Fact Sheet

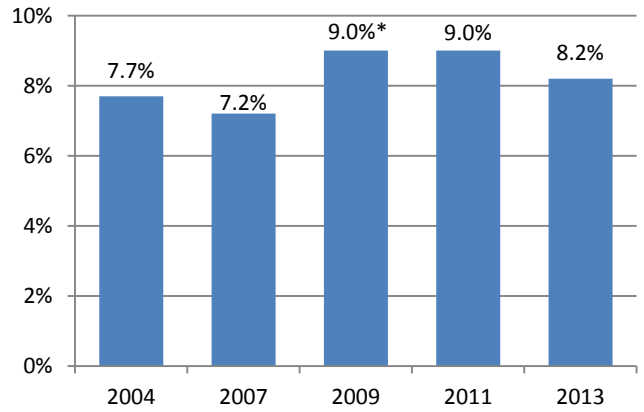
Update May 2014

Health Insurance Coverage in Minnesota: Results from the 2013 Minnesota Health Access Survey

The Minnesota Department of Health (MDH) and the University of Minnesota, School of Public Health's State Health Access Data Assistance Center (SHADAC) regularly conduct statewide population surveys to study trends in health insurance coverage and access to health care in Minnesota. This fact sheet provides results from the 2013 Minnesota Health Access Survey (MNHA) and compares those findings to surveys conducted in previous years.[1] The 2013 MNHA was conducted in the midst of a slow recovery from a major economic recession and just before implementation of major provisions of the Affordable Care Act (ACA) which have the potential to significantly affect availability and take-up of health insurance coverage in Minnesota.[2]

The results presented in this issue brief differ from the February 2014 release, as they include trimmed weights for 2009 and 2011 data and use a more accurate income measure for calculating potential eligibility for public programs.

Figure 1
Trends in the Rate of Uninsurance in Minnesota

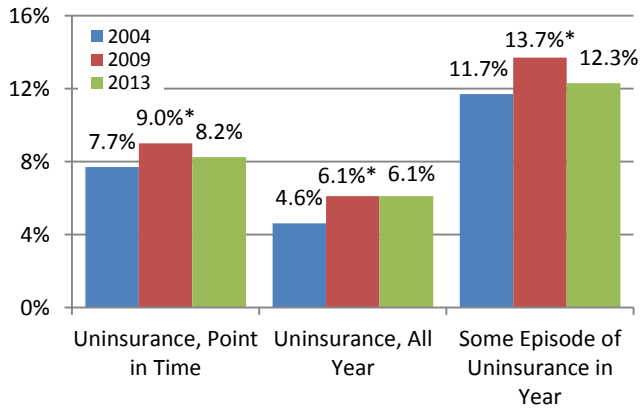


*Indicates statistically different from previous year shown at the 95% level

Minnesota saw a modest decrease in uninsurance in 2013, to 8.2%. This change in the uninsurance rate is not statistically different from the 2011 rate of 9.0%, but it marks modest movement in the right direction (Figure 1).[3] MDH estimates there were approximately 445,000 Minnesotans without health insurance in 2013, compared to 490,000 in 2011.

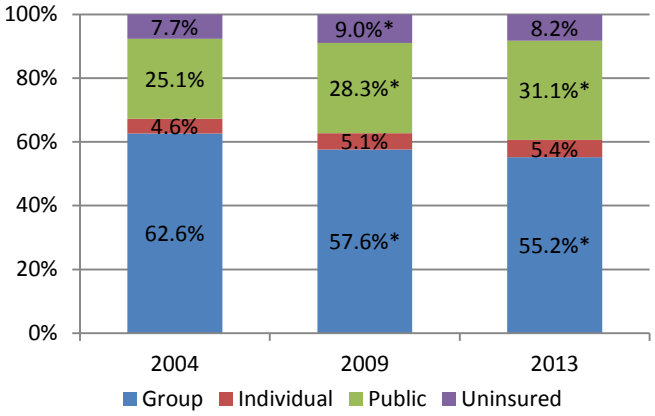
The measure of uninsurance displayed in Figure 1 is the point-in-time rate, which represents the number of people who were uninsured at the point in time at which the survey was conducted. Other typical ways to monitor changes in health insurance coverage include analyzing the share of the population that was uninsured all year (or longer) – the long-term uninsured – and the percent of the population who had an episode of uninsurance in the past year – people who experienced a gap in coverage. As shown in Figure 2, about 6.1% of Minnesotans were long-term uninsured in 2013. This rate had spiked in 2009 and has remained unchanged since then. When measuring long-term

