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Health Care Reform: The Impact of Federal Health Care Reform In Minnesota

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ABOUT SHADAC

SHADAC is a multidisciplinary health policy research center with a focus on state health policy.

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INTRODUCTION

Prior to the passage of the Affordable Care Act (ACA) in 2010, Minnesota's health insurance market was, for the most part, relatively high-functioning across indicators of health insurance access and quality of care, although the state faced common challenges in the area of health care costs. The ACA impacted Minnesota's market in all these areas, with mixed results. This paper considers Minnesota's market before and after the passage of the ACA as well as the outlook for the state's market given the current policy environment.

Minnesota's Health Care System Prior to the Affordable Care Act

Minnesota had among the lowest uninsured rates in the country before the ACA went into effect. At 8%, the state had the seventh lowest uninsured rate in the nation in 2009.[1] For children, this rate was even lower, at 7%. High rates of health insurance coverage in Minnesota were—and still are—driven by high rates of employer-sponsored coverage: 61% of Minnesotans had coverage through their employer in 2009—the fourth highest rate in the country.

Minnesota's public program generosity pre-dated ACA passage, with comparatively generous eligibility thresholds for Medical Assistance (Minnesota's Medicaid program) and MinnesotaCare, a subsidized insurance program for low-income Minnesotans who did not qualify for Medical Assistance. These programs covered most Minnesotans up to 275% of the federal poverty level ($58,300 for a family of four), much higher than the U.S. median of 90% of the federal poverty level.[2] In addition, Minnesota used funding from the Children's Health Insurance Program (CHIP) (aimed at low- and middle- income children) to cover children and pregnant women up to 283% of the federal poverty level.

Minnesota had strict regulations on its individual health insurance market before the ACA became law, with restrictions on the extent to which insurers could adjust premiums by factors like age and health status. Minnesota did not have its own regulations guaranteeing coverage offers to applicants ("guaranteed issue"), but it did have a well-functioning (albeit costly) high-risk pool (Minnesota Comprehensive Health Association), which covered individuals without access to employer-sponsored insurance and who were denied coverage in the individual market due to a pre-existing condition.

Minnesota had consistently high health care quality rankings across a variety of indices in the years predating the ACA. On the other hand—as in most states—Minnesota's health care costs were rising. Health care spending in Minnesota has been on the rise since 2000 and reached $37 billion in 2009.[3] In addition, the state faced consistent annual premium increases in the individual market, which reached 11% in 2008.[4] Premiums for coverage in the employer-sponsored market were also rising and grew by a cumulative 83% between 2000 and 2009.[5]

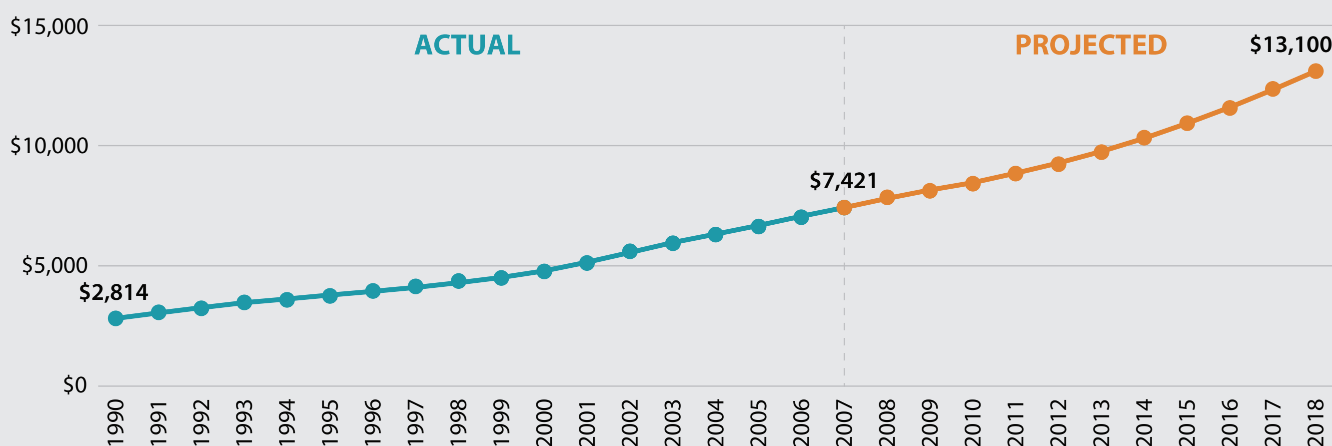
Drivers of Health Care Reform

The drivers of federal health reform were threefold: rising costs, reduced access to insurance, and poor quality of care.

