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Moderator: **Carrie Au-Yeung**

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(Carrie Au-Yeung): Hi everyone. Thanks for joining us today to learn more about coverage results from the 2017 Minnesota Health Access Survey. My name is Carrie Au-Yeung, I'm a research fellow here at SHADAC and I'll be moderating today's event.

Before we launch into the event itself I'd like to briefly review a few technical details. First, broadcast audio is available for today's webinar through your computer speakers. However, you can also listen today by telephone by dialling eight six six five one nine two seven nine six and using passcode seven three nine six nine one.

Please note that all phones will be muted for the duration of the event. If you experience any trouble with the web portion of today's call, please call the Ready Talk Helpline at eight hundred eight four three nine one six six. If you're able to log into Ready Talk but are still having technical problems, you can also ask for help using the online chat feature.

The presentation portion of today's webinar will be followed by a question and answer session. Please submit questions for the speakers at any time using the chat feature. Or you can always send a question to us using Twitter. Our handle where we'll be answering questions is At SHADAC.

Finally, today's presentation slides are available for download or viewing at W-W-W dot SHADAC dot org back slash 2017 MNHA Webinar. Today's webinar will focus on the Minnesota Health Access Survey, which is administered jointly by the Health Economics Program at the Minnesota

Department of Health and by SHADAC. And we have experts from both organizations joining us today.

Our first speaker is Dr. (Kathleen Call), SHADAC Investigator and Professor in the Division of Healthy Policy and Management at the University of Minnesota School of Public Health. Our second speaker is (Stefan Gildemeister), Minnesota State Health Economist and Director of the Health Economics Program at the Minnesota Department of Health.

Our third and final speaker is (Alisha Simon), Supervisor of the Health Access and Cost Containment Unit in Health Economics Program at the Minnesota Department of Health. From here I'll hand the call off to (Kathleen) to begin.

Dr. (Kathleen Call): Great, thanks (Carrie). So this is just a map of what we're going to walk through today. So I'm going to provide an overview of the Minnesota Health Access Survey. And (Alisha)'s going to share the main findings of the survey and also give you some information about the uninsured in 2017.

(Stefan)'s actually going to talk - reflect on the results overall and talk about some policy issues within the state. And then we'll have plenty of time for questions and answers. So again, please go ahead and Tweet or chat some questions to us.

So this is a biennial survey of health insurance coverage and access that's really considered the definitive source for Minnesota around who are the uninsured, where do they live. And it has that flexibility to allow us to ask policy-relevant questions each year as we need to shift up the survey.

It's funded by the Minnesota -- excuse me -- it's funded by the Minnesota State Legislature with matching funds from the Department of Human Services as well as operational funding support from the Health Economics Program. And this has been a partnership for a long time.

It's a general population telephone survey that we conduct both in English and in Spanish. And we have data that's comparable based on this sampling design back to 2001. And starting in 2007 we received state funding to do the survey every two years. Before that it was kind of intermittently as we could gather the money.

So the sample design -- as I said again -- is - it's a telephone survey. It's a random digits dialled design where we sample 75% from a cell phone frame and 25 from a landline frame. We're screening elderly out to a certain extent, trying to get the 64 and under population. And we also oversample prepaid cell phones in the last two waves of the survey.

It's - we had 12,436 completed interviews in 2017. The survey was conducted between June and early October of 2017. And we have an overall response rate of almost 29%. And these data again are weighted to the American Community Survey 2016 demographic characteristics of the state so that we can generalize to the state's population.

So each year we have a betting pool to see who can get closest to the new rate of uninsurance before the estimates come out. And this has to be before we even start collecting data, because we're checking our numbers as we go. We really went into this survey thinking, you know, (not) - the economy's pretty good in, you know, if we look at from 2015 to 2017. The state economy actually increased quite a bit.

There wasn't much change in terms of weekly wages and the unemployment rate was relatively stable. So we would expect that there wouldn't be much change in the rate of uninsurance, because it (does) tend to track with the economy. However, we did see an increase - or the rate of the population over 65 is growing at a much higher rate -- three times the rate -- as the population 0 to 65.

So that would lead us to believe that there would be more public program recipients simply because of folks moving into Medicare, aging into Medicare. Within that same context -- so really not expecting much change except for aging into Medicare -- the results show a lot of things going on as many of you are well aware.

We had a lot of uncertainty in the health policy space both at the state but primarily at the federal level. So the economic and demographic indicators would lead us to believe that uninsurance is stable. But there was constant discussions of the repeal of the ACA. In Minnesota there were a few health insurers that were pulling out of the private market and that impacts areas of the state very differently.

There were a series of failed votes to repeal the ACA. There was a - cost sharing for the subsidies on the marketplace ended. And then there was a - the individual mandate penalty was set to zero. But that was in - not until the end of the year and we were already out of the field. But there was just a lot going on in the policy environment that would lead us to believe that things could change.

