

Employer-Based Health Insurance in Minnesota: Results from the 2002 Employer Health Insurance Survey

Introduction

Employer-sponsored health insurance serves as the backbone of health insurance coverage in the United States. Approximately 71 percent of Minnesotans have private health insurance, with the vast majority of private coverage obtained through an employer.¹ Compared to the nation, a higher percentage of Minnesotans receives coverage through an employer, and a lower percentage is uninsured. Hence, monitoring trends in employer-sponsored health insurance coverage is critical to understanding how Minnesotans access health coverage.

This issue brief presents results from the 2002 Minnesota Employer Health Insurance Survey, sponsored by the Minnesota Department of Health and funded by a grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). The analysis documents trends in the availability of coverage, employee participation in coverage, and the cost and distribution of the financial burden of coverage in private establishments. The results from the 2002 survey are also compared to previous statewide employer surveys that were conducted in 1993 and 1997.²

Survey Results

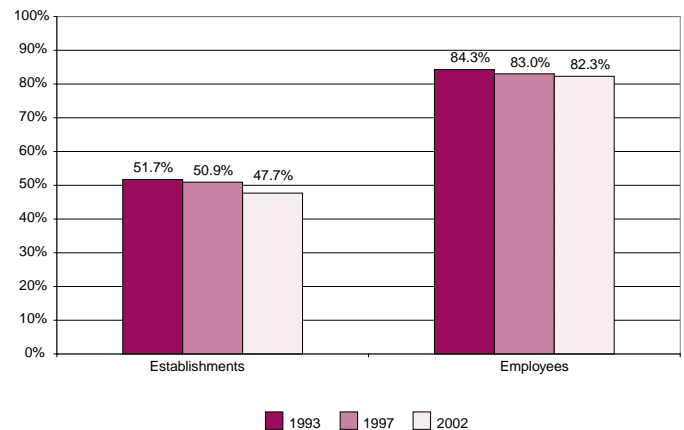
Stable Offer Rates of Coverage

In 2002, about half (48 percent) of private business establishments in Minnesota offered health insurance coverage to employees. Figure 1 illustrates that despite several years of double-digit growth in health

insurance premiums and a relatively weak economy, employers continued to offer coverage at rates comparable to 1993 and 1997 (although the figure shows a slight decline, the difference is not statistically significant). This finding of unchanged offer rates is consistent with evidence at the national level.³ We estimate that in 2002, 82 percent of Minnesota's private sector employees worked for an establishment that offered health insurance coverage (see Figure 1). This percentage has also been stable over time.

Figure 1

Minnesota Business Establishments Offering Coverage: Percent of Total Establishments and Percent of Total Employees

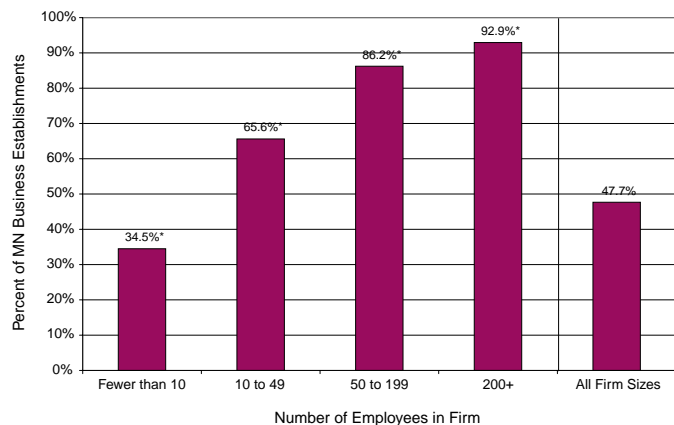


Differences across years are not statistically significant.

Figure 2 illustrates the variation in the likelihood that employers will offer health insurance coverage by firm size. Establishments in the smallest firms were the least likely to offer coverage in 2002, with only 34 percent of establishments in firms that had fewer than 10 employees offering coverage. The likelihood of offering coverage increases with firm size, with 93 percent of the largest firms offering coverage. These rates are not significantly different from offer rates by firm size reported in 1993 and 1997.⁴

Figure 2

Percent of Minnesota Employers Offering Health Insurance by Firm Size, 2002



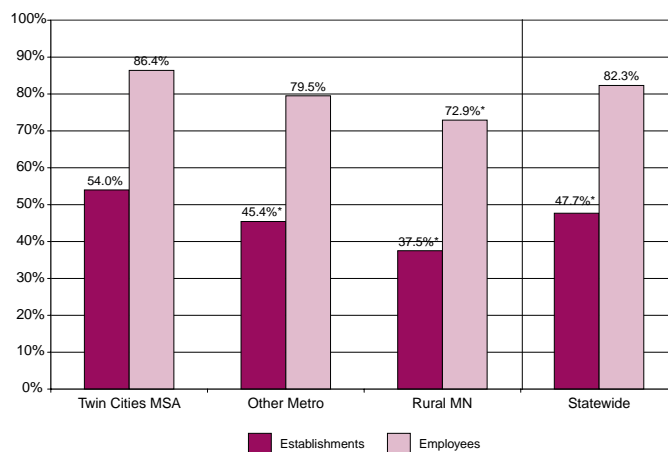
* Indicates a statistically significant difference (95% level) from the rate for all firm sizes.

