Citizens League Report

Start Right with "Right Start"

A Health Plan for Minnesota's Uninsured

public affairs
research and education
in the Minneapolis-Saint Paul
metropolitan area

CITIZENS LEAGUE REPORT

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A Health Plan for Minnesota's Uninsured

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Health Care for the Uninsured Committee
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SUMMARY

About 454,000 Minnesotans do not have the security of health insurance at some time during the year. For many of these persons the possibility of illness and its cost is an everyday concern.

Persons are uninsured because of gaps in the provision of health insurance. Most Minnesotans receive health insurance coverage through employer-sponsored plans. The very poor and elderly are eligible for government-sponsored medical assistance programs. But people with incomes which are low but still too high to qualify them for public assistance or who work for employers who do not offer health insurance, fall through the gap.

Some low-income uninsured persons are cared for by physicians and hospitals, often without charge. These providers increase charges to paying patients to offset care provided to the uninsured. Today, a competitive, cost-conscious health care system is foreclosing the opportunity to increase charges to paying patients.

Little evidence exists in Minnesota that persons in need of medical care are being denied that care. However, evidence does show that uninsured persons defer medical care until the consequences and costs of illness are much higher than they might have been had they sought care earlier. And there is evidence that the uninsured are being referred to public hospitals. As a result of postponement of care, less visible cost-shifting, and more visible patient-shifting, the general public will continue to pay for medical care provided to the uninsured through higher insurance premiums or higher taxes.

Minnesota should act now to ensure access to affordable, cost-conscious health insurance for its low-income uninsured persons.

The public needs to:

* Know how much it is paying and for what;
* Hold providers of care to the uninsured accountable; and
* Act before a crisis situation reduces the opportunity to design an affordable, cost-conscious program.

A number of community groups have studied the issue of health care for the uninsured and have made specific proposals. Together these proposals represent a spectrum of eligibility, benefits and costs as broad as the uninsured population is diverse. The long-term policy goal of these proposals is to provide the uninsured poor with health insurance.

We share the same long-term goal and recommend that the policy debate be focused on where (not whether) to start in that spectrum, recognizing that the political and budgetary process will determine the scope of the initial program. At a minimum, we recommend beginning with the "Right Start" proposal advocated by the Children's Defense Fund and adding persons leaving welfare programs to the list of those eligible to participate in the program.

We recommend a system to fill the health insurance gap for the uninsured poor -- a system that shares responsibility among government, business and individuals.

First, the state should create a voluntary health insurance plan for the uninsured. Participants should pay a portion of the premium based on ability to pay. Providers should be selected competitively from managed health care systems that meet quality and cost standards, with state pre-payment. More than one provider should be available for participant choice.

Eligibility and benefits should be phased in.

Initial eligibility should be limited to persons with annual incomes less than 200 percent of poverty who are:

a. children (0 - 5 years of age),
b. pregnant women, or
c. persons leaving the Aid to Families with Dependent Children program.

Initial benefits offered should, at a minimum, be prenatal care and primary and preventive services for children.

Eligibility and benefits can be expanded by adding additional children, adults, income levels, and benefits as political and budgetary constraints allow.

Second, to maximize the amount of federal dollars available, the Legislature should exercise its option under federal law to expand Medicaid coverage and increase income eligibility limits for the AFDC population to the maximum allowed.

Third, the state should reform current welfare medical assistance programs as it gains experience from the competitive health insurance plan.

Fourth, employers should be given incentives to provide health insurance as a benefit of employment. To accomplish this, federal law should be amended to provide states limited flexibility needed to develop tax incentives for businesses who provide health insurance to their employees -- that is, the employer offering health insurance as a benefit would be better off because of the offering.

Fifth, the public should not rely on provider charity care as a major source of health care for the uninsured. But the charity care effort currently being given by health care providers should be maintained.

The health insurance plan should be financed with participant premiums, savings from existing programs, and the general fund. The cost of our recommendations is estimated to be $24 million a year. This would cover 15,027 children and 2,475 women or about four percent of persons uninsured at some time during the year. Considering current expenditures for poor birth outcomes (FY 1986 $20.1 million),

savings from current Medicaid programs could help offset the cost of the health insurance. Maximizing federal funding also ensures that the state gets more for its money. Other welfare costs (savings in income assistance grants) should also help offset costs.

Acting will not be easy. First, because most Minnesotans are covered by health insurance there will not be a large, organized constituency for the needs of the uninsured. Second, many will argue that welfare medical insurance programs already exist to assist persons who are very poor or who become very poor due to medical needs.

The final difficulty: funds for a new system are not readily available.

Despite difficulties, it is time to start filling health insurance gaps. The recommended health insurance plan should be viewed as an investment in Minnesota's future and as a necessary component of welfare reform.

INTRODUCTION

Access to health care for the uninsured re-emerged as an important public policy issue recently. Changes in the way health care is provided, purchasers' desire to control the rising costs of health care, and changes in employment trends leave many persons with restricted access to health services and health insurance. Public policy makers are called on to find a way to provide access to health care for uninsured persons in our state and nation.

The uninsured population is not a new group. For many years, government and most businesses have ensured access to health care or health insurance for the very poor, the old (over 65), and full-time employees. Many uninsured do not fit any of these categories.

Good health is essential for enjoying the opportunities of a free society. Government is the only entity capable of ensuring access to health care for all citizens, not just the very poor or the old. And although access to health care services never has been explicitly proclaimed a right in this nation or this state, the number of programs seeking to ensure health care access and/or good health indicates an implicit commitment and belief on the part of the public and government to this end.

Now is a good time to devise a solution to the problem of access to health services for uninsured Minnesotans. We are fortunate; Minnesota is experiencing many changes in health care delivery and the state does not yet face a health care bill for its uninsured population that is unmanageable or unaffordable. This committee was challenged to recommend a solution to the problem of access to health care for the uninsured consistent with market forces helping to control health care costs. Our findings, conclusions, and recommendations follow.

HISTORICAL BACKGROUND

Until the 1970s, health care was paid for largely on a fee-for-service basis -- charges were paid, few questions were asked, and no negotiation took place between purchasers (those who pay for insurance or care) and providers (insurers, physicians, hospitals, and organized medical practices).

Health care for the uninsured was, and is to some extent today, subsidized by paying patients. Because payers were usually third-party insurers, complaints were rare. But in today's competitive, cost-conscious system, providers may no longer be willing to subsidize care for the uninsured or any other unaffiliated group. And as competition for patients tightens, all providers are forced to evaluate their charity care policies more closely.

In Minnesota, changes in the health care system are apparent in the way we pay for and deliver medical care. Since the 1970s, Health Maintenance Organizations (HMOs) have flourished. According to the Minnesota Department of Health, nearly 41 percent of Twin Cities metropolitan area residents and 24 percent of outstate Minnesotans were members of HMOs in 1985. This figure is up from three percent of Twin Cities residents and two percent of outstate residents in 1972.

The Minnesota health care system continues to change. Recently, it was reported that "virtually every major health care institution in the Twin Cities is discussing the possibility of merging with other players, seeking linkages that will generate revenue and efficiencies necessary for survival."[1] HMOs and insurance companies are also designing and marketing new products to keep current market share as well as gain more members.[2]

Market-oriented systems have helped to make access more affordable for most purchasers but, for many of the uninsured, medical insurance or medical care is still unaffordable. The changing health care system, however, provides a unique opportunity to ensure access to health insurance for the uninsured.

FINDINGS

I. THE UNINSURED

The uninsured are persons without private or public health insurance. Private health insurance includes insurance received through employment or purchased by an individual. Public health insurance includes welfare medical assistance programs, Medicare, and other publicly subsidized insurance.

In 1984 a study about the uninsured was conducted for the Minnesota State Planning Agency by ICF Incorporated. The information on the uninsured presented in this report is derived from that study.

A. Uninsured Minnesotans -- Generally

1. An estimated eight percent (342,000) of Minnesotans lack health insurance coverage at any one time during the year -- about 246,000 are always uninsured during the year and another 208,000 are uninsured some time of the year.[3] Other surveys conclude that the number of uninsured Minnesotans may be as high as ten percent.[4] Nationally, recent surveys have found 15 to 16 percent (33 - 35 million) of the population to be without health insurance.[5]

2. Experts believe that the number of uninsured individuals is growing because of: a) changes in eligibility for public medical assistance programs; b) changing employment patterns; and c) the rising cost of medical insurance.

a. Changes in eligibility for public medical assistance programs --

Federal changes to the Aid to Families with Dependent Children (AFDC) program in 1981 caused the denial of assistance (including medical assistance) to many working AFDC families.[6] In Minnesota, approximately 20,000 were taken off AFDC rolls.[7] As federal and state governments attempt to hold down the rising costs of welfare programs, eligibility requirements are being examined more closely. Recent action by Congress, public law 99-509 of the Omnibus Reconciliation Act of 1986, gives states the option of increasing eligibility standards for Medical Assistance to a level equal to 100 percent of the federal poverty level. If states do not exercise this option and instead restrict eligibility for public assistance programs, the number of uninsured will almost certainly increase.

b. Changing employment patterns --

The service sector is one of the fastest growing sectors of the national and state economy. This sector mainly consists of small firms with many part-time, minimum wage, non-organized employees who are not offered health benefits through their employers. In Minnesota, the service sector is expected to grow by almost 17 percent by 1990.[8]

c. The rising cost of health insurance --

The cost of health insurance and health plan membership is increasing.[9] As a result, employers closely evaluate health insurance offered as a benefit to employees.