We also saw really high increases -- like everywhere else in the nation -- around a greater share of the population being on high deductible or high cost sharing plans. So there might be some differences in the private market, or we assume that. So there was a lot that we were trying to kind of gather information and figure out what could be happening now. ((Inaudible)) tell you what did ((inaudible)) our results.

(Alisha Simon): So as (Kathleen) said, there were lots of things going on. And what we found was that the uninsurance rate actually went up two percentage points.

So one of the things we've noticed in the past -- and you can see on this slide -- is the uninsurance rate tends to have a lagged response to economic recessions. So in 2001, there

was a recession. Towards the end of 2001. And when we measured the uninsurance rate in 2004 we saw kind of a lagged response, increase in uninsurance rate.

Another recession started in 2007. When we measured the uninsurance rate in 2009 we saw a lagged insurance - increase in the uninsurance rate. The uninsurance rate started to go down as the economy improved between 2013 and 2014. There were some major reforms in - from the ACA. And that brought our uninsurance rate way down to 4.3% in 2015.

And then we bounced back up in 2017 to 6.3%. But we didn't see that same - we're not quite sure. It's not a lag response to the economy because the economy is not - did not go into recession between 2015 and 2017. So that was a little different than we expected. So one of the things that happened, why did the uninsurance rate went down? Or went up.

Coverage through individual market and employers fell. So we saw a decrease in private coverage. Some of that is fewer people are connected to employers that offer coverage. So that is one of the things that we measure in our survey and we have seen that go down. There's also some declining take up of employer coverage among children.

We have seen increasingly high costs in both the group and the individual market. And then the uncertainty around coverage that (Kathleen) talked about. And this trend -- of decreasing employer coverage especially -- dates back to 2001. So this graph does a really good job of just showing how we've - the percent of people with private coverage has gone down about 15% since 2001. And that's pretty much specifically in the employer market.

As expected, public coverage was going up at the same time. And those -- while it did increase three percentage points -- that was not enough to make up for the decrease in private coverage. Part of that is more people are aging into Medicare. The Baby Boomers are turning 65 at a fairly heft clip. And that was responsible for about 40% of the increase in public coverage.

The other thing that we've noticed is fewer people are losing public coverage once they're enrolled. So we're seeing less churn in our survey for people with public coverage. And that is the case in people under 65, not just over 65. And part of that -- we believe -- is because eligible people have more options to enrol and better support in the past.

So they can enrol through their county or through MNsure in the State of Minnesota -- that's our exchange -- for Medicaid. And they also - there's a lot more navigators and other assistants out there to help people get coverage. Another thing that we always look at on our survey is what are the potential sources of coverage for the uninsured?

So we know from previous surveys that many people who are uninsured do have potential access to coverage. This slide shows that information from 2013 through 2015. Kind of of note is generally around 1/5 of people without health insurance coverage in the state are eligible for employer coverage. So they or their spouse or their parent work for an employer that offers coverage that they could enrol in if they chose to, and they are not choosing to.

Once the - we also noticed that about half of people without health insurance are eligible for public coverage based on their income and access to employer coverage. So that has gone down since 2013. That probably goes along with people getting enrolled and staying in coverage. But that's still half of, you know, about 350,000 people who could potentially enrol in public coverage and haven't chosen to.

And that is a low or no cost option available to them. Since the Affordable Care Act reforms came in in 2014 people also have access to premium subsidies -- or APTC, which are Advance Premium Tax Credits -- which bring premium costs down to a percentage of their income.

And the percent of people potentially eligible for those who are uninsured has stayed the same -- just over 20% -- in both 2015 and 2017. Because of that decrease in the percent of uninsured who are eligible for public coverage, we did see a slight increase between 2015 and 2017 as far as the percent of uninsured who have access to some type of subsidized coverage. However, still almost 90% of the uninsured do have some potential access to health insurance coverage that -- for various reasons -- they are not taking advantage of.

So that kind of gets to the big question. Why don't eligible people enrol in coverage? One thing we know -- from both some work we've done in our survey in previous waves and other surveys -- is that people without health insurance also tend to be the people who are least aware of the options available to them.

Often when you ask them why don't they - they don't have coverage, they're worried or they assume they can't afford coverage. Or that they aren't eligible. And as an example of another reason why people may not be getting coverage, in a recent Commonwealth Fund survey 39% of uninsured people who had actually heard of marketplaces decided not to enrol because they thought either the ACA would be repealed or the individual mandate would be repealed.

So some of that uncertainty is kind of seeping into people's insurance decision making process. So people who are informed are making that conscious decision it's going to go away anyway. So I am not going to enrol.

