Division of Health Services Research and Policy

Research Brief

We are pleased to provide you with this summary of recent research by our faculty and staff, in keeping with our commitment to disseminate research findings to leaders in the field. We hope that you and your colleagues find this to be of interest.
–Roger Feldman, Ph.D., acting division head

Health Insurance Coverage in Minnesota from 2001 to 2004

Kathleen Thiede Call, Ph.D. and Jeanette Ziegenfuss

For the last fifteen years, health insurance coverage rates in Minnesota have been high and relatively stable. The 2004 Minnesota Health Access (MNHA) survey indicates that this is changing. The rate of uninsurance rose from 5.4% in 2001 to 6.7% in 2004, marking the first significant increase since Minnesota first began conducting its own surveys of health insurance coverage (the MNHA has been conducted five times since 1990). This research brief summarizes the results of the most recent survey and presents key comparisons between the 2001 and 2004 MNHA surveys.

Data and Methods

The 2004 MNHA survey was a stratified statewide random digit dial telephone survey, over-sampling minority and rural populations. The survey was conducted in English, Hmong, Somali and Spanish. The survey was in the field from July to December 2004, and achieved a response rate of 59% (AAPOR RR4) (The American Association for Public Opinion Research 2004) with a total sample size of 13,802. The sample design mimics that of the 2001 MNHA survey, which had a response rate of 65% and a total sample size of 27,315. The 2001 survey was conducted in English, Hmong and Spanish.

Trends in Minnesotan's coverage

The survey revealed that 77,000 more Minnesotans were uninsured in 2004 than in 2001. Using a point in time estimate of uninsurance, 343,000 (6.7%) Minnesotans were without insurance in 2004. This compares to 266,000 (5.4%) in 2001. This increase was witnessed statewide. Growth in the rate of uninsurance appears to be attributable to several factors: a loss of access to employer coverage, increased levels of poverty, and changes in the composition of Minnesota's Hispanic/Latino population. There was a dramatic increase in the rate of uninsurance among Hispanic/Latinos in Minnesota with the rate almost doubling over the three-year period (from 17.3% in 2001 to 32.7% in 2004).

Consistent with trends at the national level (US Census Bureau, Current Population Survey 2004), the increase in rate of uninsurance was accompanied by a shift away from employer-sponsored insurance. We observed a statistically significant decrease in the proportion of the population covered by employer sponsored insurance (from 69.6% in 2001 to 63.4% in 2004) and a significant increase in public coverage (from 20.1% to 25.2%). The same pattern holds when we consider only the population less than 65 years of age. Among those under age 65, the decrease in employer-sponsored insurance was from 78.3% to 72.2% and the increase in public coverage was from 10.2% to 14.8% between 2001 and 2004. As will be described in more detail below, this increase in public insurance coverage can be partially explained by increases in the proportion eligible for coverage given a shift in Minnesota's income distribution over the three-year period.

Although we saw an increase in the rate of uninsurance across each age group, the only significant increase was among 25-34 year olds, growing from 9.1% in 2001 to 13.1% in 2004. Similar to national surveys of health insurance coverage (US Census Bureau, Current Population Survey 2004), the age group with the highest rate of uninsurance in Minnesota was 18-24 year olds (13.8% in 2001 and 17.3% in 2004). The good news is that uninsurance rates remained low and stable among Minnesota's children (4.4% in 2001 and 5.3% in 2004).

Making sense of increased rates of uninsurance

The shift away from employer-sponsored coverage was not due to a change in the take-up patterns of individuals offered insurance through an employer (either their own or a family member's employer). The take-up rate of those eligible for employer-sponsored insurance remained constant over this time period (95.7% in 2001 and 95.3% in 2004). What did change was the proportion of Minnesotans who work for an employer or have a family member working for an employer that offered coverage (84.8% in 2001 compared to 81.1% in 2004), and the proportion of those offered who were eligible for this coverage (down from 97.8% in 2001 to 95.9% in 2004).