B. Demographic Characteristics of Uninsured Minnesotans

1. Many of the uninsured are children. Most of the uninsured are under 24 years of age.

Almost 30 percent of Minnesota's uninsured population are children under the age of 18. About 53 percent of the uninsured are 24 years of age or younger. Nationally, that number is about 58 percent.

Minnesota has a large number of middle-aged uninsured. A little more than 41 percent of the uninsured population is age 25 - 54. (See Appendix A, Table 1.)

2. Uninsured Minnesotans include persons of all races and ethnic origins.

Approximately eight percent of white Minnesotans, 12 percent of blacks, and six percent of Hispanics are without health insurance in Minnesota. (See Appendix A, Table 2.)

3. Many of the uninsured work.

In Minnesota, almost 75 percent of the uninsured between 19 and 64 years of age work at least part time. This represents almost fifty percent of all the uninsured. (See Appendix A, Table 3.) Nationally about 56.5 percent of the uninsured work at least part time.[10]

Minnesotans most likely to be uninsured are the unemployed, homemakers, the self-employed, persons employed only part of the year, and students. (See Appendix A, Table 4.)

4. Minnesota's working uninsured are most likely to be employed in the service sector, crafts, or farming.

Most uninsured working Minnesotans work in the service sector (41,000+), in crafts (29,000+), or farming (26,000+). The employment sector with the largest percentage of uninsured persons is labor. (See Appendix A, Table 5.)

5. About half of the uninsured are poor.

In Minnesota about 52 percent of the uninsured earn less than 200 percent of what the federal government defines as a poverty level income. Nationally, about 64 percent of the uninsured earn less than 200 percent of poverty.[11] (Poverty levels in 1986 are $11,000 annual income for a family of four and $5,360 for an individual.)

Most of Minnesota's uninsured children are poor; most uninsured adults are not. (See Appendix A, Tables 6, 7, and 8.)

II. HEALTH STATUS OF THE UNINSURED

A. Most Minnesotans believe they are in good health, regardless of their insurance status.

Most uninsured Minnesotans (86.5%) perceive their health status as excellent or good. About 88 percent of insured Minnesotans perceive their health status as excellent or good.[12]

B. Although a high percentage of the uninsured believe they are in good health, experts have concluded that the uninsured have poorer health status than the insured.

In 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded that "the uninsured appear to be in somewhat poorer health than the insured; they are 33 percent more likely to rate their health as fair or poor and spend one-third more days in bed per year than the insured do. Moreover, the uninsured in fair or poor health use fewer medical services than their insured counterparts....These individuals make one-third fewer visits to a physician than the insured in fair or poor health."[13]

Other researchers conclude that the uninsured are probably in better health than persons insured through the Medicaid program, but "medical conditions reported by the uninsured sick poor are not trivial ones. The four conditions reported most frequently are diabetes, depression, hypertension, and fractures."[14]

C. Uninsured persons may overestimate their health condition; they risk having no coverage because they may not realize the benefit of early medical attention or because the high cost of health insurance precludes them from purchasing coverage that reimburses for preventive services.

Many uninsured Minnesotans receive hospital care. In 1983, most of the care delivered was for pregnancy, childbirth, or newborn care. (See Appendix B, Tables 1 and 2.)

Hospital officials point out that much of the pregnancy, childbirth, and newborn care expenses arise because of a lack of prenatal care.[15] If such care were available, it is thought there could be substantial savings.[16] Recent studies conclude that anywhere from $3.38 to $11.00 can be saved for every dollar invested in prenatal care.[17] A recent evaluation of Minnesota's Medicaid program found that during fiscal year 1986, of $32.1 million spent for prenatal, delivery, and post-natal care, $20.1 million was spent for problem pregnancies and poor birth outcomes.[18]

The cost of health insurance is rising. Insuring for Preventive services adds to the cost. The income levels of many uninsured Persons may not be high enough to Purchase health insurance at all, much less insurance that would cover Preventive services.

III. UTILIZATION OF HEALTH SERVICES BY THE UNINSURED

A. The uninsured use fewer Preventive services and have the most significant access Problems when faced with illness.

A national survey conducted in 1982 analyzing the use of health services found that the uninsured utilized fewer Preventative services and had the most significant access Problems when faced with illness.[19] There are two reasons for this. First, having to ask for charity care is difficult. Secondly, if the uninsured person must pay for care, it is likely that the care will be put off in the hopes that the condition will get better.

B. Uninsured Minnesotans utilize hospital and outpatient visits less than the insured.

In 1985, persons who were always uninsured averaged slightly over two outpatient visits per person. By contrast, insured Minnesotans averaged almost four outpatient visits per patient. Persons insured some of the time have the highest outpatient utilization rate -- over four patient visits per person. Uninsured persons utilize hospital services less per capita than insured persons. However, when utilizing hospital services the uninsured have longer stays (9.8 days) than those always insured (6.5 days) or sometimes insured (6.7 days).[20] But "lower rates of physician visits and hospitalization by the uninsured...are not a reflection of a lower need for health care."[21]

IV. WHERE UNINSURED MINNESOTANS RECEIVE HEALTH SERVICES

When the uninsured need medical services they can turn to several providers.

A. Community-Based Services Received by Uninsured Minnesotans

Uninsured Minnesotans receive non-hospital medical services through community and public clinics, a federal unemployment health insurance program, and private physicians.

1. Community and public clinics --

There are 21 community clinics and community health centers in the metropolitan area and five clinics in outstate Minnesota. The clinics provide medical, dental, health education, and mental health services to about 100,000 patients annually. Many of these patients do not have health insurance.

Community clinics provide services on a sliding fee basis. (The amount the patient pays varies with income -- the higher the income, the higher the expected patient payment.)

The metropolitan area clinics serve about 70,000 patients a year, most of whom are of low income and most of whom are uninsured for the services provided by the clinic. A 1985 survey found that 40 percent of the clinic's clients have no health insurance at all. Another 20 percent have some insurance, but it doesn't cover the primary and preventive services offered by the clinics. (See Appendix C.) Patients at these clinics were able to pay for about one-third of the costs of the care they received. Remaining operating expenses are covered by public and private grants, contributions, or donations of supplies.

All of the metropolitan area clinics are affiliated with specialists and hospitals. Some of the specialists have agreed to provide care to individuals at the sliding-fee-scale rates used by the clinics. Hospitals agree to provide some services to clinic patients or make in-kind contributions.

The Hennepin County and Minneapolis health departments estimate that two-thirds of the patients using their services are uninsured. The remaining one-third have some type of public or private insurance. (See Appendix D, Tables 1 and 2.) Most of the services delivered at these clinics are primary or preventive.

2. Federal health insurance for the unemployed --

Since 1983, unemployed and uninsured Minnesotans in 32 counties (mostly rural) have been able to receive primary health services under a federally funded program. The national recession of the late 1970s and early 1980s resulted in passage of the federal Jobs Bill. This law provided retraining dollars, extension of unemployment benefits, and health care benefits for the unemployed. Minnesota received about $700,000 to provide medical services for its unemployed.

Decisions on how to spend the resources were made locally. In Minnesota, it was decided that the program should cover primary preventative health services -- those delivered by family practitioners, general practitioners, obstetricians, pediatricians, internists, and dentists (emergencies only).

Services have been delivered through a voucher system. The vouchers are available to the unemployed through their local unemployment insurance offices.

All types of care have been delivered under the program. Routine visits, acute problems, emergency dental visits, and pregnancy-related care have been utilized the most. (See Appendix E, Table 1.)

In 1984, 2,702 persons, the vast majority of whom were children and women of childbearing age, received services through the program. (See Appendix E, Table 2.) In 1985, 5,942 persons utilized the services of the program. During 1984 and 1985 the vast majority of use (2,215 and 3,235 visits respectively) was by women of childbearing age. (See Appendix E, Tables 2 and 3.) From September 1983 - December 1985, over 12,000 visits to physicians had been made for a cost of about $221,000. This is about 64 percent of the normal fee-for-service charges of physicians in clinics participating in the program. (See Appendix E, Table 4.)