Another question that we always like to ask is who are the uninsured? The overall profile of the uninsured didn't change in 2017. And to be honest hasn't changed much since we started measuring it. In 2017 people with the highest uninsurance rates were more likely to be young adults between 18 and 34, have lower incomes, have a high school education or less, or be people of colour and American Indians.

Not surprisingly these populations also tend to have less access to employer-sponsored coverage, which is the primary form of coverage in the state and actually in the country. What was different about 2017 from previous years is that -- in 2015 -- we kind of saw an overall decrease. Everybody gained insurance coverage, all populations, you know, kind of no matter how you looked at it.

In 2017 the uninsurance rate increases were not uniform. So we saw rate increases for the Hispanic, and Latino, Black, and Asian populations. But for American Indians rates didn't change. We saw increases in uninsurance rates for people with incomes over 300% of poverty. But people living under poverty we actually saw rates staying the same between 2015 and 2017.

We saw increases in rates for adults 18 to 25 and then 35 to 64. But adults age 26 to 34 -- which is one of the highest - one of the populations with the highest uninsurance rates -- actually maintained their coverage gains from 2015. And people with a high school education or less saw an increase in uninsurance rates, whereas people with some college and technical school maintained coverage gains from 2015.

So now we're going to show this graphically and sort of see how things over time have changed. So this graph is showing that people with the lowest incomes maintained coverage gains. And while they still have the highest rates of uninsurance they did kind of maintain those gains from 2015.

We think that is related to this population is more likely to be eligible for public programs. And we know that people are maintaining public program coverage. We are seeing the big decrease - or big increases in uninsurance were with people with higher incomes. That is probably related to costs going up. And -- at least for people in the individual market -- subsidies are not present after 400% of poverty.

And as employer market coverage costs go up -- especially cost sharing -- that's the group that may have determined that they no longer - coverage is no longer something that they want. Again, when we're looking at uninsurance rates by age most adults saw a return to the 2013 coverage levels. The one exception being those 26 to 34 year olds.

We're also happy to say that the children also maintained their coverage gains. While they tend to be a group that has high rates of health insurance, that was maintained from 2013 and is still on the low end of what we've measured in the state. People over 65 pretty much always have health insurance because of Medicare.

And again, we see a similar - a slight - well a slightly different trend with income, where people with the lowest education levels actually saw a significant bounce back or increase in their uninsurance rates in 2015. Which is sort of the opposite of what we saw with income, where people with the lowest incomes actually maintained those coverage gains. And we're not seeing the same increases in people with higher levels of educational attainment.

By race and ethnicity, we see a lot of variation. People who are white have the lowest uninsurance rates in the state. And they're also the largest population in the state. So any kind of increase or decrease tends to be significant. But they did see their uninsurance rates go back - reach back towards 2013 rates. Hispanics saw a huge, huge decrease in uninsurance in 2015. And about half of that decrease was wiped out in 2017. And with the Asian population we also saw -- and Black population -- we also saw increases back towards 2013 levels.

The good news is that the American Indian population has kind of seen an overall downward trend since 2001. It's a little bouncy -- as you can see from the line -- but the general trend is going lower. And they did maintain gains from 2013.

We also like to look at our state. Our sampling is set up so we can measure the state in the 13 economic development regions. And the overall the gains in - or the increases in uninsurance across the state happened all across the state, with the exception of the southeast of the corner of the state. All of the state kind of saw some increases in uninsurance rate. And then the slide was - the whole state became more green.

There were not any differences between rural and urban uninsurance rates in the state. There used to be a number of years ago, but those decreases - or those changes have mostly gone away and were not present. The uninsurance rate was basically the same for rural and urban Minnesota.

Another thing that's important to know is that uninsurance are also more likely to report fair or poor health. And that fair or poor health may be related to their mental health. We ask questions about healthy days and the uninsured don't have more physically unhealthy days than the general population. But they do have more mentally unhealthy days than the general population. They also lack confidence to getting needed health care.

And they report foregoing healthcare due to cost at twice the rate of the general population. And the reason this is an important thing to think about is people without health insurance do have barriers to getting health care. And these are some of the measurements of those barriers. So that not having health insurance can lead to poorer health. It can make it more difficult to get health care.

The other thing that often comes up -- and it's kind of the big uninsurance myth -- is that people who don't have health insurance don't work. That is not true. The uninsured are actually employed at basically the same rates as the state as a whole. The difference is the kind of jobs people without health insurance have.

So they're more likely to be seasonal or temporary workers. They're more likely to be self-employed. And they're also more likely to work for small businesses. These are all factors that make the chance of them having access to employer-sponsored coverage less. And they also make it more difficult to get public coverage, especially if they're seasonal or temporary workers or self-employed. Their income may fluctuate and not be steady and that may make it harder to have access to programs that are based on income.