Figure 2
Alternative Measures of Uninsurance in Minnesota



* Indicates statistically different from previous year shown at the 95% level

Figure 3
Sources of Health Insurance Coverage in Minnesota



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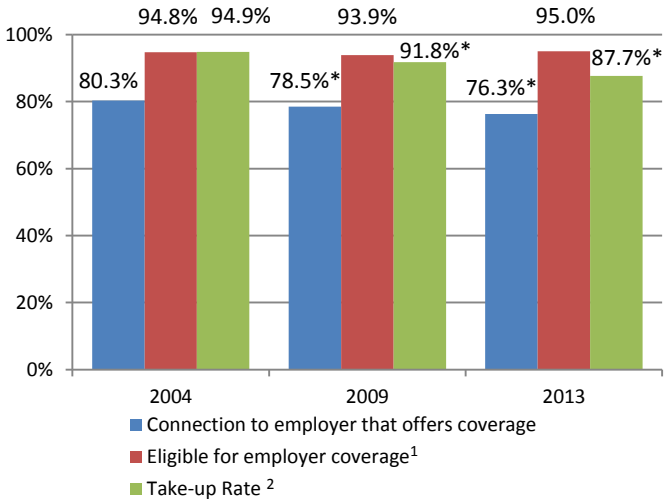
uninsurance as well as people with shorter gaps in coverage, 12.3%, or one in eight Minnesotans, experienced some episode of uninsurance in 2013. This reflects a decline compared to 2009, though it is not statistically significant.

One of the primary factors in Minnesota's historically low rate of uninsurance, as compared to national estimates, has been robust coverage by employers. That source of coverage in Minnesota, as well as nationally, has declined over the past decade, to a rate of 55.2% in 2013 (Figure 3). The decline in employer-based coverage in 2013 was more than offset by growth in public program coverage, which includes coverage through Medical Assistance (Medicaid), MinnesotaCare and Medicare; rates of coverage through public programs increased from 28.3% in 2009 to 31.1% in 2013.[4] There are a number of factors which contributed to the rise in public coverage, including an increase in the population eligible for Medicare as well as ongoing implementation of the Medicaid expansion for single adults with incomes below 75% of the Federal Poverty Guidelines (FPG).[5] Coverage in the individual market continued to account for a small and stable share of the population (5.4%). With provisions of federal health reform legislation taking effect in January 2014, many analysts anticipate increases in the share of Minnesotans who obtain health insurance through the individual market.[6]

The importance of employer-provided insurance coverage appears to be declining in Minnesota, as

Figure 4
Trends in Employer Sponsored Health Insurance Coverage
(Minnesota's Non-elderly Population)

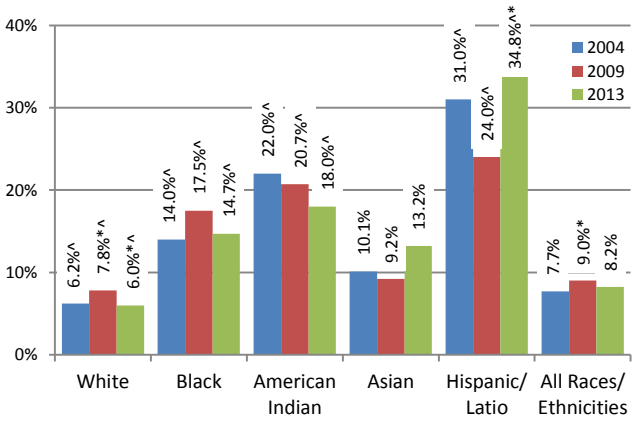


* Indicates statistically different from previous year shown at the 95% level
[1] Among people with a connection to an employer that offers coverage
[2] Among people eligible for employer coverage