Funds for the program were exhausted by the end of 1986.

3. Individual physicians and physician group practices provide care to the uninsured.

Although no formal surveys of individual physician charity care are available, many physicians indicate that they do provide some level of free care to patients who are unable to pay for it. At the same time, individual physicians, like hospitals, are concerned about their ability to continue to provide charity care.

B. Hospital Utilization by the Uninsured

1. Most Minnesota hospitals do not have formal charity care policies.

A recent survey of Minnesota hospitals found that most Minnesota hospitals do not have formal charity care policies. Instead, the decision to provide charity care is made on an ad hoc basis, when the patient arrives at the hospital.[22]

2. Despite this fact, most hospitals provide some charity care.

In 1984 and 1985 an estimated $19 million of charity care was provided by Minnesota hospitals (using the hospital's own definition of charity care). This includes charity care that was recorded in a separate charity care account and an estimate of the proportion of bad debt that should have been classified as charity care. The vast majority of this care was delivered by a few hospitals.[23] The amount of charity care provided by all hospitals averages less than two percent of any hospital's gross revenues.

However, all hospitals and their users receive indirect public funding because they are exempt from state and local taxes. For property taxes alone, this saved hospitals at least $55 million for 1987, according to the Minnesota Department of Revenue.

3. Hospital accounting procedures make it difficult to distinguish charity care from bad debt.

Most Minnesota hospitals do not separate charity care from bad debt.[24] In the past, hospitals have had no reason to separate charity care from other types of care. Today, increasing scrutiny by payers may change this situation. Until this occurs, hospitals argue that while a certain portion of bad debt is bad debt, a certain portion is also charity care.

4. Some hospitals provide charity care because they are required to fulfill federal obligations of the Hill-Burton program or because they have monies specifically reserved for the purpose of providing charity care.

a. Hill-Burton

Hill-Burton is a federal program begun in 1946. The program provided below-market capital loans to hospitals. In exchange for the loans, hospitals are required to provide a specified amount of charity care for a certain number of years after the loan was made.

In fiscal year 1984, 52 Minnesota hospitals provided almost $7 million in Hill-Burton care. This represents less than one percent of total gross revenues for all Minnesota hospitals in fiscal year 1984. In fiscal year 1985, 49 Minnesota hospitals provided $8.5 million in Hill-Burton care, representing about .72 percent of hospital gross revenues. During both of these years, more Hill-Burton charity care was provided by non-metropolitan hospitals. (See Appendix F, Table 1.)

Hill-Burton obligations are ending in most Minnesota hospitals. By 1990, only 22 hospitals will have such obligations. That number drops to eight in 1995 and one in the year 2000. (See Appendix F, Table 2.)

b. Other charity care obligations

One hospital, Saint Paul-Ramsey Medical Center, is required by law to provide care to those unable to pay for it. Other public hospitals are also committed to providing care to those unable to afford it. And we know of at least two public hospitals that receive funds from county or state government specifically to provide charity care.

Private hospitals, especially those with religious affiliation, are committed to providing care to the uninsured and some raise money specifically for that purpose. The Shriners Hospital for Crippled Children provides free clinical, surgical, and hospital care to needy children with orthopedic needs.

V. PUBLIC MEDICAL ASSISTANCE PROGRAMS

Several public assistance programs are designed to ensure access to health services for the uninsured or uninsurable. The main programs reimburse largely on a fee-for-service basis and are administered by government employees.

A. Public Welfare Medical Assistance Programs

1. Generally --

a. Health insurance is important to welfare recipients.

Two recent studies found that the lack of private health insurance is an important determinant of welfare re-entry. The studies surveyed Minnesota welfare recipients affected by the 1981 Omnibus Budget Reconciliation Act, which produced substantial changes in eligibility for the AFDC program. (In Minnesota, the Department of Human Services estimates that approximately 20,000 welfare recipients were dropped from public assistance due to the changes.) Two years after the AFDC changes, 70 percent of the adults and 60 percent of the children terminated from AFDC and Medical Assistance in Minnesota were able to remain off welfare and had private health insurance. For the remaining 30 percent, the lack of private health insurance and poor health status of mothers and children significantly increased the likelihood of welfare re-entry during the two-year period after the changes.[25]

b. Applying for and receiving public medical assistance is difficult.

In 1984, another Citizens League committee found that "the number of forms an applicant must fill out to receive income assistance (and medical assistance accompanying income assistance) range from five to fifteen in St. Louis County, 13 - 25 in Hennepin and Ramsey counties, and up to 20 in Olmstead County....A caseworker must fill out more forms than the applicant in every instance."[26] This is still true today.

c. Many persons receiving public medical assistance are forced into poverty in order to be eligible.

Minnesota's public medical program costs are high. Almost one-half of medical assistance recipients do not receive other welfare benefits. (See Appendix H, Table 2.) The recipient is eligible for medical benefits because medical expenses incurred so far exceed available income and assets that the below-poverty eligibility criteria are met.

d. Many Minnesotans eligible for public welfare assistance do not receive it.

The state Department of Human Services estimates that there may be as many as 200,000 Minnesotans who are eligible for public welfare assistance who are not receiving it.[27] Many of these persons are uninsured.

2. General Assistance Medical Care (GAMC)

The GAMC program assists persons in meeting the cost of necessary medical care. Persons ineligible for assistance through other state and federal programs may be eligible for GAMC.

a. Eligibility --

To qualify for the GAMC program, a person must be a resident of Minnesota and meet a fairly strict income and asset test. (See Appendix G, Table 1 for specific GAMC eligibility criteria.)

The average number of persons receiving GAMC assistance monthly has increased significantly since 1983 -- to an average of 20,367 persons per month in 1985. In 1981, an average of 12,944 received GAMC. (See Appendix G, Table 2.)

b. Benefits --

A wide variety of medical services are covered by GAMC. (See Appendix G, Table 3.) Between 1980 and 1985, 62 - 68 percent of GAMC dollars were spent on inpatient hospital services. Other services taking the greatest share of remaining dollars were physician services, outpatient hospital or clinic care, prescribed drugs, and dental services. (See Appendix G, Table 4.)

c. Cost --

Cost of the GAMC program rises and falls with the number of persons eligible to receive benefits. In 1983, the cost was $52.2 million, in 1984, the cost was $31.9 million, and in 1985, the cost was $57.9 million. (See Appendix G, Table 2.) Another $13 million and $18 million increase in spending are forecast for 1986 and 1987 respectively. (See Appendix G, Table 2.)

d. Financing --

GAMC is totally funded by Minnesota state and county governments. Ninety percent of the program's costs are covered by the state and ten percent by individual counties. Although the program is patterned after the federal Medicaid program, it is governed entirely by state law and regulations.

3. Medical Assistance (Medicaid)

Like GAMC, the Medical Assistance (MA) program assists eligible persons with the cost of necessary medical care.

a. Eligibility --

MA has similar eligibility criteria to those of GAMC, with the exception of age and personal asset limits. MA is for persons under 21 (and their parents) or over 65. Personal asset limits are slightly higher than those of GAMC ($3,000 for one person, $6,000 for two persons, and $200 for each additional applicant as opposed to $1,000 for each person). Income levels for MA are similar to those of the GAMC program -- both are under the federal poverty level.

Since 1982, the number of Minnesotans receiving health services through the MA program has increased. An average of over 163,000 persons per month are projected to receive health services through MA during 1986, up from an average of 134,000 persons per month in 1982. (See Appendix H, Table 1 for monthly average number of persons receiving MA benefits.)

Rural Minnesotans receive benefits under the MA program. Since 1981, payment for MA services has been divided almost evenly between the rural and metropolitan areas of Minnesota. (See Appendix H, Table 2 for urban/rural MA expenditures.)

b. Benefits --

Minnesota's MA program includes about 31 additional services not required by the federal government. Massachusetts provides 32 additional services and California provides 31. All other states with MA programs provide fewer and more restrictive additional benefits. (See Appendix H, Table 3.)

The cost of providing these optional services in Minnesota has risen from almost $288 million in 1980 to almost $514 million in 1985. (See Appendix H, Table 4.)) Most of the optional services are being provided in an attempt to save money -- i.e. home health care benefits may keep an elderly person out of a much more expensive nursing home. Even so, the vast majority of MA dollars are spent for institutional care provided to the elderly.

c. Cost --

Expenditures for the MA program increase every year. In 1981, $657 million and in 1985 $994 million were spent in Minnesota. The cost of the program is estimated to increase to $1.1 billion during 1986.[28] (See Appendix H, Table 5 for actual and projected MA costs 1985 - 1987.)