So the uninsured do actually use some health care. And we try to find out where people who don't have health insurance get health care. Most of them don't have a usual source of health care. And among those that do have a usual source of health care they're more likely to use the emergency room than -- or a public clinic -- than the rest of the population. With the exception of people with public coverage who also use public clinics at a high rate.

So people without health insurance -- while they do use health care -- they use less health care. Only about half of people without health insurance saw a doctor in the past year. That's compared to between 80 and 90% for people with health insurance. They are equally likely to have had an in-patient stay as people who are privately insured. A little less likely than people with public coverage, but that includes Medicare recipients who are more likely to be in the hospital.

And to debunk another myth about health insurance - about the uninsured. More - they are more likely to use the emergency department than the privately insured, but they're still less likely to use it than the publicly insured. So that's - the emergency room is not filled with uninsured people.

And now I'm going to turn it over to (Stefan) for some closing thoughts and what we're seeing kind of in the policy landscape. And what we learned from our survey this year.

(Stefan Gildemeister): Thank you (Alisha) and (Kathleen). Just a few closing thoughts. Over the last several years Minnesota and the national goal has really struggled with a number of issues regarding how to finance health care and insurance, how to consider affordability in health care, and to what extent the underlying trends in health care costs affect affordability and affect the availability of care or insurance policies.

So what this survey then does is provide a near-real time information about the coverage landscape in Minnesota, thereby giving policy makers tools to inform their health policy decisions. Whether they concern -- again -- how we support insurance policies, whether there are stable markets to deliver health care to individuals, and how the coverage landscape changes in some very fundamental ways.

For us a couple things stood out in this survey and our maybe thought foundations for discussions that are already occurring in the Minnesota legislature. The decline that (Kathleen) and (Alisha) spoke of in employer-sponsored coverage is of concern. Primarily because we see it happen during strong economic times.

Clearly the role of employer coverage has been declining over time, and there are a number of reasons for that. But that it occurs when Minnesotans have more or easy access to employer coverage presumably, you know, makes us really wonder whether the foundation of health insurance coverage in Minnesota -- Minnesota being a state with comparatively high insurance coverage -- whether that is changing and whether we as a state need to adjust to that.

So that one way to think about that is, you know, through public health insurance programs we have developed the mechanisms through which people who are going through transitions and are income-eligible can obtain insurance coverage. For higher income individuals whose employer coverage declined but otherwise are not income-eligible. That's not an option.

So the legislature has dealt with some of these questions through discussion of premium rebates. Through looking at reinsurance as a mechanism in the individual market to reduce health care spending. That said, public coverage as a mechanism to deliver comprehensive health insurance to eligible people in Minnesota is increasing, so the role of public health insurance coverage is becoming more important.

And then two more points I think. You know, we have served over time and through other - through a variety of analyses that health care costs keep rising. And I think what we're facing with this analysis is sort of a reminder that rising health care costs translates into rising premiums, which affects employers' and individuals' decision on whether to support or obtain insurance coverage.

So unless there is real active engagement in thinking about how to contain health care cost growth -- or in funding that health care cost inflation -- I think we will see more and more populations making that consideration whether or not insurance coverage is individually a good value.

And lastly, I think we are reminded in this study that the disparities that are baked into - that have been baked into the system by age, gender, and certainly education and race, ethnicity remain in place. And there is just much more work we need to do to understand how we can effectively address them and bring the tools -- including public (forum) coverage -- more effectively to people who are eligible for it. And I'll stop there. For us there are always more questions we want to answer. And the survey gives us tools to do that. We're sketching out a few here on this slide.

But it is barely a beginning for the two years that we have before the next survey comes out to help deepen our understanding and decision making that Minnesotans are making. And how the system overall appears to be changing. So with that, (Carrie) are we taking questions from the audience?

(Carrie Au-Yeung): Yes, we are taking questions. And I would encourage people to continue submitting them using the chat feature on the left hand side of the viewing screen. Or you can -- if you're on Twitter -- Tweet your questions to us. We are At SHADAC. We can field your question that way as well.

The first question that came through (is first) upon - it's how has the results of the 2017 MNHA been received? And can you talk a little bit about reactions to the new numbers so far as you've heard about them?

(Stefan Gildemeister): I think there were perhaps two reactions that we have observed. One is one of surprise. Because I think Minnesota expects to move in the direction of stable health insurance markets and above average coverage.

We don't have nationally comparable figures or we're not sure that they are final yet. You know, even with the increase in the uninsurance rate it is likely that Minnesota's rate is still comparatively favourable. So nevertheless there, you know, I think there's been surprise and dismay that some of the accomplishments of 2014 are seeming to be lost.

