

INSTITUTE FOR HEALTH POLICY SOLUTIONS

MinnesotaCare and “Crowding-Out”

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Title XXI requires that states establish measures to prevent the replacement of private coverage under group plans with coverage under public plans. In order to meet this requirement, some states have enacted restrictions to entry into their state child health insurance programs known as “firewalls.” This document will review the firewall provisions of MinnesotaCare, the state of Minnesota’s program which makes health insurance available to low-income uninsured Minnesotans who do not qualify for Medicaid (although certain Medicaid eligibles may opt to enroll in MinnesotaCare). It will also consider the extent to which these firewall policies were successful in preventing the “crowding-out” of private group coverage.

The Minnesota example is useful to consider because the program is often pointed to as an example of an expansive state initiative that has not experienced any significant crowd-out. The program, however, includes very stringent eligibility requirements intended to prevent crowd-out and it is important to consider the manner in which these firewalls were established and evaluated before concluding either that they were effective or that they were unnecessary.

Under MinnesotaCare, health insurance is provided through contracting health plans to families (including adults) with income below 275% of the federal poverty level (FPL). Minnesota’s Medicaid program covers pregnant women and children under age 2 with income below 275% FPL; children under age 5 in families with income below 133% FPL; and older children below poverty. Pregnant women and children eligible for both programs may elect to enroll in either one. Adults with very low income, on the other hand, must apply for the Medicaid program when it appears they may be eligible.¹ (MinnesotaCare expenditures qualify for federal matching funds pursuant to a Section 1115 (of the Social Security Act) Comprehensive Demonstration Waiver.)

Families enrolled in MinnesotaCare must contribute a fixed percentage of gross family income for coverage. The percentage ranges from 1.5% for the lowest income families to 8.8% for families at the upper end of the income scale. Children in families with income at or below 150% of poverty who have elected to participate in the MinnesotaCare program rather than Medicaid, however, pay a minimum premium of \$4 per month per child.¹

MinnesotaCare’s eligibility requirements include a number of provisions intended to minimize “crowd-out” of private employer-sponsored insurance coverage. Applicants are not eligible for MinnesotaCare if (a) they had any form of health coverage in the four months prior to application, or (b) they currently have access to employer-subsidized coverage or have had such access during the eighteen months prior to application. This provision, in effect, establishes an 18 month waiting or uninsured period for someone with access to employer based coverage. Employer-subsidized coverage is defined as a plan under which the employer

¹ Communication with Patricia Callaghan, Health Care Director, Minnesota Department of Human Services

pays at least 50% of the cost of coverage for the employee and dependents.² These firewall provisions do not apply if employer coverage is lost because of death, disability, or termination of employment (for reasons that would not disqualify the individual from unemployment benefits). However, they do apply if coverage is lost because the employer terminates the health insurance benefit. The restrictions are not applied to children in families with income at or below 150% of federal poverty.³

As stated above, for those who have had employer-sponsored coverage or access to it, MinnesotaCare requires a minimum uninsured period of eighteen months. In implementing this provision, the state looks retrospectively at the applicant's access to coverage and the length of time he/she has been without coverage and may deny enrollment based on these criteria. Many of those denied enrollment, however, may not, at the time of application, have access to an employer plan. For example, a child may be excluded if the parent has voluntarily moved from an employer that offers dependent coverage to one that does not. More significantly, a child may be excluded if the employer eliminates dependent coverage or reduces its premium contribution. The policy was developed in order to discourage employers from altering their plans in an attempt to take advantage of the availability of MinnesotaCare. However, whether or not the provision is actually working to achieve that result is uncertain.⁴

In a study designed to evaluate the effectiveness of the MinnesotaCare program in serving its target population, Kathleen Thiede Call and colleagues provide insight into whether the firewalls described above were successful in reducing the incidence of "crowd out."⁵ The researchers conducted three cross-sectional telephone surveys. Two of the surveys, conducted in 1990 and 1995, were random samples of Minnesotans of all ages and were designed to describe changes in rates of uninsurance in Minnesota. The third survey, conducted in 1994, was a random telephone survey of 800 MinnesotaCare enrollees who were enrolled in the program in mid-1994. The findings of the survey of enrollees are often cited during discussion of crowd-out. Call and her colleagues found that 7.1% of the respondents reported substituting the MinnesotaCare program for existing private coverage. Of these respondents, approximately 3% reported dropping employer-sponsored health insurance and 4% reported dropping individual coverage in order to enroll in the MinnesotaCare program. This very low level has been heralded as indication that the program has led neither to a misuse of the system nor an erosion of the private market.⁶

Those who argue that crowd-out is not an issue of great concern cite the findings of Call and her colleagues to support their position. They point to the MinnesotaCare program as an example of an expansive state health insurance program that has not encountered any significant crowd out. They also argue that other states should not be concerned about crowd-out and firewalls and other provisions to coordinate with employer coverage may not be needed. The possibility that the stringent firewalls described above led to the low crowd-out seems not to be considered.

² Communication with Patricia Callaghan, Health Care Director, Minnesota Department of Human Services

³ Overview of MinnesotaCare program taken from Merlis, Mark. "Employer Coverage and the Children's Health Insurance Program Under the Balanced Budget Act of 1997: Options for States." Institute for Health Policy Solutions. Washington, DC. September, 1997.

⁴ Call KT, Lurie N, Jonk Y, Feldman R, Finch MD. Who is still uninsured in Minnesota? Journal of the American Medical Association 278:1191-1195. October 9, 1997.

⁵ *ibid.*

⁶ *ibid.*

Others argue that crowd-out is a potentially serious threat to the private system of employer based health insurance that must be addressed. These groups point to the MinnesotaCare firewalls as examples of the types of policies required to prevent crowd-out and use the low crowd-out findings as proof that these barriers are effective. Such conclusions, however, may be premature. The study had limitations and the findings should be considered with some caution. For example, the findings are likely to be biased in the direction of lower reported crowd-out. Because survey respondents were current program beneficiaries, those who had other coverage available would be reluctant to admit to receiving benefits for a program for which they were ineligible. (Applicants are asked about their coverage status when applying for the program.) Further, the study does not address the length of waiting periods or the effectiveness of alternative eligibility policies. Without more information, establishing long waiting periods based on the Minnesota example may undermine the goal of such state reforms – to expand insurance coverage for needy populations. Finally, the survey attempts to measure the extent of crowd-out but does not consider the level of crowd-out that would have occurred without the firewall provisions. Without knowing that the firewalls actually prevented some people from enrolling makes it difficult to assume that the firewalls caused the low level of crowd-out.

Although groups on both sides of the debate have used the finding of 7.1% crowd-out to bolster their position, the available evidence does not strongly support either view. While we believe that policies designed to avoid unnecessary crowd-out are important to help ensure optimum use of funds to cover the maximum number of uninsured children in both the short and long term, it is important to find a balance so that rules are set so income eligible children who would otherwise be uninsured are able to obtain coverage.

Questions and comments can be directed to: Jennifer Sexton, 202/857-0810 ext. 101

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