Variations in the offer rate also exist at the regional level. Establishments located in the 11-county Twin Cities Metropolitan Statistical Area (MSA)⁵ are more likely to offer coverage than those in other metropolitan areas or in rural Minnesota. As shown in Figure 3, 54 percent of establishments in the Twin Cities MSA offered coverage in 2002, compared to 45 percent in the other metro areas and 38 percent in rural Minnesota. In other words, there is a 17 percentage point difference in the offer rate between establishments located in the Twin Cities MSA and in rural Minnesota. Figure 3 also shows a similar regional difference in the percentage of employees who work for a firm that offers coverage; in rural Minnesota a smaller share of employees (73 percent) work in firms that offer coverage compared to the

Twin Cities MSA (86 percent). These significant differences between the Twin Cities MSA and rural Minnesota are partly explained by the fact that, on average, establishments in the Twin Cities are larger than those in rural areas; however, labor market factors such as industry mix and competition for skilled labor also play an important role in explaining differences in health insurance offer rates. As a result, even for firms of approximately the same size, health insurance offer rates in rural Minnesota are lower than in the Twin Cities MSA. For example, 26 percent of establishments in firms with fewer than 10 employees in rural Minnesota offer coverage compared to 41 percent in the Twin Cities MSA, and 65 percent of establishments in firms with more than 10 employees offer coverage in rural Minnesota compared with 77 percent in the Twin Cities MSA.

Figure 3

Regional Variation in Health Insurance Offer Rates, 2002

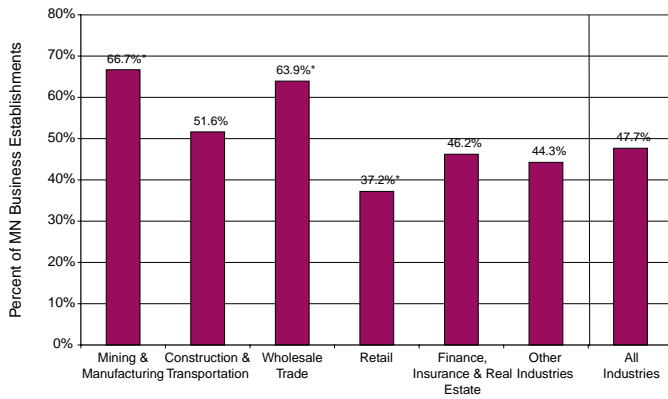


* Indicates a statistically significant difference (95% level) from the Twin Cities Metropolitan Statistical Area (MSA).

In addition to differences by region, health insurance offer rates also vary by industry. As illustrated in Figure 4, establishments in mining and manufacturing industries and in wholesale trade are most likely to offer coverage (67 percent and 64 percent respectively). In contrast, business establishments in the retail industry are the least likely to offer coverage (37 percent).

Figure 4

Health Insurance Offer Rates by Industry, 2002



* Indicates a statistically significant difference (95% level) from the rate for all industries.

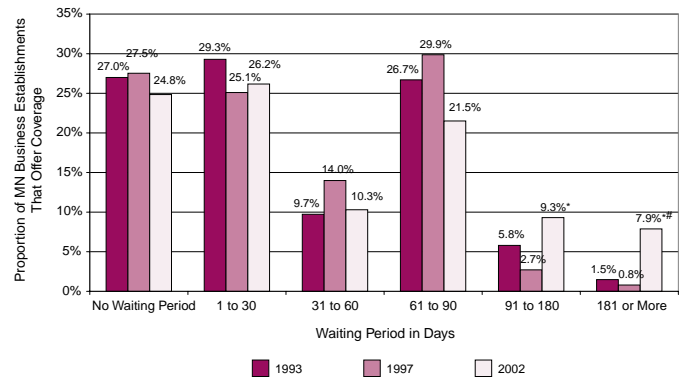
Changes in Eligibility for Health Insurance

As noted earlier, 82 percent of employees in Minnesota work for establishments that offer health insurance coverage. However, not all of these employees are eligible for coverage because employers typically require employees to work a minimum number of hours per week and/or have a waiting period before new employees are eligible for coverage. In addition, most employers do not offer coverage to temporary employees.