You know, quite frankly the other reaction is that these results you know, are - extend the political and ideological arguments over the mechanisms we have in place to deliver insurance coverage. So the ACA and whether it is effective or not. Or whether it's an appropriate tool or not. You know, the survey feeds into this not by design but because folks are sort of looking for the evidence that supports their perspective.

So I think as we continue to -- together with our partners at the University -- to do really objective analysis and you know, analysis that is not really focused on one or the other side of the argument I think we hope to be able to contribute to - that helps the discussion.

(Carrie Au-Yeung): Thanks (Stefan). Another question we had come through is probably a good one for (Kathleen). Can you talk about whether the increase in the rate of uninsurance in Minnesota is reasonable in the national context? I know you're still waiting for some of the national numbers, but can you talk about that a little bit?

Dr. (Kathleen Call): Yes. I think (Stefan) talked - touched on that a little bit. We won't know from the current population survey -- or the American Community Survey -- what Minnesota looks like compared to other states or compared to the national numbers until fall. And that'll be for 2017, the same year that we have data for and are presenting today.

The only survey that's kind of shown an increase is a survey that's done quarterly by Gallup. And they did see a kind of an uptick. But - and in NHIS as an early release program. And while their rates have been stable, what we have seen is that -- for some groups like higher income groups, 200% and 300% of the federal poverty level or above -- are going up. And that's very consistent with our results in terms of kind of the demographics of those who are seeing increases.

It's very consistent with what we're seeing in our survey. We're just not seeing that uptick yet. But we're all waiting for September to find out what the national numbers will show.

(Carrie Au-Yeung): And I want to interject. There's been a couple questions about slides for today's event. They are available at W-W-W dot SHADAC dot org back slash 2017 MNHA webinar. If you wanted to grab those slides that's where you can do that. We had a question come...

Dr. (Kathleen Call): Can I just quick say something?

(Carrie Au-Yeung): ...oh, go ahead.

Dr. (Kathleen Call): So (AJ), this is (Kathleen). Feel free to share the slides with the state network. That would be fantastic.

(Carrie Au-Yeung): Thanks (Kathleen). We had a question -- and I don't know if this is more appropriate for (Stefan) or (Kathleen) -- but are you concerned that - or (Alisha). I - this is more of a policy question. I was thinking probably one of you two.

Are you concerned that issues such as Congress's inability to fund CHIP in a timely manner will impact uninsurance rates in the state and the rest of the country over the next couple of years? I don't know which one of you would rather...

Dr. (Kathleen Call): It seems like CHIP hasn't - I mean because we're seeing such high rates for kids it doesn't seem like we're going to have that much impact. But maybe it's in ((inaudible)) to say that. Because we don't - our CHIP program is relatively small, right?

(Alisha Simon): Yes.

(Stefan Gildemeister): I think, you know, where we're really leaving the space of empirical evidence here. Because the survey - in the survey what we're trying to do is to observe behaviour. Not so much assess people's perceptions and how they are understanding of what changed or could have changed effected their individual decisions.

That said, I think we know -- through social science literature, we know through some other surveys -- that anxiety and uncertainty about the future of the ACA, the mandate, the funding affected enrolees' decisions. So we don't have any reason to believe that they are not part of - that those aren't experiences that Minnesotans also have.

The other complexity is -- I think -- for the general consumer. I think these complexities of laws financing, the tax bill, those are really intense and to understand how they affect individual people, one's self I think is really difficult to understand. So I think the bottom line is uncertainty. You know, health insurance literacy -- health insurance policy literacy or the lack thereof -- will affect people's decision making.

So whether it's CHIP or some of these other dynamics. The last year 2017 the actions of the legislature that, you know, were intended to help but came late. The decisions of insurance carriers. Those things just created a lot of tremors. And it's hard I think for people who have otherwise rich lives to sort of wade through it and to be informed.

So sorry for rambling on, but I think the short answer is not sure if it's CHIP, but certainly the uncertainty in 17 didn't help.

(Carrie Au-Yeung): Thanks. I do have a question for (Alisha) now. And I - this is kind of a two-parter. I'm combining two questions here. Can you talk about the extent to which health care costs may or may not have made the uninsurance rate go up? And can you talk about whether the survey gives us more information about the cost of care for people who have insurance.

(Alisha Simon): So those are really good questions. Some additional work that the Minnesota Department of Health does on health insurance costs generally has shown health insurance costs are rising faster than general prices, than wages. So we just see kind of a constant increase. And this is true on the national level as well.

As far as whether people actually don't get insurance because of cost, a good example in this survey is that we had about 50% of people who were uninsured said they either lost their coverage because they couldn't afford it or they didn't get new coverage after they lost their

coverage because of cost. So we do have some evidence that people are making that decision because of the cost of coverage.