Cost of Health Care

Like in Minnesota, the cost of health care was rising nationally before the ACA and was expected to continue rising into the next decade (Figure 1). In 2009, total spending for health care in the United States amounted to about $2.3 trillion and was projected to grow from roughly 6 percent of the Gross Domestic Product to almost 9 percent by 2035.[6]

Figure 1: National Health Expenditures Per Capita



Source: CMS, Office of the Actuary, National Health Statistics Group. "National Health Expenditure Data." Accessed October 2017. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html

Access to Insurance

While Minnesota had high pre-ACA rates of health insurance coverage, the rate of uninsured was growing nationally. In 2009, 50.7 million Americans lacked insurance (16.7% of the population), which represented a 32% increase from 2000.[7] Coverage levels varied widely by state, with the rate of uninsured exceeding 20% in five states in 2009 (Alaska, New Mexico, Florida, Nevada, and Texas).[8]

Coverage rates varied not only by state but also by population characteristics, and this was particularly pronounced in Minnesota. For example, in 2008, the uninsurance rates for whites (7%) compared to blacks (13%) and Hispanics (30%) differed by more than 6 and 23 percentage points respectively, and the uninsurance rate for low-income people (family income under $25,000) versus high-income people (family income over $75,000) differed by more than 17 percentage points (2% compared to 19%).[11]

Common (and legal) insurance market practices contributed to rising uninsurance rates in the years pre-dating the ACA, particularly for people without employer-sponsored coverage who had to purchase coverage on their own in the individual market. For example, insurance companies could often charge much higher prices to individuals who were old, sick, and/or female (as noted, Minnesota had regulations to limit this). In addition, insurers could deny coverage to people who were sick or previously sick (and "pre-existing" conditions included common diagnoses like acne and pregnancy).

THE CONSEQUENCES OF BEING UNINSURED

The consequences of being uninsured can be substantial. The uninsured faced less access to preventive care, greater anxiety due to medical bills, and more medical debt. For example, medical bills accounted for almost two-thirds of personal bankruptcies in 2007, and among uninsured families who became bankrupt, the average medical bill was more than $22,000. The uninsured face poorer health due to delayed or foregone health care and as a result, have a shorter lifespan—uninsured individuals are 25% more likely to die prematurely than those with health insurance.[9, 10]

Health Care Quality

The final driver of health reform was the vast variation in health care quality around the country. For example, there was a 2.5-times variation in Medicare spending across the county that was not accounted for by local prices, age, race, or underlying health of the population, indicating variation in the appropriateness of the care/services received.[12] Studies also consistently found that only 50% of people recieved recommended preventive care, and only 70% received recommended acute care.[13]

Passage of the Affordable Care Act

On March 23, 2010, President Obama signed the Affordable Care Act (ACA) into law. Its primary focus was to expand access to health insurance coverage. Over the next four years, the law was challenged but ultimately implemented, and it greatly transformed health care in Minnesota and the nation. Upon full implementation on January 1, 2014, Minnesotans gained access to new health insurance coverage options. These options included an expansion of Medicaid coverage for adults with incomes up to 138% of the federal poverty level ($33,948 for a family of four in 2018) and premium and cost-sharing subsidies to help individuals and families up to 400% FPL ($98,400 for a family of four in 2018) pay for and use coverage purchased through Minnesota's new health insurance Marketplace, MNsure.

In addition to expanded coverage options, the ACA established significant insurance market regulations aimed at increasing access to insurance. Specifically, the ACA prohibited insurance companies from denying someone coverage due to a pre-existing condition ("guaranteed issue"). The law also greatly limited insurance companies' ability to vary premiums based on personal characteristics such as gender and age. Finally, the law mandated that insurance companies allow parents to keep children on their insurance up to age 26.

