

Minnesota Department of Health

Employer-Sponsored Health Insurance in the Minnesota Long-Term Care Industry:

Status of Coverage and Policy Options

Report to the Minnesota Legislature

January, 2002



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Health Economics Program
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As requested by Minnesota Statute 3.197: This report cost approximately \$24,188.00 to prepare, including staff time, printing and mailing expenses.

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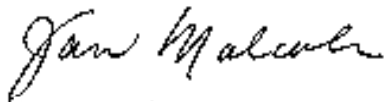
Dear Colleague:

I am pleased to provide you with a copy of *Employer-Sponsored Health Insurance in the Minnesota Long-Term Care Industry*.

As required by the Laws of Minnesota 2000, Chapter 460, Section 64, this report outlines options for providing employer-subsidized affordable health insurance to employees of programs and facilities that serve the elderly and disabled. In order to develop these options, the Department of Health conducted a survey of long-term care employers to identify the characteristics of employer-sponsored health insurance in this industry. The findings of this survey are also presented in this report. The department is grateful to the advisory committee of stakeholders representing nursing facilities, home health agencies, home and community based services, hospices, and rehabilitation facilities for their valuable input to the survey.

I hope you find this report to be a valuable source of information. Jennifer Gillespie of the MDH Health Economics Program prepared this report. Questions and comments on the report can be directed to the Health Economics Program at 651.282.6367. The Minnesota Department of Health looks forward to continued work on this important issue.

Sincerely,

A handwritten signature in black ink that reads "Jan Malcolm". The signature is written in a cursive, flowing style.

Jan K. Malcolm
Commissioner of Health

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Executive Summary

Availability and affordability of health care coverage have been long standing interests of the Minnesota Legislature. Demographic trends suggest that at the same time that the number of people needing long-term care will increase, the number of available workers will decline. In fact, the ratio of the population in the average care giving range to the population age 85 and older is projected to decrease, from 11 to 1 in 1990 to 4 to 1 in 2050. Demand for long-term care will rise due to an unprecedented increase in the size of the elderly population as the “baby boom” generation ages. Bureau of Labor Statistics estimates that, in response to this rising demand, personal and home care assistance will be among the fastest growing occupations through the year 2010, with a dramatic 85 percent growth rate expected. The availability of health insurance coverage for workers in facilities that serve elderly and disabled individual may contribute to ensuring an adequate supply of workers for these facilities. For this reason, the Minnesota Legislature directed the Minnesota Department of Health to “develop recommendations for providing employer-subsidized affordable health insurance to employees of programs and facilities that serve the elderly and disabled”.

This report presents the findings our analysis. First, the report presents results from a survey of approximately 900 employers who provide long-term care services to the elderly and disabled. The report first details the characteristics of the long-term care industry, with information on the size of employers, workforce characteristics, and geographic location. Next, the report examines the level of employer-sponsored health insurance coverage in the long-term care industry, providing comparisons to all employers statewide. Finally, the report concludes with policy options for the legislature to consider to increase the availability and affordability of employer-sponsored health insurance coverage in Minnesota’s long-term care industry.

Findings from Survey of Long-Term Care Employers

In the fall of 2000, the Department of Health conducted a survey of approximately 900 facilities that serve the elderly and disabled in order to determine the levels of insurance coverage offered by their employers. The response rate to this survey was about 65%. The survey found that, in the Minnesota long-term care industry:

- Establishments, on average, had more employees, paid lower wages, and employed more part-time workers than the statewide average for all industries;
- Turnover of workers in the industry is considerably higher than the average for all industries statewide;
- Among establishments that offer coverage, the percentage of employees eligible for health insurance was considerably lower than the statewide average;
- The percentage of health insurance premiums paid by employers for individual and family coverage was lower than the average subsidy statewide, particularly for family coverage; and

- The percentage of employees enrolled in employer-sponsored health insurance was considerably lower than the statewide average.

Options for Addressing Availability and Affordability of Coverage

The legislation requiring this study specifically charged the Minnesota Department of Health to “develop recommendations for providing employer-subsidized affordable health insurance to employees of programs and facilities that serve the elderly and disabled.” As such, the policy options contained in the report focus on supporting access and enrollment in employer coverage through long-term care employers. During the course of the study, we were unable to ascertain the degree to which long-term care employees actually lack coverage. That is, while our survey of long-term care employers documents that the availability and existence of employer-sponsored coverage is considerably lower in the long-term care industry than for other industries statewide, it is possible that these employees are accessing coverage through other means, either through a spouse or through enrollment in public insurance programs or individually purchased coverage. It is important to remember, however, that the characteristics of workers in the long-term care industry – low wage, part-time workers concentrated in greater Minnesota – are factors that are correlated with a greater likelihood of being uninsured.

The report presents the following policy options:

1. Subsidies to Employees

Data from the long-term care employer survey indicated that most employers in the industry offer coverage, but at subsidy rates below the state average for both individual and family coverage. In addition, the data indicate that the wages paid to workers in the industry are lower than the statewide average. Given the combination of relatively high offer rates, below average subsidies, and low wage employees, it is likely that there are some employees who are offered coverage but are unable to afford the employee portion of the premium.

This option would create targeted payments to low-income long-term care employees to enroll in their employer-sponsored plan. If coverage is not offered, or the employee is not eligible for the employer plan, the employee could use the payment to subsidize coverage in the individual market. While these payments could be structured in a variety of ways, the most appealing option would be modeled after the Oregon Family Health Insurance Assistance Program, where subsidies are paid directly to employees, and are therefore invisible to employers. Eligibility for subsidies for purchasing private coverage may include people who are currently eligible for public insurance programs but choose not to enroll, allowing individuals to choose between public and private coverage and reducing the cost to the state by capturing the employer contribution to the premium. Persons receiving the subsidy under this plan could be required to send in a copy of their pay stub periodically to ensure that a deduction is being made for health insurance coverage, and therefore that the subsidy is being used for health insurance.

The program could be administered by the Minnesota Department of Human Services, which already administers the state's Medical Assistance program, or could be contracted out to a private firm. There are a number of options that could be used to determine the amount of subsidy. One option would be to cap enrollee premium contributions at 5% of income and require the employee to pay all insurance-related co-payments and deductibles. Specifics would need to be determined, but some combination of enrollee premiums, employer contributions, and state funds could be used to finance this subsidy program. The state could also explore the possibility of obtaining federal matching funds under SCHIP or Medicaid for this proposal, as other states such as Oregon and Rhode Island are currently pursuing, particularly if the subsidy is used to support family coverage.

II. Subsidies to Employers to Increase Employee Eligibility and Enrollment

Most long-term care employers offer coverage to their employees albeit at relatively low subsidy levels. In addition, because of the prevalence of part-time employees, a much smaller percentage of workers for long-term care employers are eligible for coverage. Finally, a unique characteristic that distinguishes long-term care employers from other private employers is the relatively heavy state involvement in the financing of long-term care services. The combination of these factors presents an opportunity to create a program to subsidize (either directly through subsidy payments or indirectly through Medical Assistance rates) the offering of health insurance by long-term care employers, under the conditions that facilities receiving additional payments subsidize employee and family coverage at a level that increases the likelihood of enrollment (for example, subsidize 80 percent of premium for family coverage) and allow for eligibility for employee coverage for workers working at least 20 hours per week.

Participating employers may be required to contribute a fixed percentage to individual and family coverage or establish a sliding fee for employee contribution to coverage based on income. Requiring eligibility for all employees working more than a set number of hours could also increase the number of eligible workers.

The MN Department of Human Services, which is already heavily involved in the financing and regulation of long-term care services, could administer this program. Direct subsidy payments would likely require the use of state only funding, whereas administering the program as an add-on to the Medical Assistance rates paid for services, while more administratively cumbersome, would create an opportunity to obtain federal matching funds. The payment made would need to be of sufficient size so that employers choosing to participate are not placed at a disadvantage due to participating.

III. Employer Purchasing Pools

One method that would potentially make health coverage more available and affordable is the use of employer purchasing pools. These pools, in theory, allow smaller groups to gain some of the same advantages enjoyed by larger groups: the broader spreading of risk, the ability to coordinate and reduce administrative functions, and the ability to gain purchasing leverage in the market.

Theoretically, the various long-term care employers could be pooled together, and this option proposes the creation of a long-term care industry purchasing pool (either subsidized or unsubsidized) to better enable long-term care employers to purchase coverage for their employees.