Some early work looking at people with high deductible health plans -- which are people with higher out of pocket costs -- they tend to have more access barriers. Some early work has indicated that. So those are people with insurance coverage that we know they likely have higher deductibles and thus their early out of pocket costs are going to be higher. And that is a finding that is consistent other research as well.

As far as what specific costs for people, we don't ask those questions in the survey for a number of reasons. One of which it's hard for people to remember exactly how much they spent on health care in the past year. Which is - and it involves a lot of questions. So for both accuracy and the sake of survey time and what the survey time is best used for we don't get a lot into those. We do ask if people didn't get needed care due to cost, and so we do kind of get a cost in that way.

(Carrie Au-Yeung): I have another question for you (Alisha). It's right here. Can you talk about whether there is anything different about the uninsurance rate going up in 2017 than in other years when it went up?

(Alisha Simon): So I think the big thing is - it's kind of the - it's that we didn't see an economic downturn. And we talked about that a little bit. But I think the fact that we're still seeing decreases in employer coverage when we're at full employment is definitely concerning.

The fact that we're - that, you know, even with our increases in public coverage that are kind of - are tax credits. We're still not - we're still seeing a number of people - the number of people who are uninsured is really concerning. I think we expected a little bounce back with what we knew were some pretty high premium increases in the individual market in Minnesota. But that's, you

know, at this point 125, 150,000 people in the state, on a state of 5 1/2 million people. It's not a huge market.

And so that one issue shouldn't directly impact that many Minnesotans. And yet we saw a pretty big increase. So I think there's clearly something else going on. And you know, when we looked around it's really just that uncertainty in the health policy space clearly had some - people are clearly reacting to it whether it affects them or not.

(Stefan Gildemeister): May I add to that?

(Alisha Simon): Yes.

(Crosstalk)

(Stefan Gildemeister): I think the other - maybe we could bring up the chart. But the other thing that is worth noting if you - if we're looking at that increase is the magnitude is pretty substantial. So the increase is - it may not be - the size of the increase may not be statistically different from previous years. But sort of in absolute terms it is larger. Maybe one before.

(Carrie Au-Yeung): Oh, okay. This one?

(Stefan Gildemeister): One more.

(Carrie Au-Yeung): That one?

(Stefan Gildemeister): No, one previous to that.

(Carrie Au-Yeung): Oh, there we go.

(Stefan Gildemeister): You know, the magnitude of two percentage points is pretty substantial. You know, I - it's difficult to say whether this is going to be a trend. There's so much instability and uncertainty in the market. There are federal policy changes that are coming up that could affect the market. Could affect health insurance coverage and the individual market in particular.

How the legislature may react to those, how regulators may react - choose to react to that in Minnesota, those are all open questions. But you know, it's more than a correction from the unaffordable decline that one might have viewed 2015 at. So -- as (Alisha) was saying -- this is definitely a change to circumstances on the ground. And, you know, we'll just have to think about and see how what's coming and which direction it'll affect these rates.

(Carrie Au-Yeung): (Stefan) can you talk a little bit about also employer-sponsored insurance in the individual market? And how employers could be part of the solution to some of what we're seeing?

(Stefan Gildemeister): Yes. I mean employers are - have been sort of historically in a strange place. Employer coverage in the country came along sort of more as a response to an inability -- around the time of the second world war -- to fund - to support employees through wage benefits. So that's how employer coverage came to exist in Minnesota.

There is the dynamic that contributions are tax exempt. But basically there are I think two factors in -- today -- why employers continue to offer insurance coverage. One is they want to be competitive employers. So if their peers do it they want to do it as well. And secondly there's also (a mission) I think for many employers to sort of deliver good benefits to their family of employees.

At the same time, I think what we're seeing is sort of this uncomfortable dance year over year to change benefits in a way that makes a premium contribution of employees - for employees affordable and still make the policy look as if it is comprehensive enough to suit them. So it's an awkward - it's been an awkward dance.

And I think employers sort of anecdotally are saying, you know, we're just ending up being the bad guys here as health care costs drive and we have to constrain benefits. So it's difficult to say how employers will be part of this discussion. I think sort of the dynamic that employers will continue to be interested in creating competitive work environment I think will probably support employer coverage for a long time.

I think what remains worth watching is to what extent the decline of employer coverage -- if it continues -- is a result of changes in the labour market. And the extent to which we're unconnected to sort of a typical employer. Or to what - and to what extent it is an outcome of our aging populations where fewer of us are in the labour market. We certainly see changes in labour force participation that are pretty dramatic.

Or whether it is ultimately employees making the decision to not take up coverage because they sort of question the value of insurance coverage that they buy. And certainly there's plenty of anecdotal evidence to sort of support that when people end up going to the doctor then they sort of experience unexpected costs and are frustrated by it.