There were some signs in 2002 that eligibility policies used by employers had become stricter compared to 1993 and 1997. For example, Figure 5 shows a significant increase in the proportion of establishments with a waiting period longer than 90 days. In 2002, 9 percent of establishments had a waiting period of between 3 and 6 months, and 8 percent had a waiting period longer than 6 months.

Figure 5

Waiting Period Before New Employees Are Eligible for Health Insurance, 2002



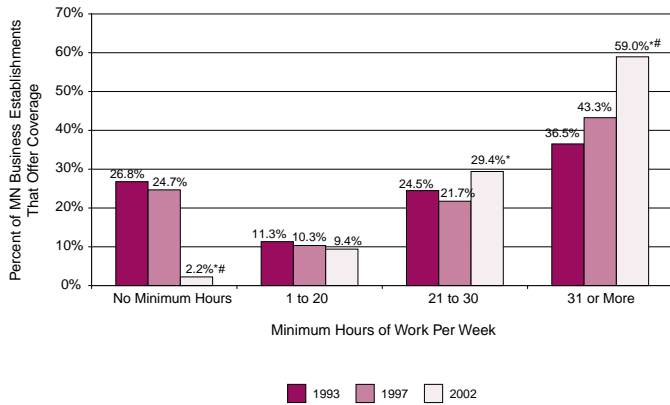
* Indicates a statistically significant difference (95% level) from previous year shown.

Indicates a statistically significant difference (95% level) between 1993 and 2002.

In addition, the proportion of establishments that require employees to work a minimum number of hours per week in order to be eligible for health insurance and the number of hours that employees are required to work has increased. Figure 6 shows that in the 1990s about one quarter of establishments (25 percent) did not require that their employees work a minimum number of hours in order to be eligible for coverage, while in 2002 only 2 percent had no minimum hour requirement. Further, in 2002 a majority of establishments offering coverage (59 percent) required employees to work more than 30 hours per week for health insurance eligibility (compared to 43 percent in 1997 and 37 percent in 1993).

Figure 6

Minimum Number of Hours Required for Health Insurance Eligibility, 2002



* Indicates statistically significant difference (95% level) from previous year shown.

Indicates a statistically significant difference (95% level) between 1993 and 2002.

Approximately 76 percent of employees who worked in establishments that offered coverage were eligible for coverage in 2002 (see Figure 7). While this estimate is lower than the rates of eligibility estimated for 1993 and 1997, the difference is not statistically significant.

Signs of Declining Takeup and Coverage

In contrast to relatively stable levels of eligibility, the percentage of eligible employees who enrolled in the coverage offered by their employer (the takeup rate) was lower in 2002 than in 1997. Figure 7 shows that 80 percent of employees eligible for coverage in 2002 took up that coverage – in other words, after increasing in the 1990s, the takeup rate has dropped back to 1993 levels (the rate in 2002 is not different at a statistically significant level from 1993). Increases in the premiums and cost sharing that employees face, discussed in more detail below, may have played a role in declining takeup.

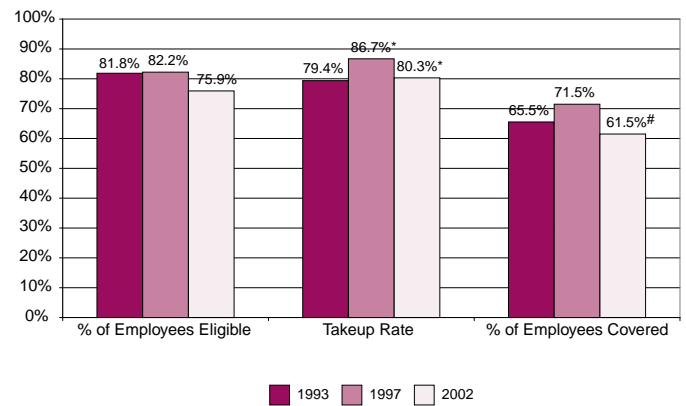
Figure 7 also illustrates the combined effect of changes in eligibility and takeup on the percent of employees in firms that offer coverage who hold

coverage through their employer’s health insurance program. In 2002, only about 61 percent of employees working in establishments that offer health insurance were covered by their own employer’s health insurance.⁶ This marks the lowest rate of coverage since 1993; while the difference between 1997 and 2002 is statistically significant, the difference between the coverage rate in 1993 and 2002 is not.

National data from employer surveys on trends in eligibility, takeup and coverage show a generally similar trend of stable eligibility and declining takeup.⁷ In addition, a recent analysis of the causes of declining rates of employer-based health insurance attributes two-thirds of the decline in employer coverage between 1999 and 2002 to declining takeup rates.⁸

Figure 7

Employees in Minnesota Establishments that Offer Health Insurance Coverage: Trends in Eligibility, Takeup and Coverage



* Indicates a significant difference (95% level) from previous year shown.