Although the survey did not measure industry of employment directly, changes in the employment market were likely responsible for the decrease in access to employer-sponsored insurance. For example, the proportion of workers in manufacturing as a percent of total employment decreased in all economic development regions in Minnesota over the same time period (Minnesota Department of Employment and Economic

continued

Development 2004)[1]. The manufacturing industry has traditionally had high offer rates of health insurance coverage. From the survey itself, we have some indication that the employer market changed over this time period. We observed a statistically significant decrease in the proportion of the population that work for large firms (501 or more employees) that are most likely to offer health insurance benefits, from 41.3% in 2001 to 39.5% in 2004. There was observed a simultaneous increase in the proportion of Minnesotans who work for mid-size firms (51-100 employees) that are less likely to offer health benefits, from 7.9% to 10.4%.

The observed increase in public health insurance coverage was likely due to a change in the income distribution in Minnesota; a greater proportion of the state's population were of low income and were therefore eligible for these programs. In 2004, 24.9% of Minnesotans were at or below 200% of the Federal Poverty Level (FPL), which is significantly higher than 20.6% of Minnesotans at this level in 2001. Further, the proportion of the population in the highest income group (over 400% of FPL) decreased significantly from 42.4% in 2001 to 38.2% in 2004. The only income category that witnessed a significant increase in the rate of uninsurance was among those at or below 100% of the FPL (growing from 13.8% to 19.9% over the three-year period). Following from this we saw an increase in the percentage of uninsured Minnesotans who were potentially eligible, but not enrolled, in public programs (from 49.7% of the uninsured in 2001 to 58.1% in 2004). The shift toward the lower end of the income distribution for the population at large, and the uninsured population specifically, does not appear to be due to employment status. The proportion that reported being employed remained stable among all Minnesotans (at approximately 76%) and among uninsured Minnesotans between 2001 and 2004 (73.2% and 72.2% respectively).

Disparities in insurance coverage

In both years, there were gaps in insurance coverage among racial and ethnic groups in Minnesota. Although Whites in Minnesota saw a significant increase the rate of uninsurance (from 4.5% in 2001 to 5.4% in 2004), they consistently enjoy the lowest rates of uninsurance. The 2004 uninsurance rate for Blacks was 11.9%, 8.4% for Asians, and 5.3% for American Indians. Although the rate of uninsurance was higher for all racial and ethnic communities than Whites in 2004, for the most part, coverage gaps did not increase. Over the three-year period, the rate of uninsurance for Blacks, Asians and American Indians was stable. The exception is for Hispanic/Latinos, where we witnessed an increase in both the rate of uninsurance and the disparity when compare to Whites. The uninsurance rate for individuals reporting Hispanic/Latino ethnicity alone or in combination with another race or ethnicity increased from 17.3% in 2001 to 32.7% in 2004.

[1] EDR2, the Headwaters Region is an exception. The Minnesota Department of Employment and Economic Development did not report manufacturing in this region in 2001.

Using available data, we attempt to make sense of this dramatic decrease in health insurance coverage among the Hispanic/Latino population. Not only has the rate of uninsurance among Hispanics increased over this time period, but also the population itself has grown significantly (U.S. Census Bureau, Population Division. 2005). Combined with the relative increase in the size of this population in Minnesota over this same time period, the change in the Hispanic uninsurance rate was a significant contributor to the overall increase in uninsurance observed in the state, accounting for 44% of the total increase in the number of people uninsured. In 2001 there was an estimated 26,000 uninsured Hispanics in the state. This increased by 34,000 to 60,000 in 2004.

Earlier, we described the statewide decrease in employer-sponsored insurance between 2001 and 2004. This trend was magnified in the Hispanic population. Between 2001 and 2004 the proportion of the Hispanic/Latino population covered by employer-sponsored insurance fell from 60.1% to 36.1%. Although there was an increase in the proportion of this population covered by public health care programs (from 19.3% to 29.7%), many more joined the ranks of the uninsured. Again, consistent with the Minnesota population at large, the decrease in employer-sponsored insurance was not due to a decrease in the rate of employment. In 2001, 77.0% of Hispanic/Latinos in Minnesota were employed, which is statistically similar to the 74.6% employed in 2004. Furthermore, employment among the uninsured Hispanic/Latino population remained constant (71.4% in 2001 and 75.0% in 2004).

Among Hispanic/Latinos, there was a decrease in the proportion that report that their employer or a family member's employer offers health insurance to some employees. This decrease was more dramatic for the Hispanic/Latino population than for Minnesotans overall. In 2001, 75.3% of employed Hispanic/Latinos worked for an employer who offered coverage to some employees. This decreased to 56.1% of the population in 2004. Of those who were offered coverage, eligibility rates remained constant (95.3% in 2001 and 90.9% in 2004). However, the take-up rate among those eligible decreased significantly from 90.2% in 2001 to 72.2% in 2004. As described below, this decline in the take-up of employer offers of coverage is likely related to their economic circumstances.