To the question of the individual market, boy we could have a whole hour discussion on that. I think I just say this much. And there's some good research that our team has done and analysis ((inaudible)) at SHADAC is working on. Sort of the - a broader analysis of what states are doing in the individual market.

It's become a very small market in Minnesota. And you know, we are spending a lot of energy on maintaining that market through reinsurance -- as I said -- through in the past rate subsidies. You know, I think it just remains to be seen what policy makers will do when federal changes are coming down and are likely to affect the you know, the remaining robustness of the market.

If the market is further split it really has the potential to -- and there's really good evidence for that -- to increase premium and drive out some of the healthy individuals seeking sort of for other mechanisms including just to pay out of pocket for health care. So I think these are really concerning policy issues. There's not a lot of time to address them.

And you know, there are stakeholders in the market that are unusual suspects here. Those are people with incomes of 400% and greater. And that may serve as a benefit to create solutions, but it's also again a small market. So remains to be seen when we have time to act on it.

(Carrie Au-Yeung): I have a question that is probably best geared toward (Alisha). If you could talk about whether the MNHA - just says to more information about the benefits for people who do have insurance relate to (Stefan)'s response about whether these benefits are getting leaner or more restrictive. Do we have any information on that from the MNHA?

(Alisha Simon): No. Not really. We did ask a question about - we asked about access to providers just in the sense that, you know, have you ever been told a provider's not taking your insurance and what kind of provider that is? But that's - and we asked - this year we asked about narrow net - if people had a narrow network. But that's sort of all. We don't ask about specific benefits.

Dr. (Kathleen Call): Right. We look to things like the maps for that. Like those that can answer the question are those that are actually designing those benefits for their employees rather than the employees themselves. So we tend to shy away from that and really just ask about their

experiences. Like do you feel like your insurance is - coverage is satisfactory. I can't remember the exact wording...

(Crosstalk)

(Alisha Simon): Yes. So it does a really good job of if you're satisfied with how your insurance protects you financially. So financial protection your insurance offers.

(Stefan Gildemeister): I mean there's a proxy for some of that though. And I don't know that - I don't think that we've done the analysis over time. But the question over whether the insurance benefits are sufficient to create financial protections is to some extent measured by who or which percent of the - what share of the population experiences barriers to health care services because of cost.

So benefits change surely because networks change. And access parameters change. And those things. But a most significant way in which benefits have changed as well is that a greater share of the cost of care is moved to individuals, typically through deductibles and cost sharing. And those -- you know, as (Alisha) said earlier -- those have a real impact -- as they're intended to -- on health care use.

And so I think as a matter of proxy we will be able to look at this by people who have individual coverage, who have employer coverage, and people who have public program coverage. We know that the uninsured experience pretty sizable barriers of course.

Dr. (Kathleen Call): Yes. And anecdotally we heard from respondents who are saying that you know, if they're - if they had to switch plans they had a high deductible and they ended up paying two deductibles over the course of the year and are no longer saving for retirement. So I mean I think

that you hear those anecdotes in other, you know, qualitative studies of what's going on in terms of the high deductible plans.

(Carrie Au-Yeung): Okay. We had a question on our sampling methodology regarding the use of telephones -- wireless and landlines -- to survey respondents. How do you deal with the population that does not have telephones?

Dr. (Kathleen Call): That's a very small and stable portion of the population. It's been stable for I think as long as the NHIS has been monitoring that. So we are able to kind of statistically correct for them. But it's really not. Even most people are not even making that correction anymore because it's just such a small number.

And when we did do those statistical corrections it had very little impact. So basically taking people who had an interruption in phone service and waiting the day to up - to make up for the folks that were out of - that didn't have service. And that's available through the National Health Interview Survey on an annual basis by state.

(Stefan Gildemeister): But the survey samples individuals who have landlines and individuals who have cell phones. And then (Alisha) do you want to say something about the prepaid cell phones as well?

(Crosstalk)

(Alisha Simon): Yes, we do oversample people with prepaid cell phones as well. So I mean this is - any survey methodology you use is going to have - is potentially going to miss parts of the population. That said, telephone surveys are a very good way to reach the vast majority of the population, especially with the inclusion of cell phones and that we're oversampling prepaid phones as well. I think that gives us a little - a more robust sample.

(Carrie Au-Yeung): Okay. A policy implication question for you. Is there any evidence or trend information from your data that indicate whether imposing a Medicaid work requirement would result in more commercially insured residents? Or to the contrary, will result in more uninsured residents? On Medicaid work requirements.

Dr. (Kathleen Call): We've looked at this earlier on as we were getting ready to put the results out. So like whether or not folks that are in Medicaid are work - less likely to work than the state's population as a whole. And there was no significant...