In general, purchasing pools often suffer from risk selection. Healthier groups within the pool end up subsidizing the cost of coverage for less healthy groups, and these healthier groups tend to exit the pool to take advantage of cheaper rates outside the pool. Over time, voluntary pools have difficulty remaining competitive, as healthier risk leaves the pool. As a result, voluntary purchasing pools have shown little success to date. A recent study found that voluntary purchasing pools had little effect on health insurance costs for their participants.

Voluntary purchasing pools, therefore, are unlikely to address the primary issues of eligibility and cost of health insurance for long-term care workers. To be effective, it is likely that a purchasing pool would need to be either: (a) heavily subsidized, to offset the cost of the risk selection and to entice healthy groups to remain in the pool, or (b) mandatory, requiring all employers to participate. A purchasing pool may be administered by the MN Department of Human Services, or by a private firm. Employer and enrollee funds would finance the pools, with additional state funds, if subsidized.

IV. Combining Subsidies to Low-Income Workers and Employers

An additional strategy to consider would combine the option of direct subsidies to low-income workers to enhance their ability to purchase coverage while subsidizing the employer to offer coverage to both part-time workers and at a level of subsidy that would make it more likely that employees and dependents would enroll. An advantage of this strategy is that it would target subsidies to low-income employees while also making coverage more broadly affordable to all long-term care workers. Assuming that a goal of efforts to increase the affordability and availability of coverage through long-term care employers is to increase the overall desirability of working in the industry, this option would further this goal.

A promising hybrid of these approaches has started to emerge. Several states, most prominently New Mexico, are examining ways to creatively use the flexibility offered under HIFA to establish “share” programs. Under these proposals, employers and employees contribute a fixed amount per month, with the State and Federal governments covering the remaining cost of coverage. For example, employers might contribute \$50 per employee per month, with the employee responsible for \$25 per month. The remaining cost of insurance would be coverage through state funds and federal Medicaid matching funds.

V. MinnesotaCare Outreach and Eligibility Expansion

All of the options presented thus far have focused on ways to enhance the availability of affordable employer-sponsored health insurance. However, given the relatively low wage structure and low levels of health insurance eligibility in the Minnesota long-term care industry, it is likely that many workers in the long-term care industry who are not eligible for coverage through a spouse are already eligible for MinnesotaCare.

In addition, if there remained concern that coverage was still unaffordable for those currently locked out of MinnesotaCare, eligibility for the MinnesotaCare program could be changed to include uninsured workers who are eligible for employer coverage and currently ineligible for MinnesotaCare because their employer subsidizes more than half the cost. This option would need to include outreach strategies for enrolling people who are already eligible for MinnesotaCare as well as those who would be newly eligible. The outreach could be conducted by the Department of Human services or by a private contractor. This option would be financed via the Health Care Access Fund as enrollment would be through MinnesotaCare.

INTRODUCTION

Availability and affordability of health care coverage have been long standing interests of the Minnesota Legislature. Demographic trends suggest that at the same time the number of people needing long-term care will increase, the number of available workers will decline.¹ Demand for long-term care will rise due to an unprecedented increase in the size of the elderly population as the “baby boom” generation ages. The Bureau of Labor Statistics estimates that, in response to this rising demand, personal and home care assistance will be among the fastest growing occupations through the year 2010, with a dramatic 85 percent growth rate expected.² Long-term care experts recently summarized the situation as follows:

...low wages and benefits, hard working conditions, heavy workloads, and the stigma attached to long-term care jobs make recruitment and retention of workers difficult, even when unemployment rates are high...Indeed, many observers refer to the current difficulty of attracting workers as a crisis.³

The availability of health insurance coverage for workers in facilities that serve elderly and disabled individuals may contribute to ensuring an adequate supply of workers for long-term care facilities. For this reason, the Minnesota Legislature directed the Minnesota Department of Health to “develop recommendations for providing employer-subsidized affordable health insurance to employees of programs and facilities that serve the elderly and disabled.”⁴

The Minnesota Department of Health used several strategies to conduct this study. First, we convened an advisory committee of stakeholders representing nursing facilities, home health agencies, home and community based services, hospices, and rehabilitation facilities. The advisory committee component of the study allowed the Department to understand the issues and concerns of the long-term care industry, to hear industry proposals and input, and to better understand the current state of health insurance coverage in the industry.

Second, the Department conducted a survey of long-term care employers. The goal of the survey was to provide information that can be used to answer the following questions:

- What is the current status of employer-sponsored health insurance among long-term care employers, including eligibility, enrollment, employer subsidy and cost sharing? How does that compare to other employers?
- Are there variations in the level of employer-sponsored coverage across different types of employers within the long-term care industry (e.g. assisted living, nursing home, etc.)?
- What are the take-up rates among long-term care employees? How does that compare to take-up rates of workers earning similar wages across the State?
- Are there geographic differences in coverage availability, cost, and enrollment?

Finally, in order to develop policy options, we examined the mechanics of efforts to increase coverage in employer-subsidized insurance. We conducted an extensive literature review, and analyzed the successes and failures of public programs or efforts designed in other states to increase employer-sponsored insurance.

This report first outlines the findings of the survey. These findings include information on the characteristics of the long-term care industry in general, as well as the health insurance offered. The second section of this report identifies potential policy options to expand the availability and affordability of health insurance for long-term care workers in Minnesota. The second section also includes a discussion of the criteria to consider when evaluating the policy options.

Employer-Sponsored Health Insurance in Minnesota's Long-Term Care Industry

In the fall of 2000, the Department of Health conducted a survey of approximately 900 facilities that serve the elderly and disabled in order to determine the levels of insurance coverage offered to employees. The response rate to this survey was about 65%. Appendix B contains details on the survey methodology and the survey questionnaire is included in Appendix C. The main findings of the survey suggest that in the Minnesota long-term care industry:

- Establishments had more employees, paid lower wages, and employed more part-time workers than the statewide average for all industries;
- Turnover of workers in the industry is considerably higher than the average for all industries statewide;
- Among establishments that offer coverage, the percentage of employees eligible for health insurance was considerably lower than the statewide average;
- The percentage of health insurance premiums paid by employers for individual and family coverage was lower than the average subsidy statewide, particularly for family coverage; and
- The percentage of employees enrolled in employer-sponsored health insurance was lower than the statewide average.

This section summarizes the survey results on the characteristics of the Minnesota long-term care industry as well as health insurance eligibility, employer subsidy, and enrollment levels.⁵

Characteristics of the Minnesota Long-Term Care Industry

Understanding the characteristics of an industry helps to explain the levels of employer-sponsored health insurance coverage that exists within the industry. Table 1 summarizes the characteristics of the Minnesota long-term care industry, with a comparison to statewide averages for all industries combined. For the purposes of the survey and this report, long-term care employers were defined broadly to include establishments with one or more employees providing health care services for the elderly or disabled in institutional, home and community-based settings.

Table 1
 Characteristics of the Long-Term Care Industry Compared with All Industries In Minnesota

Industry Characteristics	LTC Industry	All Private Industries
Percentage of Establishments with More than 50 Employees (a)	36%	6%
Percentage of Employees Working for Establishments with More than 50 Employees (a)	84%	60%
Percentage of Employees Working Part-Time (b)	53%*	23%
Percentage of Employees Working in Establishments where a Majority of Workers Earn Less than \$10 per hour	47%*	23%
Turnover (c)		
Percentage of employees who LEFT in the past 12 months	47%*	11%
Percentage of employees who JOINED in the past 12 months	45%*	11%
Percentage of establishments with high turnover (d)	70%*	40%
Percentage of employees who work in establishments with high turnover	87%*	26%

a Statewide figures based on data from the Minnesota Department of Economic Security for the third quarter of 2000. Statistical Significance was not tested.

b Statewide figures based on 1999 Medical Expenditure Panel Survey (MEPS) insurance component.

c Statewide figures based on establishments with 100 or more employees to make more comparable to long-term care industry data.

d High turnover means that the percentage of workers who left the establishment in the past 12 months and the percentage of workers who joined the establishment in the past 12 months are both greater than the statewide averages.