During fiscal year 1985, inpatient and outpatient hospital care amounted to $164 million, while skilled nursing home and intermediate care for the mentally retarded and other individuals accounted for $561 million. Physician services accounted for another $51 million. (See Appendix H, Table 4.)

d. Financing --

MA is paid for by federal, state, and county governments. Each government's share is 52 percent, 43 percent, and 5 percent respectively. In fiscal year 1985, the federal share was $517 million, the state share was $428 million, and the county share was $47 million. (See Appendix H, Table 5.)

4. GA and MA reimbursement --

The manner in which reimbursement is made for services rendered to MA and GAMC recipients is controversial. Currently, reimbursement is different for services provided by a physician and for services provided by an institution (long-term care facilities and hospitals). Both physicians and institutions argue that the reimbursement levels do not cover the costs of providing care.

Physicians are reimbursed at the 50th percentile of 1982 usual and customary charges. Institutional (long-term) services are reimbursed according to the comparative physical health of the patients in the institution, with a property allowance added. Hospital reimbursement is determined by using a modified diagnostic-related group reimbursement methodology.

While providers criticize GAMC and MA reimbursement levels as being too low, other critics argue that reimbursing for services rendered, with little restriction on the amount or type of services that can be provided, gives incentives to over-serve, i.e. the imposition of too many procedures by physicians to make up costs. These critics question how many of the procedures being performed by providers are really necessary.

5. Experimentation with public assistance programs

a. GAMC demonstration projects --

Three counties, Ramsey, Itasca, and Lake County, require GAMC participants to enroll in a pre-paid, managed health care demonstration project. Administration of the program varies among the counties. A fourth county, St. Louis, began a GAMC demonstration in February, 1987.

b. Medicaid demonstration projects --

Three counties in the state (Hennepin, Dakota, and Itasca) are currently running MA demonstration projects. The purpose of the demonstrations is to determine whether or not the rising cost of MA can be curtailed, while ensuring that recipients continue to receive quality health care.

The demonstrations enroll MA clients in pre-paid programs. All MA benefits (required and optional) are provided. Premiums paid by the state for demonstration enrollees vary widely by age and type of care. For example, in Hennepin County monthly premiums per participant range from $44.11 for an AFDC child up to age 14 to $939.68 for a disabled, non-Medicare male over 65 years of age. (See Appendix I for Hennepin County Medicaid Demonstration rate structure.) The capitation rates may increase up to 5 percent per year for inflation.

The demonstrations run for three years and should provide valuable information on health care service utilization and health status of MA recipients.

c. Voluntary HMO enrollment --

Since the late 1970s, AFDC Medicaid recipients have been able to enroll in several HMO plans voluntarily. Some HMO providers participating in the program are less than satisfied. Citing extremely generous benefit packages (more benefits than the average HMO participant receiving health benefits through his/her employer), the lack of a minimum period for sign-up, premiums insufficient to cover costs, and administrative communication problems with counties and the state, some HMOs complain of large financial losses.29

d. Potential savings through pre-paid programs --

Experimentation with reimbursement systems of Medicaid is important because in 1984 the state Department of Human Services estimated that about $30 million could be saved during the 1985-86 biennium if all MA recipients were enrolled in pre-paid plans during those two years. This figure may change when the experience of the demonstration projects is evaluated.

B. Minnesota Comprehensive Health Association (MCHA)

The MCHA program provides health insurance for Minnesotans who are uninsurable for medical reasons.

1. Eligibility --

To qualify for MCHA, a person must be a Minnesota resident and submit a three-page application with evidence that another insurance company has declined health insurance coverage during the six months previous to the time of application. There is no asset test.

2. Benefits --

MCHA insurance is similar to other private health insurance. It provides deductibles of $500 or $1,000, a six-month pre-existing condition exclusion, and maximum lifetime benefits of $250,000. The program is also available as a Medicare supplement.

3. Cost --

a. To the individual --

Cost of MCHA insurance is more than an individual would have to pay in the private sector. An actuarial committee meets every year to look at similar private health insurance in order to determine the rates to be charged to individuals. Generally, rates are 125 percent of a similar, average policy available through a private insurer. Currently the rates for coverage requiring a $1,000 deductible range from $108 to $312 per quarter (depending on age). Coverage for dependent children is available for $135 per quarter. Rates for the $500 deductible range from $156 to $411 per quarter (depending on age). Coverage for dependent children is available for $177 per quarter.

b. To the state --

The number of persons, claims, and cost of the MCHA program has increased every year since it became available. There are currently over 10,000 persons enrolled in the MCHA program. In 1983, approximately 4,000 persons were enrolled in the program. Similarly the number of claims has risen from 22,510 in 1983 to over 58,500 in 1985. Cost of the program has increased every year. In 1984, the state paid $4.7 million and in 1985, the state paid $5.5 million. (See Appendix J for further information.)

4. Financing --

MCHA is financed by enrollee premiums and state subsidies.

C. Catastrophic Health Expense Protection Program (CHEPP)

Minnesota's CHEPP program could provide assistance in meeting catastrophic health expenses. CHEPP became law in 1978 but appropriations have not been made since 1981. CHEPP was designed to assist a family in meeting extraordinary health expenses when the family is not qualified for other public assistance programs.

1. Eligibility --

Eligibility for the program is determined by federal adjusted gross family income. In general, the family is expected to spend a large amount of its income before it can qualify for benefits under the program (when medical expenses paid or incurred exceed 20 percent of household income up to $15,000, 25 percent of income between $15,000 and $25,000, or 30 percent of income over $25,000). (See Appendix K for example of how CHEPP would work.)

The typical CHEPP recipient received about $7,000 in benefits and had an income of up to $31,000. Other general characteristics and statistics of persons receiving CHEPP benefits from 1977 - 1980 show about a 50 - 50 urban/rural residency split and that about one-third of CHEPP benefit recipients were under age 44. Most CHEPP recipients were retirees, farmers, and self-employed individuals. About two-thirds of the persons qualifying for CHEPP benefits had some type of insurance coverage.[30]

2. Benefits --

Benefits available include hospital, physician, home care, and prescription drugs. The most common types of treatment for which CHEPP paid were for cancer (27 percent), neurological (11 percent), coronary (11 percent), and newborn care (11 percent).[31]

3. Cost --

From 1977 - 1981, $13 million of the $33 million appropriated by the Legislature for the CHEPP program was used.

4. Financing --

CHEPP was paid for by the state of Minnesota from its general fund.

VI. ENSURING ACCESS TO HEALTH CARE FOR THE UNINSURED

A. Uncompensated Hospital Care and Health Care for the Uninsured

Nationally, to a great extent, the issue of health care for the uninsured has emerged because of concern over rising uncompensated hospital care costs. In some states (e.g. Texas, Illinois) there is concern that uninsured patients are being "dumped" by private hospitals into public hospitals, leading to greater financial burdens on publicly financed hospitals and reducing a patient's ability to survive illness.[32] There is concern that the declining number of hospitals with federal Hill-Burton obligations may mean severely reduced access to hospital care for those without the means to pay for it.[33]

B. State Initiatives

Some states have passed legislation to reimburse hospitals for their uncompensated care costs as a means to ensure access to medical care for the uninsured. Other states have passed legislation targeting individuals, not providers, to achieve the same result. Whatever the program target group, most are funded with new tax dollars. (Below is a description of programs implemented by states prior to the 1986 session.)

1. Programs that reimburse providers

Three types of programs reimbursing providers have been implemented in some states: a) direct government payment to providers, b) direct reimbursement through all-payer rate settings, and c) revenue pools' reimbursement of hospitals.

a. Direct government payment to providers

Arizona has chosen to ensure access to health care for the uninsured through an extension of its Medicaid program. The state extends the dollars used by the Medicaid program to the uninsured by using a prudent-buyer approach to health care. Since 1982, uninsured, poor Arizonans have received their acute medical care under a system of comprehensive, prepaid capitation contracts awarded to providers using a competitive bidding process.[34]

Colorado reimburses two public hospitals with high uncompensated care costs. Specifically, the University of Colorado and Denver General Hospital receive funds earmarked to provide care for the uninsured.

b. Direct reimbursement through all-payer rate settings

Some states reimburse providers through a regulatory mechanism that incorporates projected amounts of uncompensated care into an existing hospital rate-setting structure. This spreads the burden of uncompensated care across all payers (hospital users), public and private.