well as for the nation overall.[7] The economic downturn explained part of that decline during the last few years, but our data indicates that the decline in employer coverage held by Minnesotans actually preceded the recession. Even with the recovery in employment by 2013 (Minnesota unemployment fell from a peak of 8.3% in April 2009 to 4.8% in October 2013),[8] employment-based insurance remains weak, perhaps indicating that factors other than economic performance might be affecting access to employment-based insurance. More research is necessary to understand the extent to which structural changes in the labor market, including increase in temporary and contract employment, or a change in the number of hours worked are contributing factors.[9]

As shown in Figure 4, connection to an employer that offers coverage – whether through their own employer or that of a family member –has gradually decreased over the past decade; however eligibility for employer coverage, for those connected, has remained stable.[10] Meanwhile, take-up of employer coverage has continued to decline. The decline in the take-up rate is likely affected by a mix of income and wage loss among some employees, as well as changes that shift a greater share of the increasing cost of employer-based coverage to employees. Future research will attempt to evaluate

Figure 5
Rates of Uninsurance in Minnesota by Race/Ethnicity



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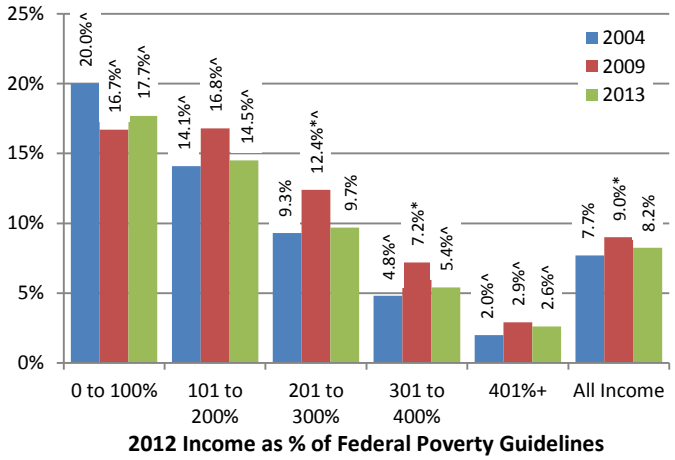
to what extent provisions of the federal ACA contribute to stabilize employment-based coverage or hasten a transition towards coverage purchased in the individual market.[11]

Disparities in health insurance coverage across various sociodemographic characteristics, including income, race, ethnicity and age remained present in 2013. In general, Minnesotans with lower incomes, non-whites and young adults are less likely to have health insurance.

Major disparities in health insurance coverage by race and ethnicity persisted in 2013, as shown in Figure 5. The uninsurance rate for Whites recovered to pre-recession levels in 2013 (6.0%), after a rise in 2009. Meanwhile, there was no improvement in the uninsurance rate for Blacks, American Indians or Asians and the uninsurance rate for Hispanics actually increased between 2009 and 2013. The persistence of high uninsurance rates for non-whites in the state, regardless of economic conditions, highlights that the existing disparities in health insurance (and health care access) are not solely explained by economics.[12]

Disparities in the uninsurance rate by income also continued, as shown in Figure 6. Minnesotans with household incomes at or below 200% of the Federal Poverty Guidelines (FPG)[13] are more than twice as likely to be without health insurance that those with higher incomes. There has been some recovery for moderate income Minnesotans, between 200% and 400% FPG; uninsurance rates which increased in