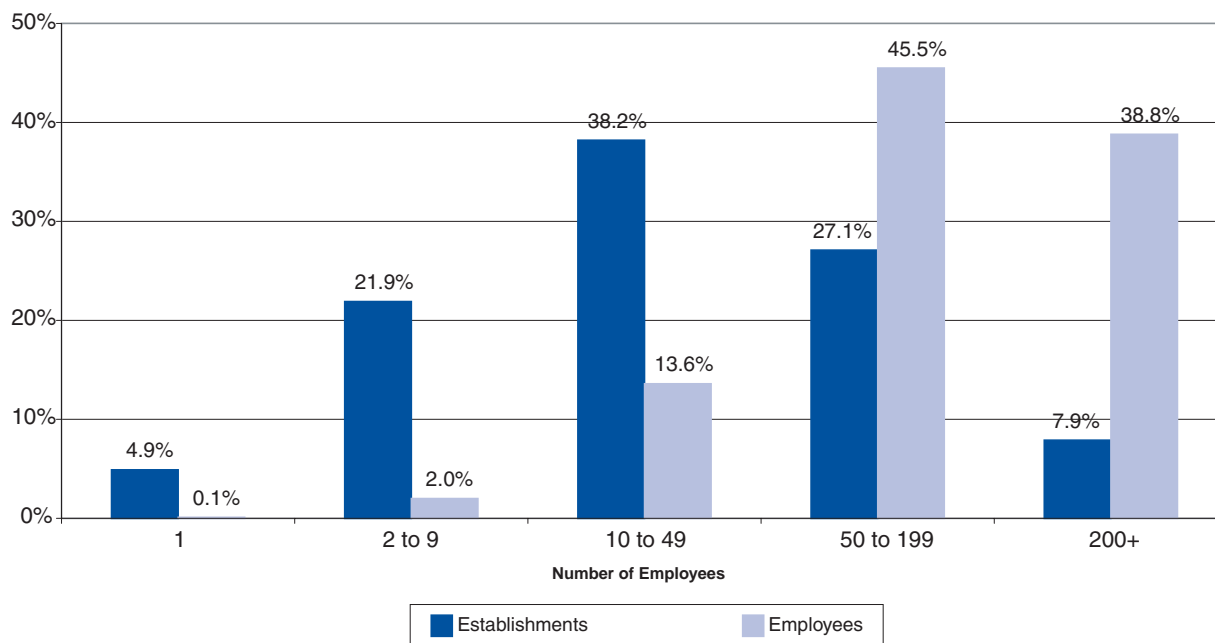
* Significant difference from statewide figure at 95% confidence level.

Sources: Health Economics Program, MDH, 2000 Long-Term Care Employer Survey. Unless otherwise indicated statewide figures are based on data obtained from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey published in "Employer Based Health Insurance in Minnesota", February 2000 Health Economics Program, MDH.

Long-term care industry employers were larger, on average, than employers in all industries statewide, as shown in Table 1. Correspondingly, employment in the long-term care industry was more concentrated in large establishments than it was in the private sector as a whole.⁶ Only 16 percent of long-term care employees work in establishments with fewer than 50 employees, compared to 40 percent of private sector employees statewide. Figure 1 illustrates the distribution of establishments and employees by firm size. While the majority of establishments in the long-term care industry (64 percent) have fewer than 50 employees, most people who work for a long-term care employer in Minnesota (84 percent) work for an establishment that has 50 or more employees. This means that the majority of workers are in firms that fall outside laws governing small employer health plans, including guaranteed issue, guaranteed renewal, and rate approval.

Figure 1

Distribution of Long-Term Care Establishments and Employees by Establishment Size



Source: Health Economics Program, Minnesota Department of Health, 2000 Long-Term Care Employer Survey.

Long-term care is provided in a variety of settings throughout the state, which generally fall into two categories, institutional or home and community based settings. According to the results of our survey, of all employees in the long-term care industry, 43 percent worked in institutional settings and 57 percent worked in home and community based settings. About half (54 percent) of employees in the long-term care industry were located in Greater Minnesota with the remaining 46 percent located in the 11-county Twin Cities metro area. Comparatively, employment in greater Minnesota represents about one-third of all of the state's workers.⁶ This concentration of workers in greater Minnesota is another characteristic of the long-term care industry that is associated with lower levels of employer sponsored coverage, as employers in Greater Minnesota are less likely to offer coverage.⁷

The Minnesota long-term care industry had a much greater percentage of part-time and low-wage employees than the state's workforce as a whole. Approximately half (53 percent) of employees in the Minnesota long-term care industry were employed part-time, compared to the statewide average of 20 percent.⁸ About half (47 percent) of long-term care employees worked in establishments where the majority of workers earned less than \$10 per hour, compared to about one quarter (23 percent) of employees in all industries combined.⁹ These characteristics (part-time and low wage) are associated with higher rates of uninsurance and lower rates of group coverage. Minnesotans

working less than 30 hours per week are twice as likely as those working more than 30 hours per week to be uninsured. Similarly, Minnesota workers with household incomes below 200 percent of the federal poverty level are more than 3 times as likely as all Minnesota workers to be uninsured.¹⁰

In addition to the high percentage of part-time and low-wage workers described above, the Minnesota long-term care industry has other characteristics that are often associated with a lower rate of employer-based coverage.

Turnover among long-term care workers is significantly higher than among all Minnesota industries on average. For this study, turnover is defined as the percentage of employees who joined or left a long-term care establishment in the past year. Nearly half (47 and 45 percent respectively) of all long-term care employees left or joined establishments in the 12 months prior to the survey, compared to about 11 percent for all industries. The turnover rates for the long-term care industry and all industries in Minnesota are included in Table 1. High turnover can affect an employer's decision to offer health insurance, as well as an employee's eligibility for health insurance coverage for a number of reasons. Most importantly, turnover is linked to coverage due to waiting periods before an employee becomes eligible.

Finally, it is important to remember that some long-term care services are provided by State-Operated Community Services (SOCS) and eligible employees of these facilities are enrolled in the State Employee Group Insurance Program (SEGIP). SOCS accounted for 3.3 percent of long-term care establishments and represents 0.5 percent of employees in the long-term care industry.

Employer-Sponsored Health Insurance in the Minnesota Long-Term Care Industry

Long-term care employers were more likely to offer health insurance than all employers statewide, as shown in Table 2. The percentage of employees working in firms that offered health insurance was also higher than the statewide average; however, the difference was much smaller. As is the case with all industries, virtually all long-term care employers offering health insurance to their employees also offered family coverage.

Table 2

Employer-Sponsored Health Insurance in the Long-Term Care Industry Compared with All Industries In Minnesota

	LTC Industry 2000	All Private Industries 1997
Employer Sponsored Health Insurance Offerings		
Percentage of Establishments Offering Health Insurance	81%*	51%
Percentage of Employees Working in Establishments Offering Health Insurance	94%*	87%
Of Establishments Offering Health Insurance, Percent also Offering Family Coverage	98%	100%
Eligibility		
Of Establishments Offering Health Insurance, Percentage of Employees Eligible for Health Insurance	57%*	83%
Employer Subsidy		
Average Employer Subsidy of Individual Coverage	76%	82%
Average Employer Subsidy of Family Coverage	55%*	70%
Enrollment		
Percentage of Eligible Employees Enrolled in Health Insurance (takeup rate)	68%*	88%
Percentage of All Employees Enrolled in Health Insurance (coverage rate)	36%*	62%
Percentage of All Employees Enrolled in Family Coverage	10%*	33%

* Significant difference from 1997 statewide figure at 95% confidence level.

Sources: Health Economics Program, MDH, 2000 Long-Term Care Employer Survey. Statewide figures are based on data obtained from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey published in "Employer Based Health Insurance in Minnesota," February 2000 Health Economics Program, MDH.

As noted earlier, the Minnesota long-term care industry differs somewhat from the private sector as a whole in that it has a higher concentration of larger employers, which are more likely to offer coverage than smaller employers.¹¹ This distinction may help to explain why, on average, long-term care employers were more likely to offer health insurance to their employees.

Employee Eligibility for Employer Sponsored Health Insurance

Despite the fact that a higher share of employees worked in establishments that offered health insurance, the percentage of employees who were eligible for health insurance in the long-term care industry was lower than the statewide average. Only 57 percent of long-term care employees who worked in establishments that offer coverage were eligible for health insurance, compared to 83 percent statewide.

As noted previously, the Minnesota long-term care industry is different from the private sector as a whole in that it has a disproportionate share of part-time workers and has a higher turnover rate among employees. Both of these characteristics decrease the likelihood of eligibility for employer-sponsored coverage. This likely is part of the reason why long-term care employees were less likely to be eligible for health insurance than employees in other industries.