Indicates a significant difference (90% level) from previous year shown.

Figure 8 provides an overview of access and coverage for all private sector workers in Minnesota – not just workers in establishments that offer coverage. As shown in the figure, the percentage of workers with access to insurance through their own employer

declined from 68 percent in 1997 to 62 percent in 2002, and the percentage with coverage through their own employer fell from 59 percent to 50 percent; however, these changes were not statistically significant.

Figure 8

All Private Sector Employees in Minnesota - Trends in Access and Coverage, 1993 to 2002



Differences in the rates across years are not statistically significant (95% level).

There is substantial variation in access and coverage by firm size. Table 1 shows that among all employees (the rightmost columns), those working in the smallest firms have the lowest rates of access and coverage. Only 34 percent of employees in the smallest firms have access to health insurance through their own employer, in contrast to 62 percent of employees statewide and 74 percent of employees working in the largest firms.

Similarly, the percentage of employees in small firms who are covered through their own employer is less than half the level for large firms. All of this difference can be attributed to the low offer rates in small firms. As shown in the left side of the table, among firms offering coverage, employees in the smallest firms are more likely to be eligible (83 percent) and more likely to be covered (70 percent) than employees in large firms (75 percent and 61 percent respectively).

Table 1

Access, Takeup and Coverage by Firm Size, 2002

	Establishments Offering Coverage			All Establishments	
	% of Employees with Access	Takeup Rate	% of Employees Covered	% of Employees with Access	% of Employees Covered
Fewer than 10 Employees	83.0%#	83.8%	69.9%*	34.1%*	28.7%*
10 to 49 Employees	79.1%	77.1%	61.5%	55.8%	43.4%
50 to 199 Employees	73.2%	80.2%	60.0%	64.0%	52.5%
200+ Employees	74.7%	80.8%	61.0%	74.2%	60.5%
All Firm Sizes	75.9%	80.3%	61.5%	61.9%	50.1%

* Indicates a statistically significant difference (95% level) from the rate for all firm sizes.

Indicates a statistically significant difference (90% level) from the rate for all firm sizes.

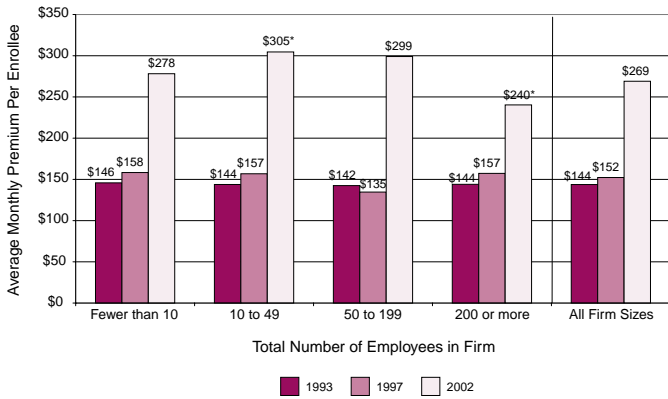
Rising Health Insurance Premiums

The trend of rising health insurance premiums in Minnesota has been apparent even to the most casual observer. Over the past several years, premiums have been growing at or near double-digit rates, and several times faster than inflation or the average worker's wages.⁹

As illustrated in Figure 9, the average monthly health insurance premium for single coverage was \$269 in Minnesota in 2002; compared to 1997, this is an average annual increase of 12 percent. The lowest increase in premium rates occurred for the largest firms (an average annual increase of 9 percent compared to 1997), while the largest increase occurred in firms with 50 to 199 employees (an average annual increase of 17 percent).

Figure 9

Average Monthly Premiums for Single Coverage by Firm Size, 1993 to 2002

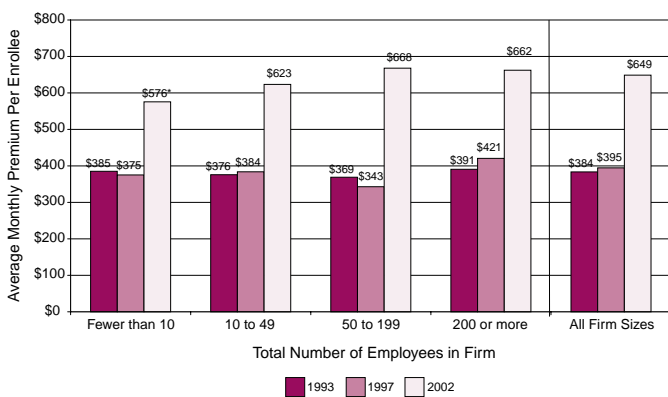


* Indicates a statistically significant difference (95% level) from average for all firm sizes.