Figure 6
Rates of Uninsurance in Minnesota by Income



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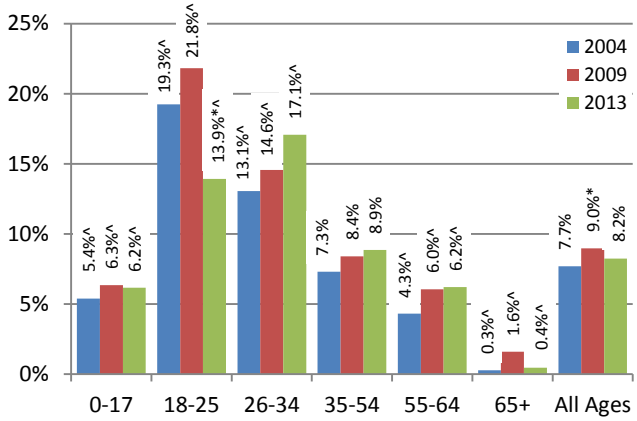
2009 have now returned to 2004 levels.

As illustrated by Figure 7, young adults aged 18-34 have higher rates of uninsurance than older adults aged 35 to 64. Nonetheless, the impact of the 2011 policy changes under the ACA, which allow young adults aged 18 to 25 to remain as a dependent on their parents' health insurance policies, can be seen in the decrease in the uninsurance rate among this population between 2009 (21.8%) and 2013 (13.9%). Interestingly, this decrease was explained primarily by the decline in the uninsurance rate among young men ages 18 to 25, which fell to 14.9% in 2013 (from 30.7% in 2009); the rates for

Figure 7
Rates of Uninsurance in Minnesota by Age



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young women of that age remained unchanged at 15.7% in 2013 (data not shown). The uninsurance rate for children (ages 0 to 17) remained stable between 2004 and 2013 and was lower than the statewide rate. Approximately 80,000 children were uninsured in Minnesota in 2013.

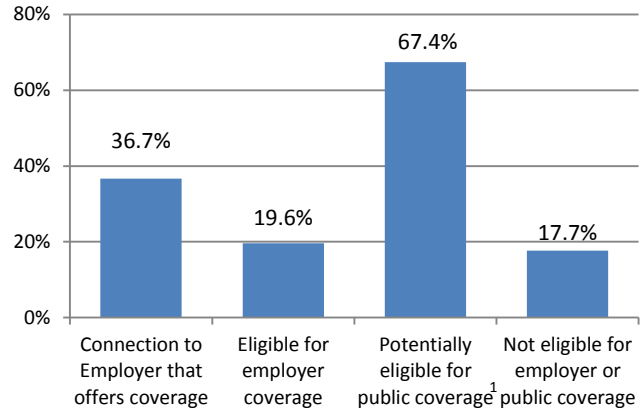
A large proportion of people without health insurance had some access to coverage in 2013 (Figure 8). Quite consistent with previous years, just over one-third (36.7%) of the uninsured has a connection to an employer who offers coverage, and about one-fifth (19.6%) were eligible for employer coverage. Most importantly, over two-thirds (67.4%) of uninsured Minnesotans were potentially eligible for coverage through a public program, such as Medical Assistance or MinnesotaCare. Overall, over three-quarters of uninsured Minnesotans are either eligible for employer coverage or for coverage through a Minnesota public health insurance program. Changes in how eligibility for Minnesota public health insurance programs is determined, with a move away from asset limits and toward an income-based approach, and the ability to enroll in programs over the internet through MNsure may help to facilitate enrollment of a greater share of this population in public programs. When asked, 73.6% of uninsured Minnesotans said they would enroll in coverage through a public health program if they learned they were eligible.

Table 1 displays the demographic characteristics of uninsured Minnesotans as compared to the total state population for 2009 and 2013. Consistent with previous analyses, the uninsured were more likely to be between 18 and 34 years old, non-white, and lower income. The uninsured were also more likely to be born outside of the United States, hold lower levels of education attainment than the overall state population and report being in poorer health or having fewer healthy days.