Employees are often required to work for a certain length of time before they become eligible to enroll in health insurance. Among long-term care establishments offering coverage, 70 percent required a waiting period. The average waiting period was 64 days. Table 3 presents the distribution of waiting periods by number of days. While the distribution of length of waiting period in the long-term care industry is not significantly different from all industries, the higher turnover rates in the long-term care industry mean a higher percentage of employees will have a waiting period in a given year.

Table 3

Length of Waiting Period, Among Establishments Offering Coverage and Requiring a Waiting Period

	LTC Industry*	All Industries
30 Days	39%	37%
60 Days	16%	18%
90 Days	42%	36%
120 Or More Days	3%	10%
Total	100%	100%

*Differences are not statistically significant at 95 percent confidence level.

Cost of Health Insurance

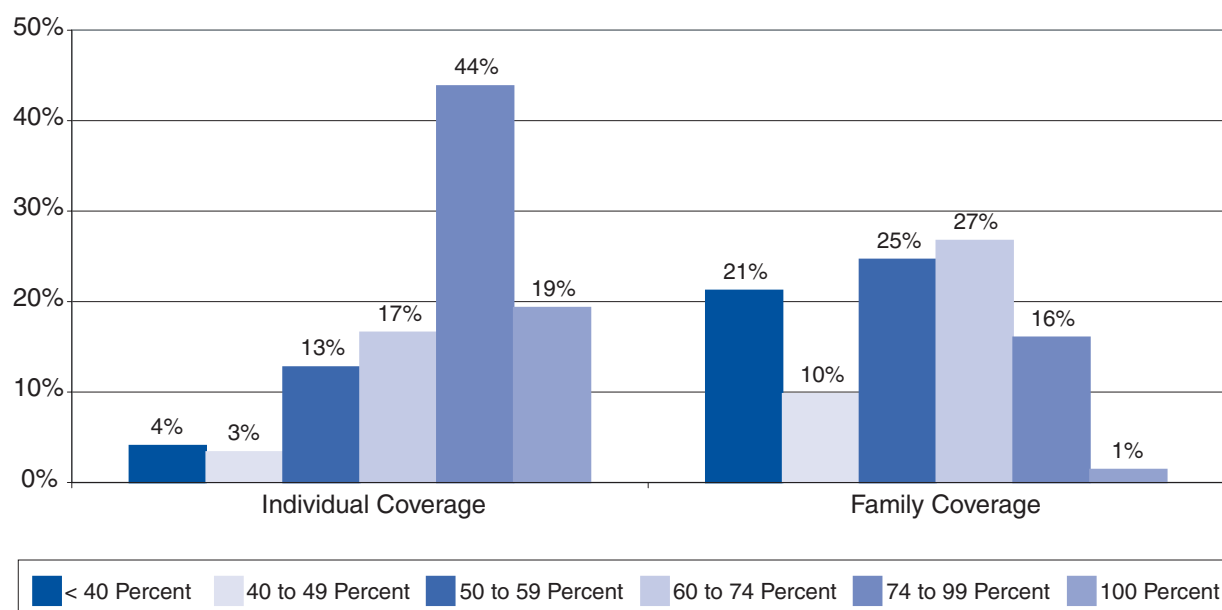
The average monthly health insurance premium for individuals enrolled in coverage in the long-term care industry in 2000 was \$193 and the premium for family coverage was \$506 per month.¹² In general, premiums for all industries have been rising rapidly in recent years making it difficult to present statewide figures comparable to the premiums reported by long-term care employers. However, discussions with representatives from the health insurance industry indicated that employers in the health services industry are generally rated for coverage at rates approximately 20 percent higher than other industries. Health insurance industry representatives also indicated that the rates are higher because workers in the long-term care industry had higher than average costs per hospital admission and per outpatient visit, a higher than average number of prescriptions per year, and higher prevalence of depression, asthma, obesity, back problems, diabetes and high blood pressure.¹³

Overall, long-term care employers subsidized the cost of insurance premiums for individuals at levels slightly lower than the statewide average. As shown in Table 2, the average amount of employer subsidy for individuals enrolled in health insurance in the long-term care industry was 76 percent, compared to 82 percent statewide.¹⁴ In contrast, subsidy levels for family coverage in the long-term care industry were significantly lower than the statewide average. Long-term care employers subsidized 55 percent of family premiums, which was 15 percentage points less than the statewide average.¹⁵

Figure 2 shows the distribution of employer subsidies for individual and family coverage in the Minnesota long-term care industry. Of those enrolled in individual coverage, only 7 percent were subsidized at less than 50 percent of the premium amount. In addition, employers subsidized the entire premium for 19 percent of enrollees. Among those enrolled in family coverage, 31 percent were subsidized at less than 50 percent of the premium amount. Employers subsidized the entire premium for only one percent of employees enrolled in family coverage.

Figure 2

Average Employer Subsidy of Health Insurance Premiums in Minnesota's Long-Term Care Industry



Source: Health Economics Program, MDH, 2000 Long-Term Care Employer Survey.

Regarding cost sharing for in-plan providers, 88 percent of enrollees were enrolled in plans that required co-pays. Co-pays were either a percentage of the cost of service or a fixed dollar amount. Among those with a percentage co-pay, nearly all (99.7%) were 20 percent or less. Of those with a dollar co-pay, the median and most frequent amount was \$15. Approximately 30 percent of enrollees were enrolled in plans that did not require a deductible. Of plans with a required deductible, the average was \$255 and the range was from \$0 to \$3,000.

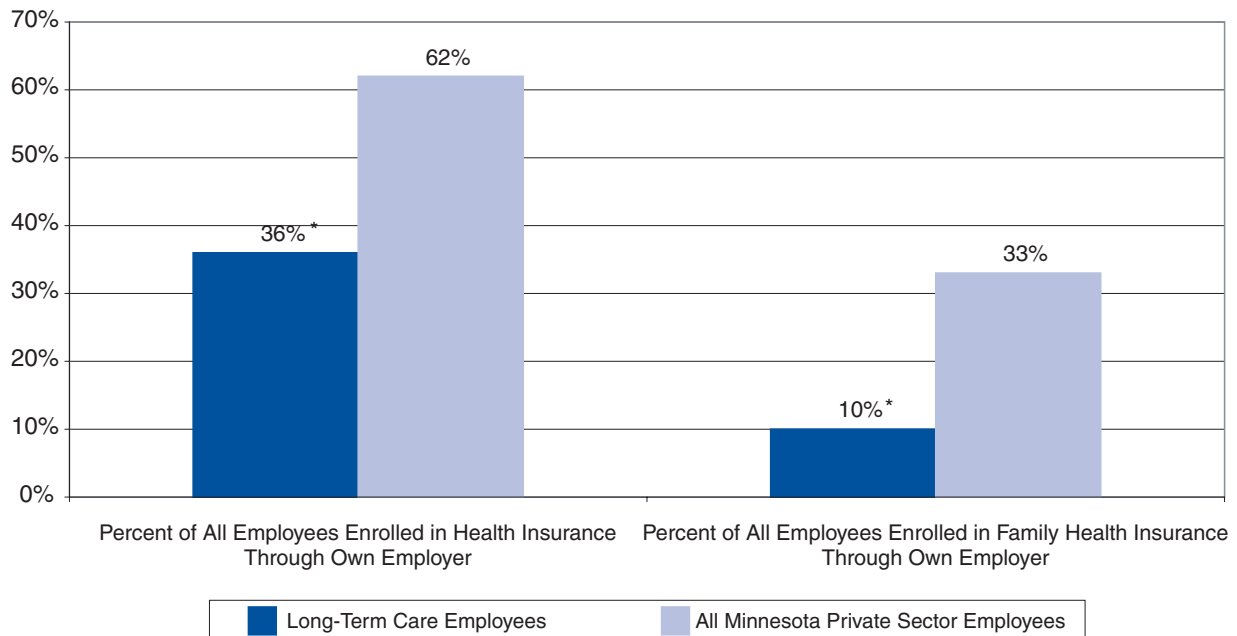
Enrollment In Employer-Sponsored Health Insurance

Two measures commonly used to describe enrollment in health insurance are takeup rates and coverage rates. The takeup rate is the percentage of eligible employees enrolled in health insurance. The coverage rate is the percentage of all employees enrolled in health insurance, including employees who were eligible to enroll and those who were not. Due to the low eligibility levels in the long-term care industry, it is especially important to consider both the coverage rates and the takeup rates to get an accurate representation of employer sponsored health insurance in the long-term care industry.