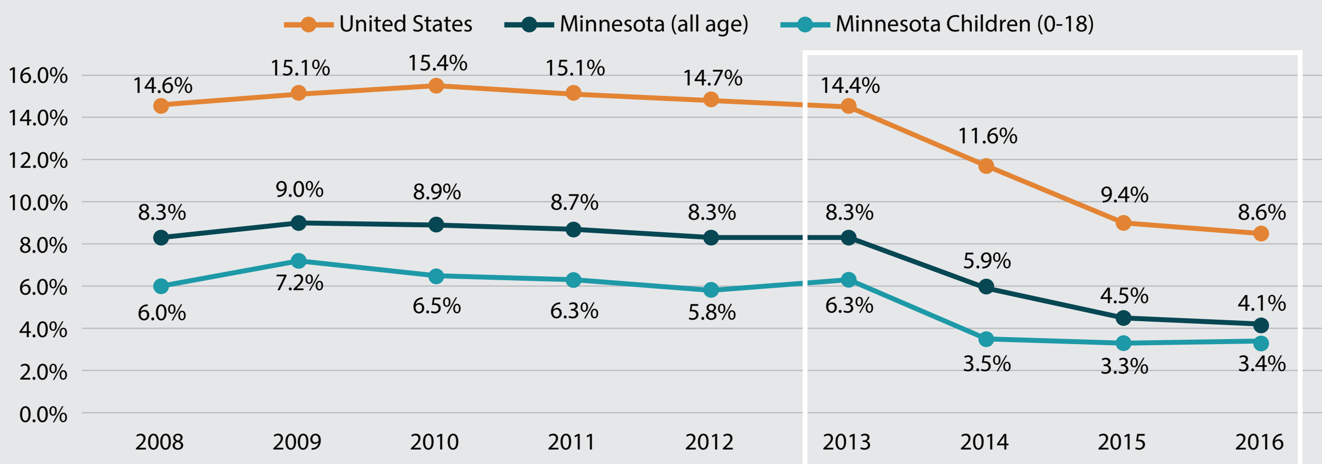
Importantly, the ACA also included a mandate that all Americans have health insurance coverage. Under this provision, individuals are required to maintain minimum essential coverage for themselves and their dependents. Those who do not meet the mandate are required to pay a penalty for each month of noncompliance. Specifically, they face annual penalty of $695 per person or 2.5% of income, whichever is greater, though exemptions are available in cases of financial hardship, religious objections, etc.

The ACA aimed to not only help people get coverage but also to access health care. For example, the law mandated "first-dollar coverage" for a core set of preventive services, meaning that insurance companies cannot charge a co-pay for services like mammograms, colorectal screenings, or autism screenings for children. The ACA also prohibited insurance companies from imposing lifetime or annual limits on coverage.

Impacts of the Affordable Care Act

Despite early glitches, particularly with the functioning of the state health insurance marketplaces (including MNsure), the law has led to historic gains in health insurance coverage. Between 2013 and 2016, the national uninsured rate dropped from 14% to 9%, and in Minnesota, the rate dropped from 8% to 4%. Notably (see Figure 2), this drop was seen in every state in the country. The most recent data for 2016 indicate that these post-ACA coverage gains have either continued or remained stable in every state in the country (with the exception of Puerto Rico), and between 2015 and 2016, the uninsured rate declined further in 39 states.[14]