(Crosstalk)

(Alisha Simon): They are less likely to work, but it's still like 60% of people under 65.

Dr. (Kathleen Call): Yes.

(Alisha Simon): It's still a pretty sizable number of people who are on Medicaid are working. And that - I think you find this in many policy things with work requirements in that there already are a lot of people working. I know Michigan has done some work on this, where they actually spoke with Medicaid recipients. And that might be a good place to go.

As far as would it - certainly any time you add a barrier to getting coverage -- or requirements for coverage -- you may see some people decide that the coverage is not worth it for them.

Dr. (Kathleen Call): I don't work at the state so I can maybe say something you can't. The question is whether or not the administrative costs of monitoring and - a work requirement would actually even save any money. And if not, I think we have to reflect on what the intent of that work requirement is.

And if it's to make people more responsible and take better care in the way that they're using services, the evidence doesn't really support that the Medicaid population is using more services if you control for health status and age. So I don't know what else I want to say on it other than...

(Stefan Gildemeister): Yes.

Dr. (Kathleen Call): ...not being a supporter.

(Stefan Gildemeister): Yes. Because the survey doesn't really provide direct evidence on it. But - so that's sort of one response. There is a lot of research that is being accumulated -- and has existed for a while -- on what is ultimately a really complex issue.

I think what will happen on the insurance coverage market is difficult to predict because so much of it depends on the extent of the work requirement. You know, which populations are covered, what will happen in the labour market, will there be jobs? And will those jobs come with employer coverage?

I think it's really difficult to imagine that this creates a resurgence of private coverage because what we're seeing clearly is a decline in private coverage. And you know, lower income individuals who mostly likely folks on Medicaid are who, you know, by definition, they will not - they will have a difficult time obtaining jobs that provide the income to pay for their share of premiums. Or to have a job with insurance coverage in the first place.

So - but as I said, I think this survey does not provide any direct evidence on that. There is plenty of evidence out there.

(Carrie Au-Yeung): We got a question about whether the MNHA collects any information about the disability community in Minnesota? Is that something we touch on?

Dr. (Kathleen Call): We have just general health status questions. Not - nothing that would actually equate to understanding disability status. We have chronic conditions, but even chronic conditions - yes. So we really can't detect that. We just have self-reported chronic conditions, healthy - physical health and mental health days, and the general health - self-report health status. Excellent, very good, good, fair, or...

(Crosstalk)

(Stefan Gildemeister): Yes. I mean over time we've been interested in sort of stratifying the population by disability status. But you know, methodologically really difficult to do. And it requires typically a lengthy series of questions to do this well. Similar to what (Alisha) was saying about health care costs.

So yes, we want to know about individual's spending and their contribution to health care costs, but this is a 15-minute survey. And as such, you know, we are - we're typically year over year thinking about three to four minutes of questions that we're shuffling around. So yes, it would be really great to ask this differently and we'll continue to look at this.

And if callers have ideas please share them with us. But other than the information that (Kathleen) spoke of, we don't really have good data on it.

(Carrie Au-Yeung): Great. And I think we have time for one final question. And a good one to probably end with is when will all the data from the 2017 MNHA be on the MDH Survey Tool site?

(Alisha Simon): The majority of it is already on the tool site. On - to be updated there on our Health Access Survey Tool. If it's not let us know quickly, because I will check on that. It should have been updated at the end of - early March, end of February, early March. So it should be there. We also have a chart book, chart book section six on the Health Economics Program website that has lots of information as well.

(Carrie Au-Yeung): All right.

(Stefan Gildemeister): And thank you for that question (Eileen). So good to know what resources are out there. I think there are a couple blogs that SHADAC wrote. We co-authored an issue brief with -- two issue briefs -- with - on a couple of topics. I believe you can find them on our website, or reach out to folks here if you need help.

But in addition, what the question referred to is a - is sort of a table maker that we have available on our website that lets users custom slice the data along a number of dimensions that may be helpful for your particular analysis and research questions.

(Carrie Au-Yeung): And I should say that we will include links to all of these resources in a follow up email to attendees. We'll have a recording for today's webinar posted. Usually we have it up within 48 hours or so. And we'll email everyone when that's up.

We'll email the slides, the briefs, and the location of the chart books and the data tool that (Stefan) and (Alisha) are talking about. I want to thank everyone for attending today's (con). Thanks very much to our speakers. That's not the right notes.

If anyone has any follow up questions to today's webinar you can email them to us at SHADAC at UMN dot edu. And there are a few questions we didn't get to and we'll try to follow up directly with people who submitted those.

As mentioned earlier, today's slides are already available at SHADAC dot org back slash 2017 MNHA webinar. Finally, again thank you to (Kathleen), (Stefan), and (Alisha). And thanks again to everyone who joined us today in the audience. Have a great afternoon.