Examples of all-payer rate setting programs are found in New Jersey, Maryland, and Massachusetts. New Jersey incorporates a specific allowance for charity care and bad debt into each of its diagnostic related group (DRG) rates. Maryland examines actual hospital uncompensated care costs and estimates of the State's Health Services Cost Review Commission, takes the lower figure, and sets the rate accordingly. Massachusetts has obtained a federal waiver to develop a new payment differential which will reimburse hospitals for the cost of charity care.

c. Revenue pools

New York and Florida ensure health care for the uninsured by distributing funds earmarked for reimbursing hospitals for uncompensated care. New York places a surcharge on reimbursement rates paid by third-party payers and Florida assesses hospitals a one percent fee on their annual net operating revenues.

2. Programs that provide options for individuals

a. Catastrophic health insurance programs

Alaska, Maine, Minnesota, and Rhode Island have developed programs for financing high-cost medical care associated with catastrophic illness. Each state program is different, but they have some common characteristics: the state is the payer of last resort after all available third-party coverage is exhausted, and eligibility criteria, income and/or asset tests, and cost-sharing/deductible payments are required to establish eligibility. (For a discussion of Minnesota's program see page 20.)

b. Risk-sharing pools

Florida, Indiana, Minnesota, North Dakota, Rhode Island, and Wisconsin have developed insurance risk-sharing plans to provide access to health insurance for high-risk (uninsurable) individuals. Connecticut has a similar program, but it is open to all state residents, not just those who are high-risk (uninsurable). (For further discussion of Minnesota's program see page 19.)

c. Government-sponsored insurance programs for certain population subgroups

Wisconsin is studying the creation of an insurance program for the uninsured and Medicaid families with working or potential working heads of households. Eligible individuals would be allowed to choose from several benefit packages in a range of prices. All but the poorest uninsured are expected to contribute some money toward the cost of their health insurance, with state government providing a subsidy. Private insurers and plans will compete for the "group." The state would promote the program to eligible individuals. Wisconsin expects to finance the subsidy with money from the state medical general relief fund and the general fund. If

more money is needed, a tax on employers not offering health insurance is being considered.35

Massachusetts has also initiated the "Healthy Start" program, which provides payment for prenatal care and hospital medical expenses for uninsured pregnant women at or below 185 percent of the poverty level who are ineligible for Medicaid. Colorado's "Community Maternity Program" provides access to care and financing for low-risk pregnant women.

3. How other states finance access to medical care for the uninsured

A variety of financing options are used by other states with programs that provide access to health care for the uninsured. (The following information is taken from "What Legislators Need to Know About Uncompensated Hospital Care," a joint paper by the National Conference of State Legislators and the Foundation for State Legislatures.)

a. Currently used --

Colorado has a direct, line item, state appropriation for the state's programs.

Ohio for many years has earmarked highway user-tax funds to finance the medical care of uninsured accident victims. Oklahoma counties have the power to raise taxes for the purpose of funding programs providing medical care to the uninsured.

New York and Florida tax hospitals to develop revenue pools which redistribute funds to hospitals providing uncompensated care.

b. Under consideration --

Massachusetts is considering an income tax checkoff to finance medical care for the uninsured or those with catastrophic medical expenses.

New Jersey is considering a tax on health insurance premiums to finance care for children with catastrophic illness.

Wisconsin expects to finance medical care for its uninsured population partially through savings experienced when redesigning their Medicaid programs.

c. Other options --

States may finance health care for the uninsured by raising any existing taxes and dedicating the funds or by creating special taxes.

C. Federal Initiatives

The federal government reviewed legislation designed to ensure access to health care for the uninsured during the past two years. None passed. A description of the legislation follows.

1. Health Care for the Uninsured Act of 1985 -- would allow states the opportunity to offer health care insurance for the uninsured. A federal health insurance program would also be established for citizens in states not establishing their own plans.

2. Access to Health Care Act of 1986 -- attempted to ensure access to health care through several mechanisms: a) providing incentives for the establishment of statewide insurance programs, b) requiring states to implement programs for the uninsured and underinsured, c) providing temporary extension of coverage for laid-off workers, d) allowing a deduction for certain group health plan contributions by self-employed individuals, and e) authorizing demonstration projects for improving access to health insurance for small employers and self-employed individuals.

3. Uninsured Workers Health Insurance Act -- would allow self-employed individuals a tax deduction for health insurance and allows other individuals who purchase health insurance for themselves a tax credit. The credit was limited to individuals or families with incomes under $30,000. The value of the credit would decline as the taxpayer's adjusted gross income increases.

4. Health Equity and Incentive Reform Act -- would require that employer contributions to employee health benefits be made part of the employee's taxable income, just as individuals purchasing health insurance for themselves use taxable income for this purpose. Taxpayers would then receive a refundable tax credit or direct payment equal to forty percent of the limit of subsidized premiums. The limit on subsidized premiums would be $65 per month per household member covered under the plan up to a maximum of $195 in 1987. The limit would be increased yearly until 1989 when it would be replaced by another set of limits based on the ages of the insured and any other important factors that help predict medical costs per person.

5. Health Plan Promotion Act of 1986 -- encouraged cost-conscious purchasing of health insurance benefits by penalizing expensive health benefits. All employer-paid health plan premiums are included in gross income. An exemption from gross income for the value of the premiums up to certain levels ($75 per month for singles, $175 per month for married taxpayers) would be allowed, regardless of who pays the premiums. Individuals with health benefits in excess of the allowable amounts would be financially penalized. The bill also raises the deductible threshold for medical expense deductions from five percent of gross income to ten.

D. "Buying Right"

The medical care delivery system has undergone many changes in the last fifteen years. These changes have had the positive effect of slowing down the growth of costs in the system. At the same time the reforms are increasingly raising concerns about the quality of care being delivered.[36] So it is relatively clear to purchasers and providers of health care that further reform is necessary.

A leading proponent of past reforms, Dr. Walter McClure, agrees. Additional reform, he argues, is necessary to ensure that the new cost-conscious health care delivery system improves the quality, efficiency, and accessibility of medical services. To ensure that the system provides efficient and quality medical care, purchasers must begin to "buy right." Purchasers are the large private and public group buyers of medical care coverage -- i.e. employers, unions, and government. Buying right means that these large purchasers would not only shop for cost, but would shop for efficient, quality medical care.

Large variations in physician practice style have been documented.[37] Some experts believe that practice style variations should be identified and understood because they suggest misuse of care and unnecessary costs.[38]

New measures for determining physician performance (quality) are being developed. A few measuring systems currently exist. For example, Medisgroups is a system presently being used by some insurers as well as some providers to monitor the performance of physicians with respect to their hospitalized patients. The patient's diagnosis and severity of illness are measured when entering the hospital and at intervals while in the hospital. Physicians' results for patients with similar diagnoses can then be compared to determine whose patients are getting better and whose are not. The results are currently being used to penalize providers, i.e. discipline, sue. (See Medisgroups example in Appendix L.)

Information about physician practice style and performance forms the basis for buying right. The consumer evaluates the information prior to purchasing health insurance.

Buying right can enhance the accessibility of health care services because costs should continue to decline while efficiency increases. Reducing costs means that there will be more money to help purchase health care for those who do not have it. Because buying right allows the purchasers to "get more for their money," proponents argue that it is the best strategy to ensure access to health care for the uninsured.

Dr. McClure believes that the uninsured must be represented by a single purchaser in order to benefit from the buying right strategy and government has the unique ability to bring the wide variety of uninsured persons together in one group.[39]

VII. HEALTH INSURANCE IN MINNESOTA

A. Regulation

Health insurance in Minnesota is regulated by the state Department of Commerce. The department evaluates the benefits and price of the policy to determine the reasonableness of the rates. Currently, the Commerce Department is accepting individual health insurance contracts with a return of 55 - 60 percent (dependent on renewability of the contract). The required group contract return is higher -- 65 percent or more. Required Medicare supplemental insurance return is the highest -- 75 percent.[40]

With the exception of Medicare supplemental health insurance, a comparison of the cost and benefits of health insurance available to individuals in Minnesota is not publicly available. So individuals and groups must compare rates and benefits by shopping around. The Commerce Department ranks individual Medicare supplemental insurance as 1+, 1, 2, and 3. Loss ratios on individual supplemental Medicare health insurance policies must be made available to the consumer.[41]

Health insurance in Minnesota is subject to certain limitations. Minnesota mandated health insurance benefits are found in statute. (See Appendix M, Table 1 for list.) Qualified health insurance plans, those offered by employers desiring tax deductibility of health insurance costs, require additional benefits. (See Appendix M, Table 2.)

HMOs are regulated by the state Department of Health. Benefits required of HMOs are similar to those required by other medical insurers.