There were some notable changes in the distribution of the uninsured in 2013 compared to 2009, including:

- Non-native born uninsured accounted for a greater share in 2013, increasing the disparities already present.
- Males still accounted for a disproportionately greater share of the uninsured compared to the overall population, albeit a smaller one

Figure 8
Potential Sources of Insurance Coverage for the Uninsured



[1] Preliminary results reporting public program eligibility used the income of all household members. Here we only include the income of those in the household that would be included when a family member applied for public coverage (e.g., spouse, parent/guardian, dependents). Family income may be lower than household income, thus the percent potentially eligible for public programs is higher in this report (67.4% compared to 62.1% in preliminary results)

- The proportion of uninsured who were White fell nearly 25%, while the proportion of the overall population who were White declined more modestly in 2013 (5%).
- Although the share of the population that is Hispanic/Latino remained stable, they accounted for a larger portion of the uninsured than in 2009 (a change from 10.9% to 20.2%).
- The income distribution for the total population skewed slightly lower in 2013 than 2009; however, aside from the larger percentage of uninsured at or below poverty, there were no differences in the income distribution of the uninsured population.
- Differences between the Twin Cities and Greater Minnesota that were present in 2009 were no longer observable in 2013.
- More uninsured people were married in 2013 than in 2009.
- Finally, more uninsured people reported poor health, and have fewer healthy days than the population as a whole.

As in previous years, the uninsured were as likely to be employed as the state population as a whole (Table 2). Nonetheless, a larger share of the uninsured was self-employed or worked for an employer with 50 or fewer employees. Compared with the overall population, more uninsured Minnesotans held temporary or seasonal jobs, and fewer worked over 40 hours per week.

Table 1
Demographic Characteristics of the Uninsured

	All Uninsured		Total Population	
	2009	2013	2009	2013
Gender				
Male	64.6%^	56.4%*^	49.4%	49.3%
Female	35.4%^	43.6%*^	50.6%	50.7%
Age				
0 to 5	6.5%	7.2%	8.2%	8.0%
6 to 17	10.9%^	11.2%^	16.4%	16.5%
18 to 24	22.7%^	15.9%*^	9.1%	9.6%
25 to 34	22.1%^	26.5%^	13.2%	12.8%
35 to 54	28.0%	28.8%	29.9%	27.1%*
55 to 64	7.6%^	9.8%^	11.3%	13.0%*
65+	2.1%^	0.7%^	11.9%	13.0%
Race/Ethnicity[1]				
White	76.7%^	60.9%*^	87.8%	83.4%*
Black/African American	10.5%^	11.1%^	5.4%	6.2%
American Indian	3.7%^	3.6%^	1.6%	1.6%
Asian	3.8%	7.6%	3.7%	4.7%*
Hispanic/Latino	10.9%^	20.2%*^	4.1%	4.8%
Country of Origin[2]				
US Born	85.3%^	73.6%*^	92.4%	91.7%
Not US Born	14.7%^	26.4%*^	7.6%	8.3%
Family Income, as % of Poverty				
0 to 100%	20.5%^	28.4%*^	11.0%	13.2%*
101 to 200%	30.3%^	31.1%^	16.2%	17.6%
201 to 300%	23.5%^	18.2%	17.0%	15.4%*
301 to 400%	12.5%^	10.4%^	15.6%	16.0%
401%+	13.1%^	11.8%^	40.2%	37.8%*
Greater MN/Twin Cities[3]				
Greater MN	53.5%^	44.9%*	45.5%	45.8%
Twin Cities Metro	46.5%^	55.1%*	54.5%	54.2%
Marital Status[4]				
Married	30.7%^	38.8%*^	60.5%	59.5%
Not Married	69.3%^	61.2%*^	39.5%	40.5%
Education[5]				
Less than high school	17.1%^	17.3%^	7.6%	7.2%
High school graduate	34.1%^	32.0%^	25.5%	24.1%
Some college/tech school	33.0%	32.5%	30.7%	33.1%*
College graduate	11.9%^	14.3%^	23.7%	23.5%
Postgraduate	3.9%^	3.9%^	12.4%	12.2%
Health Status				
Excellent/Very Good	53.2%^	50.3%^	67.2%	66.6%
Good	27.9%^	31.1%^	21.8%	22.2%
Fair/Poor	18.9%^	18.6%^	11.1%	11.2%
Healthy Days (mean)[6]		5.4^		3.7

* Indicates statistically different from previous year at the 95% level
^ Indicates statistically different from total population within year at the 95% level
[1] Distribution may add to more than 100% since individuals were able to choose more than one race/ethnicity
[2] Reported for individuals 3 years and older.
[3] Greater Minnesota is the area outside the seven county Twin Cities Metropolitan Area.
[4] Reported for individuals 18 and older.
[5] For children, refers to parent.
[6] The measure of healthy days, developed by the Centers for Disease Control, was added to the survey in 2013.