In 2000, the takeup rate in the long-term care industry was 68 percent, which was 20 percentage points lower than the statewide average for all industries in 1997 (see Table 2). The coverage rate in the long-term care industry is also much lower than the statewide average, as illustrated in Figure 3. Just over one-third (36 percent) of all long-term care employees in Minnesota were enrolled in health insurance through their employer, compared to 62 percent statewide.¹⁶

Figure 3

Health Insurance and Family Health Insurance Coverage Rates



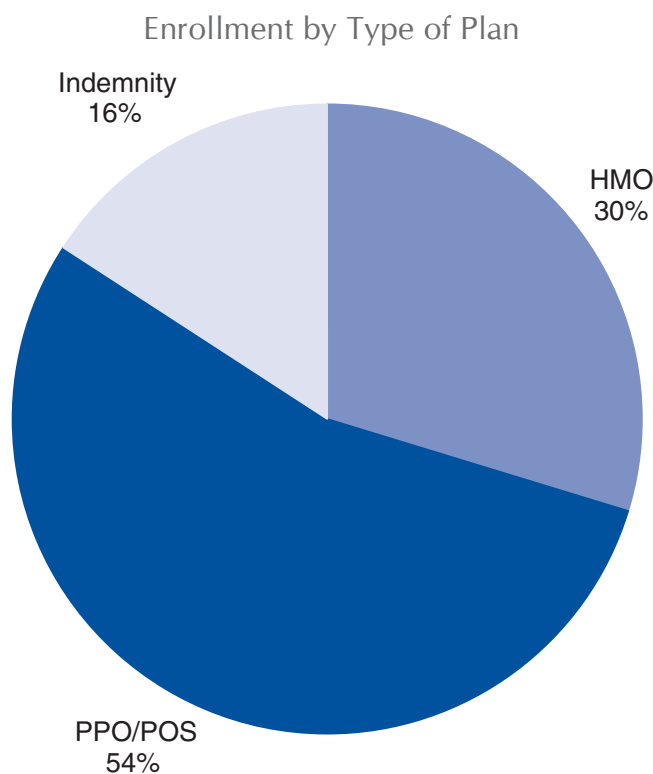
* Significant Difference from statewide figure at 95% confidence level.

Sources: Health Economics Program, MDH, 2000 Long-Term Care Employer Survey. Statewide figures are based on data obtained from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey published in "Employer Based Health Insurance in Minnesota," February 2000 Health Economics Program, MDH.

The percentage of employees in the long-term care industry who were enrolled in family coverage (10 percent) was also lower than the statewide average of 33 percent. It is difficult, however, to determine to what degree the difference in family coverage is due to different workforce demographics, low subsidies for family coverage, the existence of spousal health care benefits, or other factors.

Employers were asked about the type of plan offered to employees. If more than one plan was offered, responses were based on the plan with the largest number of employees enrolled. Preferred Provider Organization (PPO)/Point of Service (POS) plans had the largest percentage of enrollees (58 percent).¹⁷ Figure 4 illustrates the distribution of enrollment by plan type. Few establishments (17.7 percent) offered a choice of plans, although the percentage of long-term care establishments offering a choice of plans is higher than the statewide average.

Figure 4



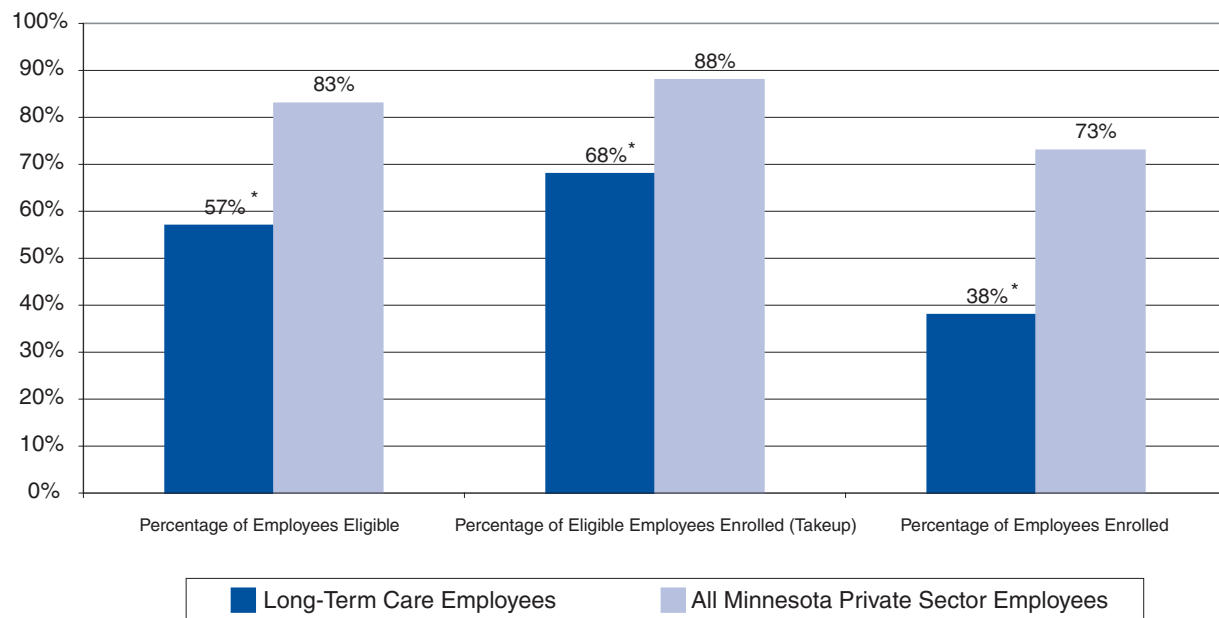
Source: Health Economics Program, MDH, 2000 Long-Term Care Employer Survey.

Because employers in the long-term care industry paid less of the cost of the health insurance premiums, the cost to employees in this industry was greater than the statewide average. This higher cost is exacerbated by the fact that this is a relatively low wage industry, making it less likely that employees in the long-term care industry can afford to enroll in health insurance when it is offered to them.

Summary of Survey Findings

The findings from this survey suggest that health insurance coverage in Minnesota's long-term care industry differs substantially from the state as a whole. Health insurance eligibility, takeup and enrollment in the long-term care industry are compared to the statewide rates in Figure 5. Despite the fact that the percentage of employers offering health insurance was higher than average in the long-term care industry, employees were less likely to be eligible for health insurance and less likely to enroll in either individual or family coverage. In addition to lower rates of eligibility due to high levels of part-time employment and high turnover rates, relatively low wage levels and low employer subsidies are the most likely reasons why employer-sponsored health insurance coverage in the long-term care industry is lower than it is for employees throughout Minnesota.

Figure 5
Health Insurance Eligibility, Takeup, and Enrollment Among Establishments Offering Coverage



* Significant Difference from statewide figure at 95% confidence level.

Sources: Health Economics Program, MDH, 2000 Long-Term Care Employer Survey. Statewide figures are based on data obtained from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey published in "Employer Based Health Insurance in Minnesota," February 2000 Health Economics Program, MDH.

OPTIONS FOR ADDRESSING AVAILABILITY AND AFFORDABILITY

This section of the report identifies potential policy options to expand the availability and affordability of health insurance for long-term care workers in Minnesota, beginning with a discussion of factors for consideration in evaluating the options.

The legislation requiring this study specifically charges the Minnesota Department of Health to “develop recommendations for providing employer-subsidized affordable health insurance to employees of programs and facilities that serve the elderly and disabled.” As such, the options contained in this section focus on supporting access and enrollment in employer coverage through long-term care employers. During the course of the study, we were unable to ascertain the degree to which long-term care employees actually lack coverage. That is, while our survey of long-term care employers documents that the availability and existence of employer-sponsored coverage is considerably lower in the long-term care industry than for other industries statewide, it is possible that these employees are accessing coverage through other means, either through a spouse or through enrollment in public insurance programs or individually purchased coverage. It is important to remember, however, that the characteristics of workers in the long-term care industry — low-wage, part-time workers concentrated in greater Minnesota — are factors that are correlated with a greater likelihood of being uninsured.