In 2002, the average monthly premium for family coverage was \$649, an average annual increase of 10.5 percent since 1997 (see Figure 10). Establishments in firms with the fewest employees were estimated to have the lowest family premium (\$576), which is significantly lower than the average monthly premium family coverage for all firms.

Figure 10

Average Monthly Premiums for Family Coverage by Firm Size, 1993 to 2002

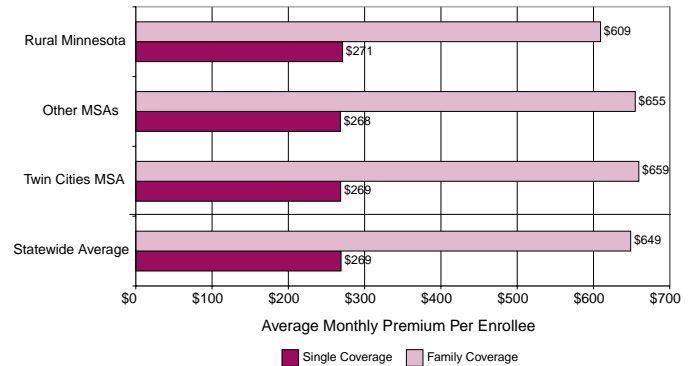


*Indicates a statistically significant difference (95% level) from average for all firm sizes.

There is little regional variation within Minnesota in the level of health insurance premiums. Figure 11 shows some difference in the family premium between rural Minnesota and the statewide average, but the difference is not statistically significant. However, findings on cost sharing discussed below demonstrate that while the cost of premiums on average does not differ across regions, on some measures the comprehensiveness of benefits does. In other words, while premiums are comparable regionally, what they purchase may differ by region.

Figure 11

Average Monthly Premiums in Minnesota for Single and Family Coverage by Region, 2002



Regional premium estimates are not significantly different from the statewide average (95% level).

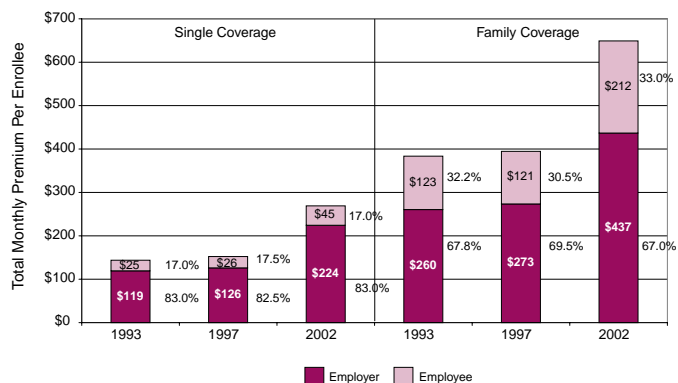
Employer/Employee Shares of Cost

One concern among observers and policy makers has been that the rising cost of health insurance could result in a significant shift of the burden of premiums from employers to employees, possibly leading to a decline in the takeup rate by employees. Alternatively, employers can change benefit sets in ways that reduce premium growth but also shift more of the responsibility for health care costs to enrollees (for example, by raising deductibles or copayments). This section examines the extent to which employers are using these strategies in response to rising costs.

As shown in Figure 12, the share of the premium paid by employees was relatively unchanged in 2002 compared to 1997 and 1993. On average, employees contributed 17 percent of the premium for single coverage and 33 percent of the premium for family coverage in 2002. While the employee share of contribution has remained stable, an observation that matches findings at the national level,¹⁰ because of the rapid growth in premiums the actual dollar amount that employees paid as their share of premiums increased substantially. In 2002, employees paid an average of \$45 per month for single coverage, which represents an increase of 71 percent compared to 1997; for family coverage, employees paid on average \$212 per month in 2002, an increase of 75 percent compared to 1997.

Figure 12

Average Employer and Employee Contribution to Premiums in Minnesota



The difference in the rate of contribution across years is not statistically significant (95% level).

While the share of contribution differs between single and family coverage, with employees paying a significantly greater share of the premium for family coverage, the rate of contribution does not differ significantly by firm size (see Figure 13). However, establishments in firms with fewer than 10 employees are more likely to fully subsidize health insurance premiums than larger firms. As shown in Figure 14, in firms with fewer than 10 employees that offer

health insurance, nearly two-thirds (64 percent) of enrollees are not required to pay anything for single coverage; this compares to 29 percent for all firms. Similarly, employees enrolled in health insurance in the smallest firms are more likely not to have to contribute to the premium for their family coverage than employees in all firms; 34 percent of enrollees in the smallest firms do not contribute to the premium, compared to 9 percent for all firms. This finding is consistent with results at the national level.