Table 2
Employment Characteristics of the Uninsured

	All Uninsured		Total Population	
	2009	2013	2009	2013
Employment Status				
Employed	66.2%^	73.5%*	71.6%	72.9%
Not Employed	33.8%^	26.5%*	28.4%	27.1%
Employment Type (for those employed)				
Self Employed	22.0%^	19.0%^	11.7%	12.4%
Employed by Someone Else	78.0%^	81.1%^	88.3%	87.6%
Number of Jobs (for those employed)				
One Job	90.1%	85.7%	89.3%	88.4%
Multiple Jobs	9.9%	14.3%	10.7%	11.6%
Size of Employer (for those employed)				
Self Employed, no employees	16.2%^	11.8%^	5.8%	5.5%
2 to 10 employees	27.6%^	22.4%^	12.1%	11.9%
11 to 50 employees	15.7%	19.4%^	12.1%	11.5%
51 to 100 employees	11.5%	15.1%^	11.3%	9.6%*
101 to 500 employees	11.9%^	11.2%^	17.8%	18.1%
More than 500 employees	17.2%^	20.0%^	40.8%	43.4%*
Type of Job (for those employed)				
Temporary/Seasonal	20.1%^	21.8%^	8.2%	9.3%
Permanent	79.9%^	78.2%^	91.8%	90.7%
Hours Worked per Week (for those employed)[1]				
0 to 10 hours	1.2%	3.0%	2.1%	2.4%
11 to 20 hours	10.2%	10.8%^	6.9%	6.4%
21 to 30 hours	17.6%^	9.1%*	7.7%	8.3%
31 to 40 hours	46.4%^	54.5%	54.3%	53.8%
More than 40 hours	24.5%	22.6%^	29.0%	29.1%

* Indicates statistically different from previous year shown at the 95% level.
^ Indicates statistically different from total population within year at the 95% level.
For children the employment characteristics refer to a parent
[1] Hours worked per week at a primary job for those with more than 1 job. For those who had more than one job, total hours worked per week was collected in 2013. In previous years, only hours at a primary job was collected.

Methodological Notes

The Minnesota Health Access (MNHA) surveys are stratified random digit dial telephone surveys. In 2013 interviews were completed with 11,778 respondents. Due to dramatic increases in exclusive cell phone use over time, since 2009 the MNHA sample has included both cell and landline telephones to ensure appropriate representation of the state's population. As the percentage of the population who uses cell phones has increased,[14] the percentage of interviews completed on cell phones has also increased. In 2013, 56.4% of completed interviews were conducted through a cell phone.

Consistent with national trends, the MNHA response and cooperation rates have decreased over time, with both reaching 48 percent in 2013. Each year, interviews were conducted in English and Spanish; in addition, interviews were conducted in Hmong in 2001 and 2004, and Somali in 2001.

As in previous years, statistical weights were used to ensure that survey results are representative of the state's population. The 2013 data were weighted to be representative of population distribution of the state based on age, race/ethnicity, education, region, home-ownership nativity and household size. Additionally, the data were weighted to represent what is known to date about the prevalence of cell phone households and the distribution of telephone usage (i.e., landline-only, cell phone-only and dual landline and cell phone households). Weight trimming was employed in 2013 to limit the effect of outliers; point estimates, including the uninsurance rate, were not substantively affected by the procedure. The weighting methods applied in 2013 were then

applied to the 2009 and 2011 MNHA surveys which also employed a dual frame sample to ensure comparability over time. Estimates presented here for 2004, 2007, 2009 and 2011 may differ slightly from previously published results.