In addition, while finding ways to increase the enrollment of long-term care workers in health coverage is a primary goal, it is also the case that policymakers are concerned about the current and potential future shortage of workers in the long-term care industry. Therefore, policy options that increase the availability and affordability of health coverage also have the potential benefit of increasing the attractiveness of long-term care as an employment option.

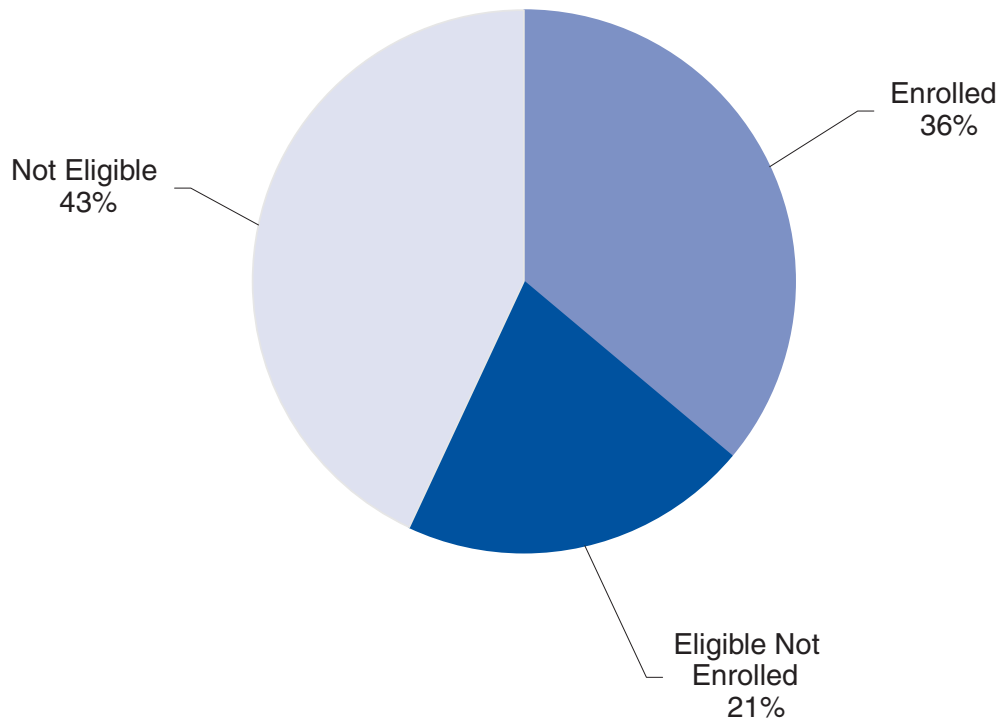
Factors for Consideration

Based on the findings of the survey of long-term care employers describe above, it is useful to think of the long-term care workforce in three groups. As illustrated in Figure 6, long-term care workers fall into three categories, those *enrolled* in health insurance sponsored by their employer (36 percent), those *eligible but not enrolled* in health insurance sponsored by their employer (21 percent), and those *not eligible for* health insurance sponsored by their employer (43 percent).

Given the variation within the industry, the optimal approach may be a combination of some of the following options. For those in the enrolled category for example, policies might be aimed at increasing the affordability of family coverage to address the disparities between the long-term care industry and other industries. Similarly, for the workers in the eligible but not enrolled category, policies might target low-income employees to address affordability of coverage. Finally, for those in the not eligible category, policies might address expanding eligibility for coverage.

Figure 6

Employer-Sponsored Insurance Status of Long-Term Care Workers (a)



(a) Includes coverage through own employer only, and not coverage as a dependent on someone else's policy.

Source: Health Economics Program, MDH, 2000 Long-Term Care Employer Survey.

Health policy is almost always about choosing among alternatives that involve tradeoffs. As a backdrop for choosing among policy options, some of the tradeoffs involved in promoting health insurance coverage of long-term care workers are outlined below. Options may be prioritized by the extent to which they:

- Capitalize on high offer rates by focusing on increasing eligibility and enrollment in employer sponsored plans**

Nearly all long-term care employees (94 percent) work in establishments that offer health insurance to some of their employees. Most employers therefore already have the administrative mechanisms in place to offer coverage.
- Target uninsured low-income workers, or all workers**

While a disproportionately low percentage of long-term care employees are enrolled in health insurance through their own employer, they are not necessarily uninsured. Only 5.4 percent of Minnesotans are uninsured.¹⁷ Among those who are uninsured, 49.2 percent are potentially eligible for existing public programs. An estimated 22.4 percent have access to employer-sponsored coverage, either through their own employer or someone else's.¹⁹

We know that workers in the Minnesota long-term care industry are disproportionately part-time and low-wage. What is unknown, however, is whether household incomes of these workers are low.

- **Leverage employer contributions**
While the average employer subsidy of coverage is lower among long-term care employers than the average across all industries, many employers already subsidize a portion of individual and family coverage.
- **Capture available federal funds**
National studies of public subsidies of employer sponsored insurance show that subsidies must usually be very high to increase take-up rates.²⁰ Federal funds could offset the cost burden to the state. Federal funds may potentially be secured through three sources: Medical Assistance matching payments for enrollment in MA coverage (either directly or through employer coverage), SCHIP funds, and payments to MA providers. The Federal Government, through the Health Insurance Flexibility and Accountability Demonstration Initiative (HIFA), has indicated a willingness to explore areas of flexibility.
- **Address individual or family coverage**
The percentage of premiums paid by long-term care employers for individual and family coverage is lower than the statewide average. This is especially true for family coverage; long-term care employers subsidize 55 percent of the premium compared to 70 percent on average across all industries.

Policy Options

1. Subsidies to Employees

As described earlier in this report, data from the long-term care employer survey indicated that most employers in the industry offer coverage, but at subsidy rates below the state average for both individual and family coverage. In addition, the data indicate that the wages paid to workers in the industry are lower than the statewide average. Given the combination of relatively high offer rates, below average subsidies, and low wage employees, it is likely that there are some employees who are offered coverage but are unable to afford the employee portion of the premium.

This option would create targeted payments to low-income long-term care employees to enroll in their employer-sponsored plan. If coverage is not offered, or the employee is not eligible for the employer plan, the employee could use the payment to subsidize coverage in the individual market. While these payments could be structured in a variety of ways, the most appealing option would be modeled after the Oregon Family Health Insurance Assistance Program, where subsidies are paid directly to employees, and are therefore invisible to employers. Eligibility for subsidies for purchasing private coverage may include people who are currently eligible for public insurance programs but choose not to enroll, allowing individuals to choose between public and private coverage and reducing the cost to the state by capturing the employer contribution to the premium. Persons receiving the subsidy under this plan could be required to send in a copy of their pay stub periodically to ensure that a deduction is being made for health insurance coverage, and therefore that the subsidy is being used for health insurance.

The program could be administered by the Minnesota Department of Human Services, which already administers the state's Medical Assistance program, or could be contracted out to a private firm. There are a number of options that could be used to determine the amount of subsidy. One option would be to cap enrollee premium contributions at 5% of income and require the employee to pay all insurance-related co-payments and deductibles. Specifics would need to be determined, but some combination of enrollee premiums, employer contributions, and state funds could be used to finance this subsidy program. The state could also explore the possibility of obtaining federal matching funds under SCHIP or Medicaid for this proposal, as other states such as Oregon and Rhode Island are currently pursuing, particularly if the subsidy is used to support family coverage.

II. Subsidies to Employers to Increase Employee Eligibility and Enrollment

As noted earlier, most long-term care employers offer coverage to their employees albeit at relatively low subsidy levels. In addition, because of the prevalence of part-time employees, a much smaller percentage of workers for long-term care employers are eligible for coverage. Finally, a unique characteristic that distinguishes long-term care employers from other private employers is the relatively heavy state involvement in the financing of long-term care services. The combination of these factors presents an opportunity to create a program to subsidize (either directly through subsidy payments or indirectly through Medical Assistance rates) the offering of health insurance by long-term care employers, under the conditions that facilities receiving additional payments subsidize employee and family coverage at a level that increases the likelihood of enrollment (for example, subsidize 80 percent of premium for family coverage) and allow for eligibility for employee coverage for workers working at least 20 hours per week.

Participating employers may be required to contribute a fixed percentage to individual and family coverage or establish a sliding fee for employee contribution to coverage based on income. Requiring eligibility for all employees working more than a set number of hours could also increase the number of eligible workers.