B. Health Insurance and Employment

1. Employment is an important factor in determining the availability of health insurance.

A Minnesota Department of Jobs and Training survey found that the working poor tend to hold jobs that are temporary, seasonal, part-time, or low-paying.[42] Only 36 percent of the working poor have medical coverage through employment, while 71 percent of unemployment insurance recipients and 67 percent of labor force participants receive medical insurance through employment.[43]

In Minnesota an estimated two million persons (1.3 million employees and 700,000 dependents) are covered under health insurance plans provided by employers.[44] An additional 765,000 Minnesotans purchase health insurance outside of their employment. Over 275,000 are covered by the MA or GAMC program. Another 540,000 are covered by Medicare. And 342,000 Minnesotans (171,247 who work) do not have health insurance coverage at all.[45]

2. Employment-based health insurance and public health insurance (MA, GAMC, Medicare) are subsidized by governments.

The cost of employment-based health insurance is excluded from the taxable income of its recipients as well as the taxable income of the employers providing the benefit. The U.S. Department of Health and Human Services estimates that by 1987 the federal tax expenditures (cost to the government in lost revenue), including social security taxes for employer-sponsored health insurance, will total $35.2 billion. The department believes that this will increase to $50.4 billion by 1991. In Minnesota, the tax expenditure for employment-based health insurance was estimated to be $190 million in 1985.[46]

Persons eligible for a public program (GAMC or MA) receive tax-free medical care coverage. These benefits are totally financed by the federal, state, and county governments.

Persons having to purchase health insurance on their own receive no subsidy. No public subsidy is provided to individuals purchasing health insurance on their own. Not only must they pay, generally, higher premiums because they do not belong to a large group -- they must purchase their health insurance with after-tax dollars.

An example illustrates subsidization of health insurance:

	Person A	Person B
1. Cash wages	$30,453	$32,695
2. Social Security Tax (employee share)	(2,147)	(2,305)
3. Employee's income tax	(2,996)	(3,489)
4. Employer-provided health insurance	2,400	-0-
5. Employee's after-tax income + value of health insurance (family coverage @ $200 month)	$27,710	$26,901

(Example taken from The President's Tax Proposal to the Congress for Fairness, Growth, and Simplicity, May, 1985.)

Person B's income would be reduced by the amount necessary to purchase health insurance coverage. Assuming Person B were able to purchase the same coverage at the same price as Person A, his/her income would be reduced by $2,400 for an after-tax income of $22,501.

Because most of the employed uninsured work temporary, part-time, and/or service sector jobs, wages are generally lower than those of employers providing health insurance benefits.

C. Limitations on Employment-Based Health Insurance

In 1945, Congress granted states the right to regulate the insurance business. State regulation, however, does not apply to employers who are self-insured, because the federal Employee

Retirement Income Security Act of 1974 supersedes state laws relating to employee benefit plans.

In 1980, a federal court determined that the mandatory benefit laws enacted in Minnesota did not apply to self-insured employee benefit plans because of ERISA.

ERISA also limits the ability of states to mandate employer-based health insurance, because of the pre-emption. Only the state of Hawaii currently mandates employer-based health insurance. It is able to do so as a result of an Act of Congress passed in 1982 exempting the state from ERISA. Hawaii is in a unique position in its ability to mandate health insurance, not just because of its exemption from ERISA, but also because its geographic location allows it to mandate coverage without putting itself at a competitive (business) disadvantage.

D. Types and Cost of Health Insurance Available Privately (Not Through Employer)

Generally, the cost is greater and benefits fewer when an individual purchases health insurance privately. This occurs because there is no opportunity for the insurer to spread the risk when individuals purchase insurance. Benefits may remain the same if an individual purchases health insurance through an HMO plan. Benefits provided through a traditional health insurance policy usually provide coverage for hospitalization and primary services, but exclude preventive services (including maternity care). Most policies have pre-existing condition exclusions and require deductibles and co-payments, which have the effect of limiting coverage for primary services that do not cost more than the deductible. (Appendix N provides a sample of private health insurance, traditional and HMO coverage, available in Minnesota.)

CONCLUSIONS

1. The traditional methods of providing health insurance work well for most Minnesotans. But there are too many Minnesotans without coverage.

Most Minnesotans receive their health insurance as a benefit of employment. And many poor Minnesotans receive their health insurance through public welfare programs. Unfortunately, eight to ten percent of Minnesota's population does not fit either of these categories.

2. It is neither fair nor efficient to have health insurance coverage determined by employment status.

Low-income citizens need health insurance, even if they are unable to secure it through employment. The financial consequences of a severe illness suffered by the uninsured affect all Minnesotans because the public ultimately pays, directly or indirectly, for unpaid care provided to uninsured individuals.

Most people receive health insurance through their employers as a tax-free benefit. Persons not receiving health insurance through their employers must purchase it with after-tax dollars and, because of federal limitations, are not even guaranteed a tax deduction for the cost.

Federal and state governments are subsidizing individuals with high paying, high benefit jobs at the expense of the working poor, who are less likely to be offered health insurance as a benefit of employment. Employment status should no longer be the only vehicle through which health insurance is made available to the working poor.

3. Lack of health insurance has an adverse effect on the use of health services by the uninsured.

The uninsured make fewer medical visits than the insured, particularly for preventive and primary (non-hospital) services. We agree with the experts who believe that the uninsured are less healthy than the insured partly because of their medical care utilization patterns.

An uninsured person has no incentive to visit a physician before an illness becomes serious. The individual might, in fact, have an incentive to wait until the illness is serious enough to require a hospital visit because hospitals with charity care obligations will provide necessary care free of charge. This behavior has two negative consequences: it is risky to the health of the uninsured and expensive for the public.

4. The public can no longer depend on the traditional way of providing and paying for medical care received by the uninsured.

In the past the public has paid for medical care received by the uninsured two ways: through explicit funding and through cost-shifting. Both methods of financing are threatened.

Explicit property taxes help finance public hospitals and clinics providing charity care. Continuing to rely on property taxes for charity care will be difficult in the near future for several reasons. First, raising any tax is politically unpopular. Second, changes in federal revenue sharing and possible changes in state revenue sharing may increase the programs which must be funded by revenues raised through the property tax system. Third, financing health services through the property tax system places an inequitable burden on counties that own and operate public hospitals and clinics.

Cost-shifting finances most of the medical care provided to the uninsured. Cost-shifting is not a smart way to finance medical care provided to the uninsured. First, persons with third-party coverage pay more for their services in order to subsidize the care given to those persons without coverage. Second, cost-shifting does not allow payers to monitor what they are purchasing and hold providers accountable. Third, increasing competition, with payers willing to pay only for the care provided to their members, threatens this payment form.

5. Financing medical coverage for uninsured Minnesotans visibly is in the public interest.

Financing coverage for the uninsured visibly is important. Such a system will give taxpayers knowledge of the amount being spent and the services being purchased. Taxpayers will also be able to hold providers accountable for services rendered.

6. Providing medical coverage for the uninsured is manageable.

Although the number of uninsured Minnesotans is large, it is not so large as to be unmanageable or unaffordable. Nor is there a crisis in Minnesota; as far as we can tell, the uninsured are not yet being denied necessary medical care. Because Minnesota is a leader in health care, we are presented with a unique opportunity to purchase affordable, efficient, and quality medical services for uninsured Minnesotans.

7. Government has the responsibility to arrange access to health insurance for Minnesotans who cannot afford to make arrangements themselves.

Minnesota's health care market will not and cannot be expected to deliver all of the needs of the uninsured. Many of the uninsured do not have the financial resources to participate in the marketplace. The marketplace may not provide for their special needs, such as language and cultural differences. Government will have to ensure that affordable medical coverage is available to the uninsured, in spite of the limitations placed on states by the federal ERISA policies.

8. A managed health care system is the best way to ensure affordable health insurance.

Managed health care places more responsibility for the medical access habits of individuals on providers than the traditional fee-for-service system. For example, in a managed health care system, it is to the provider's benefit to encourage patient visits to the physician early on in an illness, rather than waiting until the illness is so severe it requires hospitalization. In addition, such a system can encourage use of cost-effective providers and more appropriate utilization. Because managed health care is cost sensitive, it is the best way to ensure affordable health insurance.

9. The provision of charity care by health care providers should not be relied on as a major source of care for the uninsured.

Charity care is a small part of total health expenditures. Nevertheless, many health care providers will likely re-evaluate their charity care policies as competitive pressures intensify. Thus, public reliance on charity care for the uninsured is risky, at best. However, given the limits on any new program, we expect there to be a need for continuing charity care by health care providers to help fill the gap.

10. Public welfare medical assistance programs are in need of reform to help meet the needs of uninsured Minnesotans.

Many persons might wonder why there are so many uninsured persons in a state with generous public welfare programs. Possibly many would rather remain uninsured than go through the difficult process of qualifying for public medical assistance programs.