Endnotes

[1] More detailed results can be obtained online at http://www.health.state.mn.us/divs/hpsc/hep/chartbook/index.html and pqc.health.state.mn.us/mnha/Welcome.action. Additional findings will be reported throughout the year.

[2] More information about baseline metrics of access to coverage and care in Minnesota that may be affected by federal health reform implementation can be found in a companion publication to this fact sheet: Minnesota Department of Health/Health Economics Program, "Health Care Access in Minnesota, Baseline Analysis for Assessing the Impact of the Health Reform in the State," Issue Brief, February 2014.

[3] As with all surveys, there is a margin of error associated with these estimates. Therefore, apparent differences between estimates may actually not be statistically significant. Unless otherwise noted, differences between estimates in this fact sheet are only reported if they are statistically significant. Generally, statistical significance in this fact sheet is determined at the 95 percent level.

[4] In the interest of readability, the analysis in this fact sheet presents data for a subset of years available. Estimates for alternate years can be obtained online: https://pqc.health.state.mn.us/mnha/Welcome.action

5 In 2012, 75% FPG was $8,377.50 for a single adult. http://aspe.hhs.gov/poverty/12poverty.shtml, Federal Register, Vol. 77, No. 17, January 26, 2012, pp. 4034-4035

[6] Gruber and Gorman estimate the size of the individual market will nearly double by 2016. See https://www.mnsure.org/images/Report-GruberGormanUpdate-2013-02-28.pdf.

[7] See State Health Access Data Assistance Center. 2013. "State-Level Trends in Employer-Sponsored Health Insurance." SHADAC Report.Minneapolis, MN: University of Minnesota

[8] United States Bureau of Labor Statistics

[9] For example, see http://mn.gov/deed/newscenter/publications/review/september-2013/whos-counting.jsp.

[10] Some data suggests that the rate at which employers in Minnesota offer coverage has declined very modestly in total, with a slight decrease in offer rates for private employers with fewer than 50 employees, but no change for employers with more than 50 employees between 2010 and 2012. Agency for Healthcare Research and Quality. *Percent of private-sector establishments that offer health insurance by firm size and selected characteristics* (Table I.A.2), 2010 (July 2011), 2011 (July 2012), 2012 (July 2013). Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC.

[11] Modeling performed in 2012 to estimate the potential impact of Minnesota's health insurance exchanges suggests that by 2016 there would be a minimal impact on employer-sponsored health insurance coverage, with most of the expected growth in coverage coming in the individual market and state public programs coverage. See https://www.mnsure.org/images/Report-GruberGormanUpdate-2013-02-28.pdf.

[12] For more information on disparities and health equity, please visit the MDH Center for Health Equity, http://www.health.state.mn.us/divs/chs/healthequity/

[13] Family income and poverty is measured as a percent of the Federal Poverty Guidelines. A family of four in 2012 was considered to be in poverty if their income was at or below $23,050. Federal Register, Vol. 77, No. 17, January 26, 2012, pp. 4034-4035

[14] Nationally, almost two in five households in 2013 were reachable only by cell phone (39.4 percent). This represents an increase of nearly 15 percentage points in cell phone only households compared to 2009. Blumberg SJ, Luke JV. Wireless substitution: Early release of estimates from the National Health Interview Survey, January–June 2013. National Center for Health Statistics. December 2013. Available from: http://www.cdc.gov/nchs/nhis.htm. In Minnesota in 2012, 35.7% of adults and 36.7% of children lived in wireless-only households. Blumberg SJ, Ganesh N, Luke JV, Gonzales, G. Wireless substitution: State-level estimates from the National Health Interview Survey, 2012. National health statistics reports; no 70. Hyattsville, MD: National Center for Health Statistics. 2013.

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.

For more information, contact the Health Economics Program at (651) 201-3550 or health.hep@state.mn.us. This issue brief, as well as other Health Economics Program publications, can be found on our website at http://www.health.state.mn.us/healtheconomics

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