The Hispanic/Latino population in Minnesota changed over the three-year period of time. Like all Minnesotans, Hispanic/Latino Minnesotans were more likely to be poor in 2004 than 2001; however, this shift in the income distribution was much more pronounced (17.6% of Hispanic/Latinos had incomes below 100% of the FPL in 2001 as compared to 37.8% in 2004). This trend was also documented among uninsured Hispanic/Latinos. In 2001, 31.2% of uninsured Hispanic/Latinos lived below 100% of the FPL, compared to 55.6% in 2004.

We observed other changes in the composition of the Hispanic/Latino community in Minnesota over the past three years. For example, Hispanic/Latinos were less likely to be born in the United States in 2004 than 2001 (30.9% in 2001 as

continued

compared to 52.1% in 2004). Since 2001, there was also a shift in the proportion of the Hispanic/Latino community who had lived in Minnesota for a longer period of time. In 2001, 45.7% of Hispanic/Latinos in Minnesota had been in the state for ten years or more. In 2004, this proportion was 32.2% of the Hispanic/Latino population. The percentage of the Hispanic/ Latino population that reported living in the state for two to four years increased from 13.2% to 24.4%. This could indicate a lack of familiarity with Minnesota's health care system.

Conclusion

Minnesota witnessed the first significant change in uninsurance in fifteen years. Using data from the 2001 and 2004 MNHA surveys, we observed an increase in public coverage driven by increased poverty in the state. There has been a parallel decrease in employer-sponsored insurance. This shift was not due to a decrease in the proportion of the state that is working. Instead, we observed fewer employees working for firms that offer coverage and fewer of those employees being deemed eligible. This is likely attributable to the increase in proportion of Minnesotans working in midsize firms (51-100) as compared to large employers (more than 500 employees), and the accompanying loss of manufacturing jobs in the state over the same period of time.

Disparities in racial and ethnic insurance coverage remain. We observe a significant increase in the rates of uninsurance for the White and Hispanic/Latino populations. The increase of uninsurance for Hispanic/Latinos in Minnesota was the most dramatic. Many of the trends highlighted above for the Minnesota population as a whole are present but more severe for the Hispanic/Latino population. Further, we observed important changes in the demographic characteristics of the Hispanic population in the state (a decrease in the proportion who are US born, and an increase in those relatively new to Minnesota).

These trends do not bode well for Minnesotans. Health insurance is a key indicator of access to health care in the U.S. Those lacking health insurance are less likely to have a usual source of medical care, are more likely to face difficulty obtaining care when needed, and are in worse health than those with health insurance. The public health mantra advises that prevention is cheaper than treatment, yet those without health insurance often cannot afford to be prevention minded. There is a role for both public health care programs and employers in encouraging greater access to health insurance coverage.

Acknowledgements

This study was funded by the Blue Cross and Blue Shield of Minnesota Foundation, the Minnesota Department of Human Services, and by a grant awarded to the Health Economics Program at the Minnesota Department of Health from the federal Health Resources and Services Administration State Planning Grants Program. Translation of the survey into Hmong and Somali was funded by the Hennepin County Community Health Department. Survey work was conducted in collaboration with the Center for Survey Research in Public Health at the University of Minnesota School of Public Health.

References

1. The American Association for Public Opinion Research. 2004. *Standard definitions: Final dispositions of case codes and outcome rates for surveys. 3rd edition*. Lenexa, Kansas: AAPOR. Available at: http://www.aapor.org/pdfs/standarddefs_3.1.pdf
2. Minnesota Department of Employment and Economic Development. 2004. Labor market information. Available at: http://www.deed.state.mn.us/lmi/Home.htm
3. US Census Bureau, Current Population Survey. 2004. *Historic health insurance tables*. Current Population Survey, 1988 to 2004 Annual Social and Economic Supplements. Available at: http://www.census.gov/hhes/www/hlthins/historic/index.html
4. U.S. Census Bureau, Population Division. 2005. *Population estimates: State population datasets.* Available at: http://www.census.gov/popest/datasets.html