The MN Department of Human Services, which is already heavily involved in the financing and regulation of long-term care services, could administer this program. Direct subsidy payments would likely require the use of state only funding, whereas administering the program as an add-on to the Medical Assistance rates paid for services, while more administratively cumbersome, would create an opportunity to obtain federal matching funds. The payment made would need to be of sufficient size so that employers choosing to participate are not placed at a disadvantage due to participating.

III. Employer Purchasing Pools

One method that would potentially make health coverage more available and affordable is the use of employer purchasing pools. These pools, in theory, allow smaller groups to gain some of the same advantages enjoyed by larger groups: the broader spreading of risk, the ability to coordinate and reduce administrative functions, and the ability to gain purchasing leverage in the market.

Theoretically, the various long-term care employers could be pooled together, and this option proposes the creation of a long-term care industry purchasing pool (either subsidized or unsubsidized) to better enable long-term care employers to purchase coverage for their employees.

In general, purchasing pools often suffer from risk selection. Healthier groups within the pool end up subsidizing the cost of coverage for less healthy groups, and these healthier groups tend to exit the pool to take advantage of cheaper rates outside the pool. Over time, voluntary pools have difficulty remaining competitive, as healthier risk leaves the pool. As a result, voluntary purchasing pools have shown little success to date. A recent study found that voluntary purchasing pools had little effect on health insurance costs for their participants.²¹

Voluntary purchasing pools, therefore, are unlikely to address the primary issues of eligibility and cost of health insurance for long-term care workers. To be effective, it is likely that a purchasing pool would need to be either: (a) heavily subsidized, to offset the cost of the risk selection and to entice healthy groups to remain in the pool, or (b) mandatory, requiring all employers to participate. A purchasing pool may be administered by the MN Department of Human Services, or by a private firm. Employer and enrollee funds would finance the pools, with additional state funds, if subsidized.

IV. Combining Subsidies to Low-Income Workers and Employers

An additional strategy to consider would combine the option of direct subsidies to low-income workers to enhance their ability to purchase coverage while subsidizing the employer to offer coverage to both part-time workers and at a level of subsidy that would make it more likely that employees and dependents would enroll. An advantage of this strategy is that it would target subsidies to low-income employees while also making coverage more broadly affordable to all long-term care workers. Assuming that a goal of efforts to increase the affordability and availability of coverage through long-term care employers is to increase the overall desirability of working in the industry, this option would further this goal.

A promising hybrid of these approaches has started to emerge. Several states, most prominently New Mexico, are examining ways to creatively use the flexibility offered under HIFA to establish “share” programs. Under these proposals, employers and employees contribute a fixed amount per month, with the State and Federal governments covering the remaining cost of coverage. For example, employers might contribute \$50 per employee per month, with the employee responsible for \$25 per month. The remaining cost of insurance would be coverage through state funds and federal Medicaid matching funds.

V. MinnesotaCare Outreach and Eligibility Expansion

All of the options presented thus far have focused on ways to enhance the availability of affordable employer-sponsored health insurance. However, given the relatively low wage structure and low levels of health insurance eligibility in the Minnesota long-term care industry, it is likely that many workers in the long-term care industry who are not eligible for coverage through a spouse are already eligible for MinnesotaCare.

In addition, if there remained concern that coverage was still unaffordable for those currently locked out of MinnesotaCare, eligibility for the MinnesotaCare program could be changed to include uninsured workers who are eligible for employer coverage and currently ineligible for MinnesotaCare because their employer subsidizes more than half the cost. This option would need to include outreach strategies for enrolling people who are already eligible for MinnesotaCare as well as those who would be newly eligible. The outreach could be conducted by the Department of Human services or by a private contractor. This option would be financed via the Health Care Access Fund as enrollment would be through MinnesotaCare.

APPENDIX A

MINN.LAWS 2000 CHAPTER 460 SEC. 64

Sec. 64. [EMPLOYEE HEALTH INSURANCE.]

The commissioner of health shall examine issues related to rising health insurance costs and shall develop recommendations for providing employer-subsidized affordable health insurance to employees of programs and facilities that serve the elderly and disabled. In conducting this study, the commissioner may also examine the affordability and availability of health insurance coverage for lower-income Minnesotans generally. In developing these recommendations, the commissioner shall consult with affected employers, consumers, and providers and may require facilities to provide information on health insurance offered to their employees, including information on eligibility, enrollment, cost and level of benefits. The commissioner shall provide recommendations by January 15, 2002, to the chairs of the house health and human services policy and finance committees and the senate health and family security committee and health and family security budget division.

APPENDIX B

SURVEY METHODOLOGY

The legislation that directed this study required the Department of Health (MDH) to examine employer-subsidized health insurance of employees of facilities that serve the elderly and disabled. As a first step, we attempted to define the universe of employers that serve the elderly and disabled, which we refer to as long-term care providers. Using data from the Department of Human Services on Medical Assistance payments and MDH data on licensed facilities, we identified approximately 3,000 employers in Minnesota who fit the definition.

We also analyzed Department of Economic Security (DES) data to ascertain the number of employees in the industry. However, despite considerable effort, the DES data did not allow us to obtain an accurate count of the number of employees in this industry. It is important to note that this is a particularly difficult universe to define which is further compounded by the fact that there is no single source of information on all the providers. The industry has experienced significant consolidation through mergers, closures and name changes that also made the universe a challenge to define. However, we believe that the sample that we constructed captured the industry as accurately as possible.

Surveys were sent to a stratified random sample of 900 employers representing home and community based care providers and institutional settings in both Greater Minnesota and the 11-county Twin Cities metropolitan area. The survey applied to employees at each physical location of business, i.e. the establishment level. The one-page survey was mailed in the Fall of 2000 and the response rate was approximately 65%. Statistical weights were developed to adjust for differences in probability of selection by provider type and geography. Due to the complex design of the survey, analysis of statistical significance was conducted using Stata software.

The survey responses analyzed in this report include 581 establishments and account for 39,000 employees. Using statistical weights, we estimate that the industry as a whole includes 181,000 employees. Based on our understanding of employment in the state and in the health care industry as a whole we believe this number represents the upper end of a range of possibilities. Depending on the definition of long-term care employees and the data source used, the number of employees can range from 77,000 to 181,000.

Due to the difficulty in establishing the population to sample, we included a question on the survey to screen for the type of clients served. Respondents were asked about the percentage of their clients who are disabled, elderly, or other. Respondents with a majority of patients in the other category were not included in analysis for this report.

The survey responses were analyzed for differences in response rates by provider type and geography and no difference was found. The possibility that survey respondents were systematically different from non-respondents (non-response bias) was also evaluated. A phone survey of non-respondents was conducted to determine whether or not non-respondents offered health insurance. No difference in likelihood of offering coverage was found between survey respondents and non-respondents. Finally, some survey responses were identified as suspect or illogical. These employers were contacted in order to clarify their survey responses. In instances where the issues could not be resolved, the responses were excluded from the analysis in this report. In total, 49 survey responses were excluded from the analysis presented in this report.