Figure 2: Uninsured Rate Over Time, 2008 - 2016



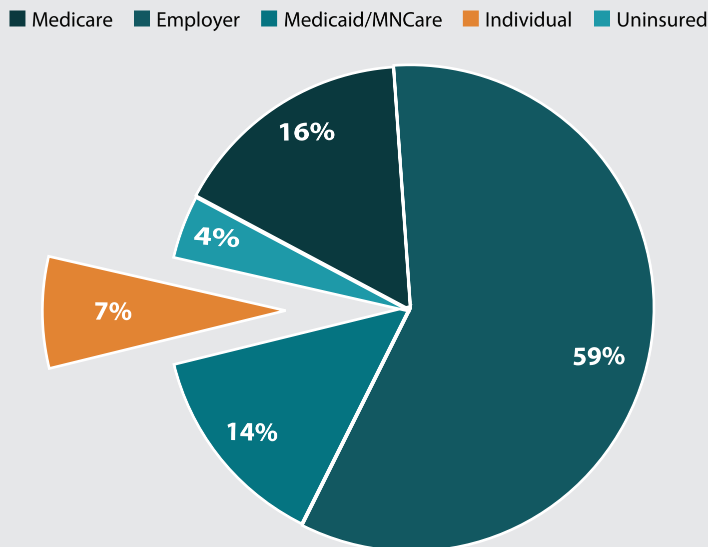
Source: SHADAC Analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) Files, State Health Compare, SHADAC, University of Minnesota, statehealthcompare.shadac.org. Accessed October 2017.

Gains in health insurance were particularly strong among groups that have had historically high rates of uninsurance. The population of Americans identifying as Hispanic or Latino had the lowest rates of insurance coverage before the ACA and the largest gains in coverage after ACA implementation. After remaining stable from 2011 to 2013, rates of insurance coverage among Hispanics/Latinos increased by 9.3 percentage points, meaning 6.3 million more non-elderly Hispanics/Latinos had insurance coverage in 2015 than in 2013. Asian Americans and African Americans also gained health coverage under the ACA with increases in rates of insurance coverage of 7.2 and 6.6 percentage points, respectively. This increase in coverage resulted in a historic narrowing of the gap in coverage between whites and populations of color between 2013 and 2015, with all represented racial/ethnic groups experiencing a reduction in the coverage gap.[15]

These declines in coverage can be attributed to a large increase in Medical Assistance enrollment, Minnesota's Medicaid program, which grew by 292,117 enrollees between 2013 and 2015.[13] There were also gains in Minnesota's individual market, in part facilitated by MNsure. As of October 2017, more than 130,000 individuals were enrolled an individual health insurance plan through MNsure (a net gain of roughly 61,000 in this market). In addition, many of these enrollees (73%) received a tax credit, which averaged $300 per month.[16]

THE INDIVIDUAL MARKET IN PERSPECTIVE

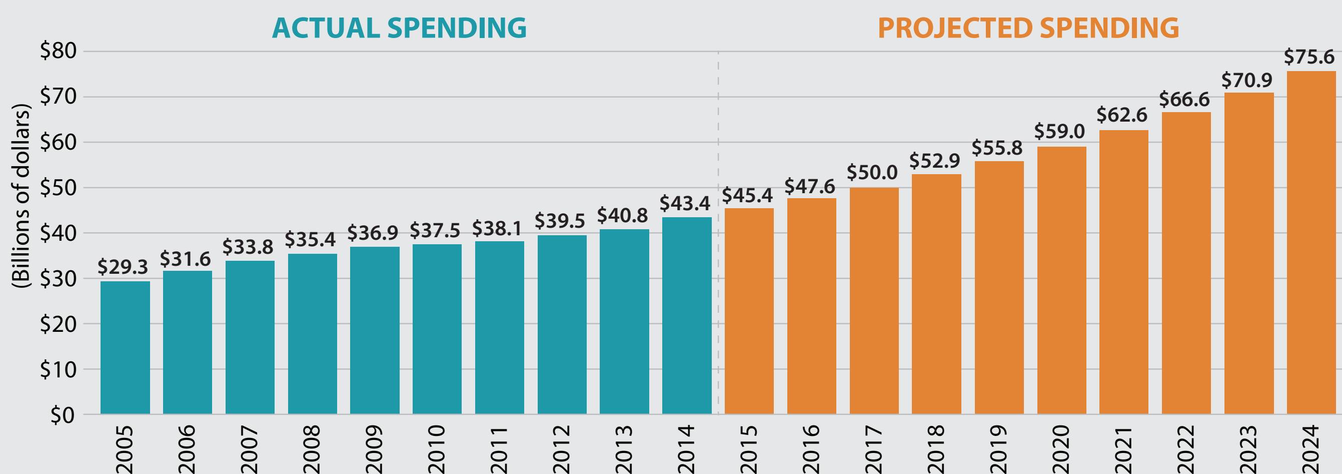
Figure 3: Minnesota Primary Source of Health Insurance, 2016



While much of the media coverage and policy debate focuses on the individual market and the health insurance marketplaces, such as MNsure, it is important to consider that this is a relatively small segment of the population. In Minnesota, the individual market represents roughly 400,000 individuals (7% of the population), and only about one-third are enrolled through MNsure.