Figure 13

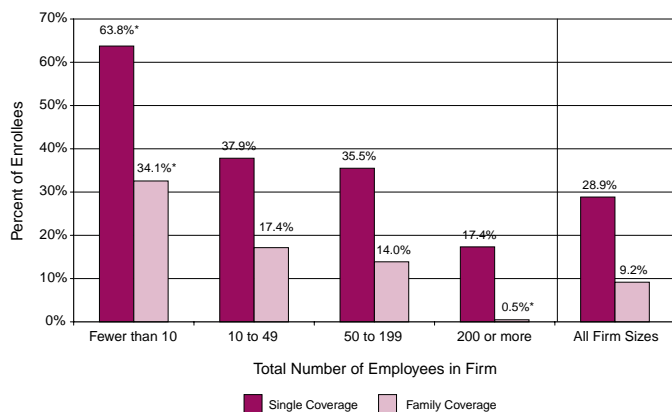
Employee Contributions to Premium by Firm Size, 2002



Employee contributions by firm size are not significantly different from the rate for all firm sizes (95% level).

Figure 14

Percent of Enrollees Whose Employer Pays 100 Percent of the Health Insurance Premium, 2002



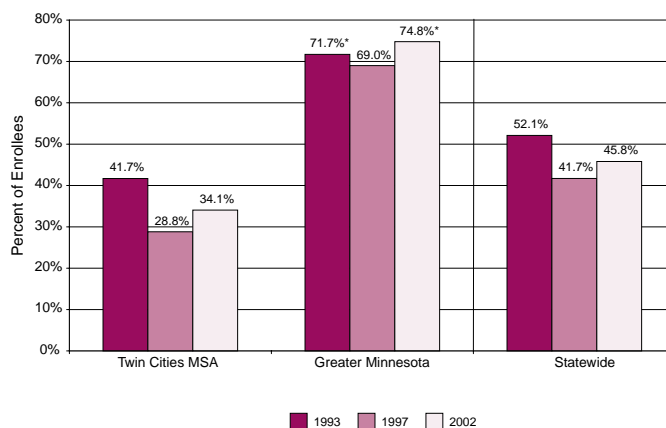
* Indicates a statistically significant difference (95% level) from the rate for all firm sizes.

In general, there are two types of enrollee out of pocket expenses. A deductible is an annual dollar amount that an enrollee is required to pay before the insurance plan covers any claims (except that preventive services are often not subject to a deductible). After the deductible is met, enrollees may also have to contribute to the cost of services through either a fixed copayment or a fixed percentage of the cost (coinsurance); the level of copayment and/or coinsurance may vary by the type of health care service provided.

In 2002, about half of covered Minnesota employees (46 percent) were in health plans that require a deductible. This rate is comparable to 1993 and 1997 and does not differ significantly by the size of the firm. However, as shown in Figure 15, at the regional level there are significant differences: in Greater Minnesota, a substantially greater proportion of enrollees is enrolled in a health plan that requires a deductible (75 percent) compared with the statewide average (46 percent) or the Twin Cities MSA (34 percent).

Figure 15

Proportion of Enrollees in a Health Plan that Requires a Deductible



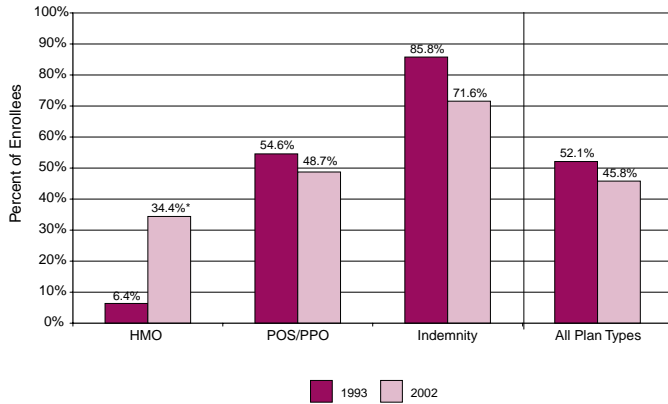
* Indicates statistically significant difference (95% level) from the statewide rate. Differences across years are not statistically significant.

A further interesting trend is the degree to which certain types of health plans require a deductible. In the early 1990s, HMOs generally required little cost sharing. In 1993, only 6 percent of employees enrolled in HMOs were required to pay a deductible. As Figure 16 shows, a decade later, one third of employees with HMO coverage were required to pay a deductible. While this represents a substantial increase relative to 1993, enrollees in indemnity plans remain more likely to face a deductible (72 percent) than enrollees in HMOs.