Appendix C

2000 MINNESOTA DISABILITY AND ELDERLY CARE PROVIDERS HEALTH INSURANCE SURVEY

SECTION A - General Employer Information	
1. Which of the following provider types describes your establishment? (check all that apply)	
<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Day Training & Habilitation Center
<input type="checkbox"/> Hospice	<input type="checkbox"/> Personal Care Provider
<input type="checkbox"/> Institution for Mental Disease (IMD)	<input type="checkbox"/> Approved Day Treatment Center
<input type="checkbox"/> ICF/MR	<input type="checkbox"/> Home Health Agency
<input type="checkbox"/> Rehabilitation Agency	<input type="checkbox"/> Public Health Nursing Organization
<input type="checkbox"/> Home & Community Based Service Provider	<input type="checkbox"/> Other _____
2. What is your operating budget for your current fiscal year?	\$ _____
3. How many years has your establishment been in operation?	\$ _____
4. How many permanent employees did you employ as of October 1, 2000? (excluding temporary or seasonal workers)?	Part-time _____ + Full-time _____ = Total _____
5. How many temporary or seasonal employees did you employ as of October 1, 2000?	Part-time _____ + Full-time _____ = Total _____
6. How many permanent employees earned the following hourly wage on October 1, 2000?	
Less than \$7 per hour	Part-time _____ + Full-time _____ = Total _____
Between \$7 & \$9.99 per hour	Part-time _____ + Full-time _____ = Total _____
More than \$10 per hour	Part-time _____ + Full-time _____ = Total _____
7. In the past 12 months, how many permanent employees have joined your establishment?	_____
8. In the past 12 months, how many permanent employees left your establishment?	_____
9. How many of your employees are members of a union?	_____
10. What percentage of your patients are?	Disabled _____ Elderly _____ Other _____
11. Do you offer health insurance to any of your employees? Yes___ No___ (If no, skip to SECTION C)	
SECTION B - Health Insurance Benefits	
12. Do you offer family coverage?	Yes _____ No _____
13. How many of each of the following types of plans do you offer your employees? (Definitions on opposite side of page)	
<input type="checkbox"/> A health maintenance organization (HMO)	<input type="checkbox"/> A preferred provider organization (PPO)
<input type="checkbox"/> A point of service plan (POS)	<input type="checkbox"/> A traditional indemnity plan
14. Do you require new employees to work for a certain length of time before they are eligible for health insurance?	No___ Yes___ If yes, indicate number of days _____
15. Number of permanent employees eligible for coverage on October 1, 2000?	Part-time _____ + Full-time _____ = Total _____
16. Number of permanent employees enrolled in individual coverage on October 1, 2000?	Part-time _____ + Full-time _____ = Total _____
17. Number of permanent employees enrolled in family coverage?	Part-time _____ + Full-time _____ = Total _____
18. Typical monthly premium for individual coverage?	\$ _____ % paid by employer _____
19. Typical monthly premium for family coverage?	\$ _____ % paid by employer _____
20. What was the percentage change in premiums from the previous year?	_____
21. How much is the annual deductible for individual coverage?	_____
22. How much do employees with individual coverage pay when they receive services (co-pay)?	_____
SECTION C - No Health Insurance Benefits	
23. What was the last year you offered health insurance to any employees?	Year _____ Never _____

SURVEY ID#

2000 MINNESOTA DISABILITY AND ELDERLY CARE PROVIDERS HEALTH INSURANCE SURVEY

Instructions for completing the survey:

- Please provide the contact information requested on this page and answer each of the questions on the opposite side of the page.
- All questions on this survey apply to employees at your physical location of business, i.e. your establishment, except for QUESTION #3. Where applicable, Question #3 applies to your firm, which may consist of more than one establishment.
- If you do not know the exact answer to a question, please provide an approximate answer.
- **SECTION B** If your company offers more than one plan, please answer the questions in SECTION B based on the plan with the largest number of employees from your company enrolled.
- **Question # 13.** For this question, the following definitions apply:
 - HMO - only pays for care when members receive it from a specified list or network of physicians and hospitals.
 - POS - uses a primary care physician, sometimes called a "gatekeeper", to control access to a specified network of physicians and hospitals, but leaves members free to use physicians and hospitals not in the network at a higher cost.
 - PPO - is a plan in which patients receive a list of "preferred" providers. Patients pay less when they use physicians or hospitals on the list. They remain free to seek care from a physician or hospital not on the list but they pay more.
 - Traditional Indemnity plan - this is a plan with no list of physicians or hospitals and no restrictions on choice of physicians or hospitals.
- **Question #21.** If your plan includes multiple deductibles, please provide the deductible for *physician services* provided by in-plan providers. If no deductible, please indicate zero.
- **Question #22.** If your plan includes multiple co-pays (or multiple forms of coinsurance) please provide the co-pay amount for *office visits* provided by in-plan providers. If no co-pay, please indicate zero.
- After you have completed the survey, you may wish to make a photocopy of your questionnaire for your own files. Your file copy will be an important reference in case we need to call you to clarify any of your responses.
- If you have questions about this survey or need help completing it, please contact Jennifer Gillespie, Senior Policy Analyst, Health Economics Program, Minnesota Department of Health at 651.282.6324 or jennifer.gillespie@health.state.mn.us.
- When the survey is complete, please mail your questionnaire in the enclosed self-addressed stamped envelope to:
Minnesota Department of Health - Att. Jennifer Gillespie
P.O. Box 64975
St. Paul, MN 55164-0975

PLEASE RETURN YOUR SURVEY BY NOVEMBER 3, 2000

Contact Information: Please complete this section thoroughly and accurately

Name of person completing the survey: _____

Your title: _____

Your telephone: (____) _____ Fax: (____) _____ Email: _____

ENDNOTES

¹ Robert Wood Johnson Foundation, 1996. *Chronic Care in America: A 21st Century Challenge*, Eatontown, NJ. This study found that the average range of age of caregivers nationally was 50 to 64. It was also found that by 2050, the ratio of the population in the average care giving range to the population age 85 and older is projected to decrease to 4 to 1, from 11 to 1 in 1990.

² Bureau of Labor Statistics 2000. *Occupational Outlook Handbook*. Washington, DC: US Department of Labor. For the same period, the number of home health aides is expected to increase by 75 percent and nursing assistants by 25 percent.

³ *Who Will Care For Us? Addressing the Long-Term Care Workforce Crisis*, Robyn Stone with Joshua Weiner. October 2001. The Urban Institute and the American Association of Homes and Services for the Aging.

⁴ The text of the authorizing legislation, Laws of Minnesota 2000, Chapter 460, Section 64, is included in Appendix A.

⁵ Unless otherwise noted, comparisons made to statewide health insurance figures are based on data obtained from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey. These findings were published in *Employer Based Health Insurance in Minnesota*, February 2000, Health Economics Program, MDH.

⁶ Statewide figures based on data from the Minnesota Department of Economic Security, ES 202 Data for the third quarter of 2000.

⁷ Employees in Greater Minnesota are 14 percentage points less likely to work in establishments offering coverage.

⁸ Medical Expenditure Panel Survey (MEPS) Insurance Component, 1999.

⁹ These differences in low-wage workers are statistically significant at a 95 percent confidence level.

¹⁰ Based on analysis of the 2001 Minnesota Health Access Survey, Health Economics Program, MDH, uninsurance rates for Minnesotans working less than 30 hours per week was 10 percent compared to 5 percent for those working more than 30 hours per week. Group average rates were 66 percent and 86 percent respectively. Uninsurance rates among workers with household incomes below 200% of the federal poverty level were about 18 percent compared with 5 percent overall.

¹¹ The likelihood of offering coverage increases with firm size: about 65 percent of establishments in firms with 10-49 employees and 82 percent of establishments in firms with more than 50 employees offered coverage in 1997.

¹² The dollar amounts shown reflect the average monthly premium paid by enrolled employees. The average premium available to all employees in the industry (including those who are eligible by not enrolled) is somewhat higher.

¹³ These estimates are based on health insurance claims and not workers compensation related claims. Information presented by representatives from Blue Cross Blue Shield of Minnesota to insurance coverage work group of the Long-Term Care Task Force, January 7, 2002.

¹⁴ The percentages shown reflect the average subsidy for employees enrolled in health insurance. The average subsidy available to all employees in the industry is somewhat lower, suggesting that employees faced with lower than average subsidies are less likely to enroll in coverage.

¹⁵ These figures exclude establishments that offer family coverage, but do not subsidize any portion of the premium in addition to what they contribute for individual coverage.

¹⁶ In general, take-up rates and coverage rates change slowly over time. Therefore, while this report compares 2000 long-term care employer experience with 1997 total employer experience, the comparisons are relevant.

¹⁷ The following definitions of plan types were provided in the survey.

HMO – A Health Maintenance Organization only pays for care when members receive it from a specified list or network of physicians and hospitals.

POS – Point Of Service plan uses a primary care physician, sometimes called a “gatekeeper”, to control access to a specified network of physicians and hospitals, but leaves members free to use physicians and hospitals not in the network at a higher cost.

PPO – A Preferred Provider Organization plan is a plan in which patients receive a list of “preferred” providers. Patients pay less when they use physicians or hospitals on the list. They remain free to seek care from a physician or hospital not on the list but they pay more.

Traditional Indemnity plan - this is a plan with no list of physicians or hospitals and no restrictions on choice of physicians or hospitals.

¹⁸ 2001 MN Health Access Survey, Health Economics Program, MDH.

¹⁹ 2001 MN Health Access Survey, Health Economics Program, MDH.

²⁰ Len Nichols, Urban Institute, Presentation for the State Coverage Initiatives, July 19, 2001.

²¹ Long, Steve and Marquis, Susan. “Pooled Purchasing: Who Are The Players?” *Health Affairs*, July/August 1999, pp105-111.

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