Source: SHADAC Analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) Files, State Health Compare, SHADAC, University of Minnesota, statehealthcompare.shadac.org. Accessed October 2017.

Figure 4: Health Care Spending in Minnesota



Source: Gildemeister, S. "Minnesota's Health Care Ecosystem: An Overview." Presentation to the Select Committee on Health Care Consumer Access & Affordability. July 12, 2017. Accessed October 2017. http://www.senate.mn/working_group/2017-2018/1450_Select_Committee_on_Health_Care_Consumer_Access_and_Affordability/1.%20MDH%2 0Presentation%20-%20 Minnesota%20Health%20Care%20Market%20101.pdf.
Note: Data for 2014 remain preliminary

As noted, the Affordable Care Act was focused on expanding access to coverage and included only limited provisions that addressed cost and quality. As a result, the cost of health care continues to rise. Premium rate increases in Minnesota's individual market between 2016 and 2017 were as high as 67% (the current average annual premium is more than $6,800, though this goes down to $3,000 after accounting for tax credits), and for the more than 25% of individual market consumers without a tax credit, the cost is extremely high.[17] Indeed, a report by the Minnesota Council of Health Plans suggests that between 50,000 and 70,000 Minnesotans chose not to purchase on the individual market between 2016 and 2017 despite the individual mandate, likely due to rising costs.[18] Premiums for employer-sponsored coverage are also going up. Between 2015 and 2016, annual premiums for employer-sponsored insurance in Minnesota increased from $5,651 to $6,030.[19]

Besides doing little to control costs, the Affordable Care Act also reduced choice for some consumers. Because the ACA requires that health insurance plans include a certain standard of benefits, individuals do not have access to the less generous insurance options available pre-ACA, often favored by the young and healthy. Further, instability in the individual market in many states has led insurance companies to exit the market, sometimes meaning that individuals have only one or two insurers from which to choose a plan.[20]

Health Reform Today

The focus of the current health reform debate in Minnesota is the state's individual health insurance market. After the exit of major insurers from MNsure, Minnesota's Insurance Commissioner negotiated enrollment caps with the remaining insurers to incentivize them to them to continue to participate in the Marketplace. Minnesota lawmakers have since passed several bills to stabilize the market and lower premiums. In January 2017, the Minnesota Legislature passed a temporary health insurance premium relief bill that gave Minnesotans with individual market coverage a 25% rebate on their 2017 premiums. More recently, the state passed legislation to set up a state-funded reinsurance program to support the individual market. The program—Minnesota's Premium Security Plan—will reimburse health insurers for 80% of insurance claims between $50,000 and $250,000. The program is projected to reduce 2018 premiums by 20% from what they would otherwise be. [21]

MEDICAID AND CHIP IN THE SCHOOLS

Medicaid and CHIP provide insurance to almost 30,000,000 children in this country and pay for nearly half of births nationwide. Starting in 1988, Medicaid began reimbursing schools for certain services used by children who qualify under the Individuals with Disabilities Education Act (IDEA) (e.g., physical and speech therapy) as well as select screenings (e.g., vison and dental) for qualifying children. In 2015, Medicaid paid for almost $4 billion in school-based health care. (In Minnesota, it was slightly over $1 million.) Not surprisingly, education groups are concerned about federal plans to cut Medicaid funding. The American Association of School Administrators has argued that Republican plans to repeal the Affordable Care Act and cut Medicaid will negatively impact children. Indeed, research has found that children covered by Medicaid experience a range of positive, long-term health and economic effects, including higher high school graduation rates, so it stands to reason that Medicaid cuts will do the opposite. [23]