We have other concerns with the current structure of public medical assistance programs. First and foremost, these programs do not purchase care in an efficient way. Second, paying for services, even at discounted rates, gives incentives to providers to over-serve patients in an attempt to make up for the discounted rates. And third, participants have no incentives to utilize preventive and primary services in less expensive clinics or physicians' offices rather than at institutions. Consequently, government cannot know its financial liability in advance.

Examination of the major expenditures in the MA and GAMC program shows, in fact, that nursing home and in-patient hospital services make up a large portion of the expenses.

As Minnesota state government seeks to reduce taxes, welfare spending is increasingly vulnerable. If government reformed the public welfare medical assistance programs, it should be able to cover more people with the same amount of money. If public programs are not reformed, the only way to attempt to cut costs is to cut eligibility, benefits, or reimbursement to providers. Experience with these options shows that none of these cuts guarantees long-term cost savings.

11. The Employee Retirement Income Security Act of 1974 (ERISA) is a major barrier for states seeking to ensure that health insurance is available to all its citizens.

Federal policies play a major role in the provision of health insurance through employers. ERISA governs employee benefit plans nationally, pre-empting state laws and limiting the ability of states to mandate employer-based health insurance. While ERISA has provided many benefits, technical prohibitions in the law limit a state's ability to structure incentives for employers offering health insurance. The benefits of ERISA should be maintained but states need exemptions to the law to explore action which might maximize the provision of health insurance as a benefit of employment.

12. Ensuring access to health insurance requires a program with a spectrum of eligibility and benefits as broad as the uninsured population is diverse.

The uninsured are a diverse group and their health insurance needs will also be diverse. A program ensuring access to health insurance for this population should be sensitive to these diverse needs.

RECOMMENDATIONS

Summary -- We recommend a system to fill the health-insurance gap for the uninsured poor -- a system that makes government, business, and individuals partners.

The Legislature should: a) create and phase-in a voluntary, competitive health insurance plan for the uninsured with annual incomes below 200 percent of poverty; b) maximize federal funds by expanding Medicaid; c) reform current public medical assistance programs using the model and experience gained from the competitive health insurance plan; and d) in order to maximize employment-based health insurance, seek a waiver or amendment to federal employee benefit laws in order to develop tax incentives for businesses which provide health insurance to their employees. Health care providers should be encouraged to maintain the current level of charity care.

Introduction

There are many options for ensuring access to health care for the uninsured. We decided that the recommended solutions should: a) provide easy access to affordable health insurance to those individuals who must purchase health insurance for themselves and their families, b) be consistent with the competitive market forces, c) be affordable for and implementable within the state, and d) maintain provider commitments to charity care for uninsured individuals.

We reviewed the options in use or under consideration by others. Most state initiatives ensure medical care to the uninsured by providing funds to reimburse hospitals and other providers for their uncompensated care costs. These solutions were unacceptable in Minnesota for several reasons. First, the level of uncompensated care provided by Minnesota hospitals is very low. Second, direct reimbursement of hospitals leaves little opportunity for prudent purchasing and accountability for public funds. Third, such a system of reimbursement provides no incentives for the efficient delivery of medical services on the part of providers. And fourth, reimbursing hospitals would do nothing to promote less costly medical services such as preventive and primary medical care.

We reviewed the proposals being made by other community groups in Minnesota. Each proposal is unique to a sector of the uninsured population. The costs of each proposal range from $17 - $100 million annually. But all of the proposals share the long-term policy goal of ensuring that the uninsured poor have the opportunity to receive health insurance coverage of some form.

Doing nothing is not an option because, in the end, the general public ultimately pays the bill. The choice is between paying explicitly with controls or implicitly without control.

We recommend a system that pays for health insurance for the uninsured explicitly with controls. A solution that focuses the policy debate on starting somewhere in the spectrum of proposals being made by other groups. A system that shares responsibility among government, business, and individuals.

A. The Minnesota Legislature should establish a health insurance plan for the uninsured.

The task of ensuring access to health insurance for all low-income uninsured Minnesotans will be long and difficult. Nevertheless, the Legislature should begin that process with a small program that can expand or contract as need and funds arise. The health insurance plan we propose provides this flexibility.

The most practical way to keep the cost of premiums down for participants and government is the traditional mechanism that spread the risks among many persons. Such an approach allows the state to act as a purchaser, able to anticipate the needs of its group.

1. Given implementation and financing constraints, the program should be phased. Eligibility and benefits should be phased in, beginning, at a minimum, with the "Right Start Program" advocated by the Children's Defense Fund.

Eligibility should begin with persons with annual incomes less than 200 percent of poverty who are:

a. children (0 - 5 years of age),
b. pregnant women, or
c. persons leaving AFDC.

Initial benefits offered should, at a minimum, be prenatal care and primary and preventive services for children. The benefits should grow to offer comprehensive coverage (similar to that required of Minnesota HMOs).

The number of potential participants with annual incomes under 200 percent of poverty is large. The potential costs to the state are also large. Given limited dollars to fund the program, we recommend that itbe phased in by making the plan initially available only to a very small portion of the uninsured and by limiting benefits.

First priority should be given to children, 0 - 5 years of age, pregnant women, and persons leaving AFDC or General Assistance. We know that the benefits of preventive services for pregnant women and children far outweigh the costs of providing these services. Such an investment should result in long-term savings.

We learned that health insurance is important to welfare recipients. So we designed the plan to be a bridge out of welfare dependency and recommend that persons leaving the income assistance system be given the option of receiving health insurance from the plan.

2. Before expanding the program beyond its initial stage, the Legislative Auditor should evaluate the program.

Phasing in the program will allow the state to gain valuable experience. This experience should help the plan take shape prior to the time it is made available to all who would qualify. An extensive evaluation of the experience should be undertaken prior to the time the plan is expanded.

3. The long-term policy goal of the health insurance plan should be to phase in eligibility for all uninsured Minnesotans with incomes below 200 percent of poverty and expand benefits to those required by law of HMOs.

Expanded Eligibility --

We were charged to recommend a system that ensures access to health care for the involuntarily uninsured. Drawing the line between those who are voluntarily uninsured and those involuntarily uninsured was a very difficult task. The fact that society usually bears the cost of a catastrophic medical incident by either of these two groups made the decision even more difficult. After considerable discussion, we recommend limiting eligibility for the plan, even in the long run, to individuals and their families with annual incomes of 200 percent of poverty or less.

Any line will make it difficult for persons close to the cutoff point to participate in the plan. For example, under our proposal a person making 200 percent of poverty one year and 201 percent of poverty the next year will be allowed to participate only one of two years in the program. Nevertheless, we feel strongly that any individual or family with an annual income over 200 percent of poverty should be able to purchase health insurance from a private vendor. We also believe that extending eligibility beyond 200 percent of poverty would place government at a competitive advantage over private insurers serving the same market. Finally, we recognize that drawing no line creates the possibility of extremely large public expenditures for a benefit we've come to expect will be provided by private sector employers.

Expanded Benefits

Our discussion on the benefits to be offered by the insurance plan was lengthy. Some members advocated a very limited benefit package of preventive, primary, and acute medical services. These members argued that such a benefit package was the most cost-effective and affordable package of benefits as well as the most likely to change the manner in which the uninsured access medical services. Other members felt, given that most persons receive large indirect subsidies for health insurance as an employment benefit, it would be inequitable to provide fewer benefits for the uninsured. We decided to recommend that the insurance plan provide benefits similar to those provided to most working Minnesotans as a long-term goal.

4. The Legislature should construct the plan to: a) be cost efficient, b) be affordable to participants, c) be simple to administer and qualify for, d) provide quality care, e) provide reasonable access to services, and f) allow choice for participants.

a. To ensure a cost-efficient insurance plan, the Legislature should require competitive bidding. Only companies licensed to insure in Minnesota should be allowed to bid for the business.

As government becomes a purchaser of health insurance it is able to participate in the health care marketplace. Competitive bidding on a predetermined package of benefits is the best way for government to ensure itself of the lowest cost possible and limited liability.

b. To ensure affordable premiums, the plan should require participants to pay a portion of the premium based on a sliding fee. Persons with incomes below the federal poverty level should not be required to pay a premium. Those with incomes up to double the poverty level should pay a premium based on a sliding fee, reaching full payment at 200 percent of poverty.

The success of the health insurance plan will depend on the ability of individuals to participate. The cost of health insurance is still rising. Competitive bidding should help moderate this rising cost; even so, this cost might not be affordable to many of the uninsured.

So we recommend that health insurance for uninsured persons and families with annual incomes under the poverty level be totally subsidized by the state. While this might seem expensive, if persons with this income choose to participate in the health insurance plan instead of current welfare programs, the potential cost savings in income grants is large. And because the state would purchase insurance instead of reimburse for services, there should be a savings in the medical coverage.