Among enrollees who had a deductible, the average deductible in 2002 was \$497, more than 1.5 times the level of 1997 (\$323).¹¹

Figure 16

Proportion of Enrollees in Health Plans that Require a Deductible by Plan Type, 1993 and 2002



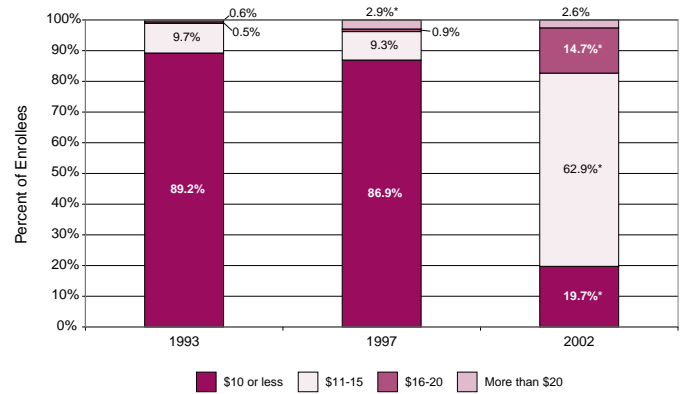
* Indicates a statistically significant difference (95%) level between 1993 and 2002.

In 2002, most Minnesota employees with employer-based coverage (86 percent) were enrolled in health plans that required some form of cost sharing at the point of service. This is comparable to 1993 and 1997, and little difference exists by region and firm size. Sixty-three percent of enrollees had a fixed copayment, another 17 percent of enrollees had a coinsurance requirement, and 6 percent faced both coinsurance and copayment.

Copayments increased significantly between 1997 and 2002. On average, enrollees who had a copayment requirement for a physician visit paid \$15 in 2002, compared to \$10 in 1993 and 1997. As shown in Figure 17, the distribution of copayments has changed over time. In 2002, most enrollees faced copayments between \$11 and \$15 (63 percent), with a much smaller share (20 percent) paying the copayments of \$10 or less that were common in the 1990s. In contrast to the trend in copayments, the level of coinsurance, where applicable, has remained largely unchanged and remains mostly at 20 percent.

Figure 17

Distribution of Copayments for a Doctor Visit, 1993 to 2002



* Indicates a statistically significant difference (95% level) in the distribution compared to previous year shown.

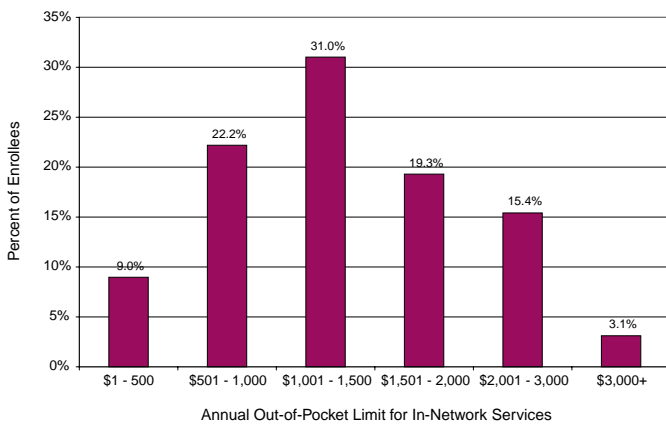
Note: Chart includes only enrollees in plans that require copayments. For PPO and POS plans, refers to copayment for in-network services.

Increasingly, enrollees in employer-based coverage also face deductibles or copayments that vary by service type. For example, many enrollees have a separate deductible or copayment for hospitalizations or for prescription drugs.

While this issue brief has documented some increase in deductibles and copayments, the data for 2002 show no increase in the average maximum amount of health care cost that employees are responsible for – the out-of-pocket limit. Virtually all employees with employer-based coverage have an out-of-pocket limit (95 percent). Figure 18 shows that in 2002 most enrollees had an out-of-pocket limit for individual coverage and in-plan usage between \$500 and \$1,500 (53 percent). Combining the categories, 62 percent of enrollees with cost sharing would have been required to pay no more than \$1,500; however, the remaining 38 percent had an out-of-pocket limit higher than \$1,500. In general, the out-of-pocket limit does not vary by region and is also fairly consistent across firm sizes and type of health plan. One exception is the average out-of-pocket limit for enrollees in HMOs, which was significantly higher than the statewide average (\$1,995 compared to \$1,606).