Health reform continues to be the focus of the national political debate as well. President Trump campaigned on repealing and replacing the Affordable Care Act, and there have been at least seven Republican plans for replacing the Affordable Care Act since he took office. These bills had mixed and sometimes conflicting provisions. Proposed provisions included (among others) a complete repeal; immediate or delayed rollback of the Medicaid expansion; caps on Medicaid spending; increasing choice by allowing insurers to provide lower-cost, stripped-down insurance plans; elimination of the individual mandate; and softening of insurance market regulations. Almost all the plans prioritized enhancing state flexibility related to health care regulation (e.g., allowing states to decide what benefits are mandated). All versions of the Republican bills that have been scored by the Congressional Budget Office were projected to substantially increase the number of uninsured.[22]

To date, bills to repeal/replace the Affordable Care Act have all failed to pass the Senate. That said, the Trump administrative can significantly reform health care without overhaul legislation from Congress—in the form of new rules and executive orders as well as other legislative vehicles. For example, Trump recently signed an executive order intended to expand access to health insurance plans that have more limited benefits at a reduced cost.24 In addition, the administration has signaled that it will cease cost-sharing reduction payments to insurers that were designed to offset the costs of deductibles and copayments for low-income Americans.[25] The elimination of these payments could have a negative impact on premiums as well as

on health insurers' willingness to participate in the market. The administration also released a rule that exempts employers and insurers from covering or paying for coverage of contraceptives if they object "based on [their] sincerely held religious beliefs" (contraceptive coverage was mandatory under the Affordable Care Act).[26] In addition, the administration reduced the budget for advertising to encourage enrollment in health insurance marketplaces and limited federal grants to organizations that help consumers navigate the process.[27] Most recently, in December 2017, President Trump signed legislation overhauling the nation's tax code that included a provision repealing the ACA's individual mandate tax penalty.[28] The impact of this change on the health insurance market as a whole—and the individual market in particular—is not yet known, but experts are concerned about the likelihood of adverse risk selection as healthier individuals choose to opt-out of purchasing health insurance in the absence of a mandate to carry coverage.

Another area under federal consideration is CHIP, a health insurance program aimed at low-income and middle-income children. The program covers roughly 9 million children and 370,000 pregnant women across the country. While the program has historically garnered bipartisan support, Congress failed to renew CHIP in 2017, and funding for the program lapsed on September 30, 2017. While states can continue to use unspent funds, some states, including Minnesota, have exhausted their funds or will do so before the end of the year. If CHIP is not reauthorized, Minnesota would lose federal funding that helps cover 125,000 children, 200 infants, and 1,700 undocumented pregnant women.[29]

Looking Ahead

Federal direction on health reform remains unclear, and this uncertainty may be taking a toll on coverage gains made under the Affordable Care Act. Findings from a recent survey found that the national uninsured rate among adults increased 1.4 percentage points since the end of last year.[30] Findings from a different survey showed similar results and highlighted that the rise in the uninsured rate was concentrated among adults with incomes too high to qualify for premium subsidies.[31] Given the lack of federal direction and action on reform—and faced with potential coverage losses—many states, including Minnesota, are likely to move forward with state-specific legislation to stabilize their individual markets and provide coverage for their residents.

RESOURCES

SHADAC State Health Compare:
State-level data on health insurance coverage, cost, access, utilization, quality, public health, and health behaviors.
http://statehealthcompare.shadac.org/

State-Level Trends in Employer-Sponsored Health Insurance:
http://www.shadac.org/publications/state-level-trends-employer-sponsored-health-insurance-2012-2016-chartbook-and-state

Conservative think tank with writings on health reform:
https://www.americanexperiment.org/healthcare/

Liberal think tank with writings on health reform:
http://familiesusa.org/

Media sources that cover health care well:

Politico (Dan Diamond)
http://www.politico.com/staff/dan-diamond

Vox (Sarah Kliff)
https://www.vox.com/authors/sarah-kliff

Forbes (Avik Roy)
https://www.forbes.com/sites/theapothecary/people/aroy/#39f6f67d2496

Kaiser Health News (Julie Rovner)
https://khn.org/news/author/julie-rovner/

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