Persons and families with annual incomes between 100 and 200 percent of poverty should pay a portion of their health insurance premium based on a sliding fee. We anticipate that this will enable many of the uninsured to receive essential coverage at affordable rates.

c. To ensure simple administration and eligibility, an asset test should not be required for participation.

Existing public welfare medical insurance programs are difficult to apply and qualify for, partly because of the asset test. These difficulties may deter persons who are eligible for the program from requesting assistance. A new program providing health insurance for the uninsured should be simple in order to be attractive to the potential recipients.

Accountants and experts warn us that there are persons able to shelter income who, in fact, have substantial incomes and assets. Not having an asset test opens the program to potential abuse. After much debate, we were unable to design an asset test, simple enough to avoid abuse and to administer easily and at low cost, that would not discourage potential participants. The MCHA health insurance program, paid for by the state and participants, does not require an asset test. Given these facts, we recommend that an asset test not be required for participation in the plan. Instead, income and an inability to access health insurance through more traditional means should be the only tests.

d. To ensure high quality medical care, bidders should be required to provide performance measurements of providers in accordance with community standards.

Quality is a difficult term to define. Our discussions about quality centered on the idea of being able to identify providers who compete, not only on the basis of cost and benefits, but also on their performance.

There is evidence that physician practice styles vary greatly. These variances are part of the reason for cost differences, with little or no difference in the outcome to the patient. Our discussions about existing and new technologies to measure provider quality lead us to recommend that all insurers awarded contracts be required to provide quality data on a routine basis. Such data should be based on the performance of individual providers. We anticipate that this type of quality information will lead to more coverage for less cost and the state will be able to expand the program cost-efficiently.

e. To ensure accessible services, bidders should be required to: i) arrange for provision of services in locations accessible to the population being served and ii) provide for the special needs of the population being served.

A lot is known about the uninsured. Those qualifying for the plan are likely to live in certain neighborhoods of the metropolitan area as well as certain areas of the state. Bidders should be required to provide evidence of an ability to provide services in geographic locations accessible to the population.

Reasonable access to services means more than just geographic access. Many of the uninsured may need other "social" services such as translators or counselors. For this reason, bidders should also be required to ensure the availability of these services to plan participants, to the extent they are necessary.

f. To ensure choice, participation should: i) be voluntary and ii) offer a limited number of plans/insurers from which to choose.

The voluntary nature of the plan means that there will be less than 100 percent participation. Nevertheless, we decided not to force participation. The income level of those eligible for the program may not be high enough, given the cost of other necessities, for participation.

Forcing participation might also send a message to providers that we do not want to send -- that they can reduce their commitment to provide charity care. It is not the intention of the plan to assure providers that all patients receiving and needing medical services will have health insurance coverage. This program should not diminish the charity care obligations of providers. It should, however, reduce their charity care burden.

We recognize that voluntary participation with sliding fees represents the opportunity for adverse selection. That is, only persons who need the insurance are likely to enroll in the program if they have to pay a portion of the premium. But the state has a program for persons who are uninsurable due to a previously existing medical condition. While we do not intend the plan to be a substitute for MCHA, we recognize that the public will ultimately bear the cost of services provided to uninsurable persons with low incomes. Neither the old nor new system will change this situation.

We recommend choice within the plan for participants. A limited number of insurance contracts should be granted for this purpose. In addition to providing choice for participants, awarding multiple contracts provides incentives for insurers to improve their programs in order to gain more participants.

5. Administration should occur in a manner consistent with other state health insurance (not welfare) programs, such as the Minnesota Comprehensive Health Association. The state departments regulating the insurance and health industries should set the specifications and policy for the plan and be responsible for overseeing its administration.

Administration of the program will be extremely important to its success. We were impressed with the administration of the MCHA health insurance program and recommend that administration of the proposed plan be similar.

6. The Legislature should finance the new plan through:

a. premiums from the participants,
b. welfare savings, and
c. the general fund.

The estimated cost of the first phase of the proposed plan is $17 million per year. We expect early prenatal intervention to realize savings in the state Medicaid program, which currently spends a great deal of money as a result of poor birth outcomes. We recommend these savings be applied to funding the proposed health insurance plan. Premiums from participants should also be dedicated to the costs of the plan. Other necessary monies should be appropriated from the general fund.

B. The Legislature should enact a targeted expansion of Medicaid designed to meet the need of the uninsured population with maximum federal matching of funds, by:

1. Increasing income eligibility limits for Medicaid to the federal maximum of 133 percent of the AFDC grant standard, for the AFDC population; and

2. Expanding coverage for pregnant women and infants as allowed under the 1986 Reconciliation Act.

We recommend expanding Medicaid eligibility as a form of financing. Recent federal legislation allows expanded coverage for pregnant women and infants. Expanding eligibility will allow the state to maximize the federal dollars available to pay for necessary care to this population. The estimated cost to the state for this expansion is $7 million a year.

While we feel strongly that it is essential for federal and state governments to get control of the spiraling costs of public welfare medical assistance programs, we cannot expect Minnesota not to participate in the new opportunities to enroll more uninsured persons in Medicaid. No state can afford to put itself at a competitive disadvantage.

C. The Legislature should reform public medical assistance programs by becoming a purchaser of insurance for welfare recipients, not just a reimburser for services rendered, in a manner consistent with the recommendations for the insurance plan for the uninsured.

Public welfare medical assistance programs continue to grow, both in costs and the number of people served, even though income eligibility levels have not kept pace with inflation. At the same time, thousands of Minnesotans who are eligible for the programs are not being served.

We expect public programs to make the most use of every dollar in order for programs to remain affordable. Welfare medical assistance programs do not. The programs continue to purchase services in an inefficient way. Traditional providers of care have limited incentives to service welfare patients in a cost-effective manner. Welfare patients have limited incentives to access the medical system in cost-efficient ways or disincentives to access the system in expensive ways. The result: costs of public welfare medical assistance programs are impossible to predict and continue to increase annually.

Traditional suggestions for saving money under the current structure of public welfare medical assistance programs are to cut eligibility, cut benefits, or both. But there are already too many uninsured Minnesotans, so cutting people off is unacceptable. Although cutting benefits is appealing, cost savings would be limited due to the nature of the program. Many optional benefits provided in Minnesota are offered as more cost-effective alternatives to mandatory benefits. Nevertheless, the programs must become more cost-efficient if the public is to continue to provide services for the very poor.

We did not undertake an extensive review of the public welfare medical assistance programs. Nevertheless, it is clear to us that the programs can be used as a means to provide medical coverage to the uninsured if they are reformed. We recommend that both the General Assistance Medical Care program and the Medical Assistance program be reformed in a manner consistent with the recommendations for the health insurance plan. That is, government should become an efficient purchaser of health insurance, not just a reimburser for services rendered. In this way programs can use money that is saved to expand eligibility and services, not cut them.

D. The Legislature should seek to maximize employer-sponsored health insurance by seeking a waiver or amendment to federal law that would provide states the limited flexibility needed to develop tax incentives for businesses who provide health insurance.

Current federal law restricts the ability of states to develop incentives for employers who provide health insurance benefits to their employees. If limited flexibility were available, states could develop tax incentives to ensure that employers offering health insurance are better off than employers not offering health insurance, without undoing the benefits gained from passage of ERISA.

The state-sponsored insurance plan that we recommend should be structured so that a) employers who provide insurance for employees aren't penalized relative to employers who allow their employees to be covered by the state plan instead, and b) individuals who need insurance will have more incentive to work -- and receive health benefits through their employers -- than to forego work and rely upon the state-sponsored plan.

The risks of abuse increase in the long run, because we recommend that eligibility ultimately include all uninsured persons under 200 percent of poverty.

E. Health care providers should be encouraged to maintain their current commitment to charity care for persons who are unable to pay for necessary services.

We recognize and share public concern that a new program of health insurance might simply replace charity care already being given by health care providers, instead of offering new benefits to the uninsured. However, we expect that the demand for charity care will continue, because only a small number of people will be covered under the inital phase of the proposed program.

We recommend that the charity care effort be maintained. The state health department is considering gathering information about charity care levels as part of its routine health care cost information system. This information should be made available to the Legislature on an ongoing basis for their determination as to whether any action is necessary.

Minnesota's Uninsured Poor Population

		Poor	Near Poor	Low Income	TOTAL
	0 - 5	4,498	4,016	6,063	15,027
A	6 -17	33,067	4,579	12,610	50,256
G	18 -24	25,926	3,130	13,125	42,181
E	25 -54	38,967	10,565	14,493	64,025
	55 -64	2,982	550	3,685	7,217

Poor = Family income less than federal poverty level
Near Poor = Family income 100 - 125 percent of federal poverty level
Low Income = