian Economic Development Association (AEDA), St. Paul	Minneapolis Urban League, Minneapolis	Asian Economic Development Association (AEDA), St. Paul	Minneapolis Urban League, Minneapolis
NorthPoint Health and Wellness Center, Inc., Minneapolis	West Side Community Health Services, Inc., St. Paul	NorthPoint Health and Wellness Center, Inc., Minneapolis	The Arc Greater Twin Cities, St. Paul	United Family Medicine, St. Paul	NorthPoint Health and Wellness Center, Inc., Minneapolis	NorthPoint Health and Wellness Center, Inc., Minneapolis	NorthPoint Health and Wellness Center, Inc., Minneapolis	NorthPoint Health and Wellness Center, Inc., Minneapolis	NorthPoint Health and Wellness Center, Inc., Minneapolis
Health Access MN, Inc., St. Paul	Western Community Action, Inc., Marshall	Health Access MN, Inc., St. Paul	Native American Community Clinic, Minneapolis	Health Access MN, Inc., St. Paul	Somali Health Solutions, Minneapolis	Centro Cultural Chicano, Minneapolis	Stairstep Foundation, Minneapolis	Hmong American Partnership (HAP), St. Paul	
St. Cloud Area Somali Salvation Organization (SASSO), St. Cloud	Asian Economic Development Association (AEDA), St. Paul	Generations Health Care Initiatives (insureDuluth), Duluth	Generations Health Care Initiatives (insureDuluth), Duluth		Native American Community Clinic, Minneapolis	United Family Medicine, St. Paul			
The Arc Greater Twin Cities, St. Paul	Minneapolis Urban League, Minneapolis	Arrowhead Economic Opportunity Agency, Inc. (AEOA), Virginia	Arrowhead Economic Opportunity Agency, Inc. (AEOA), Virginia		St. Cloud Area Somali Salvation Organization (SASSO), St. Cloud	Communidades Latinas Unidas En Servicio (CLUES), St. Paul			
West Side Community Health Services, Inc., St. Paul	NorthPoint Health and Wellness Center, Inc., Minneapolis	West Side Community Health Services, Inc., St. Paul	West Side Community Health Services, Inc., St. Paul						
Western Community Action, Inc., Marshall	Pillsbury United Communities (PUC), Minneapolis	Western Community Action, Inc., Marshall	National Association on Mental Illness (NAMI Minnesota), St. Paul						
Stairstep Foundation, Minneapolis	St. Cloud Area Somali Salvation Organization (SASSO), St. Cloud	Stairstep Foundation, Minneapolis							
Somali Health Solutions, Minneapolis	Somali Health Solutions, Minneapolis	Community Resource Connections, Bemidji							
Minneapolis Urban League, Minneapolis	Stairstep Foundation, Minneapolis	Mid-Minnesota Legal Aid, St. Cloud							
Southside Community Health Services, Inc., Minneapolis	United Family Medicine, St. Paul	Planned Parenthood Minnesota North Dakota South Dakota, St. Paul							
Centro Cultural Chicano, Minneapolis	Mid-Minnesota Legal Aid, St. Cloud								