Figure 18

Out-Of-Pocket Limits for Single Coverage, 2002



Summary

This issue brief identifies important ways in which the system of employer-sponsored health insurance has responded to changes in the health care marketplace:

- Health insurance offer rates among Minnesota establishments remain stable; however, there continue to be significant differences in offer rates by firm size and region.
- Some establishments have implemented longer waiting periods and are requiring that employees work longer hours in order to be eligible for health insurance coverage.
- Participation by Minnesota employees in their employer’s health insurance program has declined to levels of the early 1990s. This translates into lower rates of coverage among employees who work for firms that offer health insurance.
- Statewide, the percentage of employees with access and coverage through their own employer also appears to have declined, although this change was not statistically significant.

- The cost of health insurance coverage has increased significantly. Between 1997 and 2002, the average annual growth of premiums was 17 percent for single coverage and 10.5 percent for family coverage.
- While the actual dollar amount of the premium for which employees are responsible has increased significantly, the share of the premium that Minnesota employees pay on average has been stable.
- Consistent with national trends, there is also evidence of increases in enrollee cost sharing in 2002 compared to 1997. The level of deductibles and copayments has increased over the past several years.

In summary, while it is encouraging that the share of the premium paid by employees has remained constant despite double-digit increases in premium growth, the rise in the amount of the premium, the evidence of increase enrollee cost sharing, and the decline in takeup rates give cause for concern about the impact of rising costs on Minnesota’s historically strong system of employer-based health insurance. It will be important to monitor these trends and their impact on health insurance coverage and costs in Minnesota.

Appendix: Methods and Data

Results presented in this issue brief are based on data from the 2002 Minnesota Employer Health Insurance Survey, which was a telephone survey of 2,287 Minnesota employers who were selected from a random sample of private (non-agricultural) business establishments. The sample was stratified by establishment size and region and was drawn from the state’s unemployment insurance files (ES-202)¹²; the telephone survey had a response rate of approximately 65 percent.

Because establishments in the sample were chosen randomly, statistical weights can be used to generalize results to the state overall and by firm size and region. The weighting strategy in 2002 varied slightly from methods used in previous years. Data from 1993 and 1997 were re-weighted to match the 2002 approach; in some instances, this produced results that differ slightly from previously published analysis.

In preparing the data for analysis, we used imputation techniques to minimize the bias from missing or flawed data. Imputation was used most extensively for the calculation of single and family premium, and employer contribution to health insurance premium.

Finally, to account for the complex sample design features of this and previous Minnesota employer surveys, we analyzed the data using the statistical software package Stata, version 8.0.

Endnotes

¹ Minnesota Department of Health, Health Economics Program, “2002 Minnesota Distribution of Insurance Coverage,” April 2004.

² Data presented for the years 1993 and 1997 are from the Robert Wood Johnson Foundation’s Employer Health Insurance Surveys.

³ The Kaiser Family Foundation and Health Research and Educational Trust, “Employer Health Benefits: 2004 Annual Survey,” September 2004.

⁴ Minnesota Department of Health, Health Economics Program, “Employer-Based Health Insurance in Minnesota,” February 2000.

⁵ The Twin Cities MSA includes the following Minnesota counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. The “other metro” area includes St. Louis, Houston, Clay, Olmsted, Benton, and Stearns counties. The remaining 70 counties comprise the rural Minnesota region.

⁶ This survey only measures the rate at which employees obtain coverage through their own employer. Many people who do not have coverage through their own employer are covered through the employer of a spouse. Analysis of other data suggests that about 16 percent of employees who do not have coverage through their own employer have employer-based coverage through a family member. (Minnesota Department of Health, unpublished analysis from the 2001 Minnesota Health Access Survey.)

⁷ Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey Insurance Component and The Kaiser Family Foundation and Health Research and Educational Trust annual employer surveys. The decline in takeup observed in the KFF/HRET survey is smaller and more recent, and limited to firms with fewer than 200 employees.

⁸ Linda J. Blumberg and John Holahan, “Work, Offers, and Take-Up: Decomposing the Source of Recent Declines in Employer-Sponsored Insurance,” Health Policy Online, The Urban Institute, May 17, 2004.

⁹ Minnesota Department of Health, Health Economics program, “2003 Health Insurance Premiums and Cost Drivers,” August 2004.

¹⁰ The Kaiser Family Foundation and Health Research and Educational Trust, “Employer Health Benefits: 2002,” p. 76

¹¹ Unfortunately, data from the 2002 Minnesota Employer Health Insurance Survey does not allow precise disaggregated estimates.

¹² Unlike in 2002 and 1993, the sample for the 1997 survey was drawn from a listing of the nation’s employers, the Dun’s Market Identifiers (DMI) file compiled by the Dun & Bradstreet corporation.

The Health Economics Program conducts research and applied policy analysis to monitor changes in the health care marketplace; to understand factors influencing health care cost, quality and access; and to provide technical assistance in the development of state health care policy.

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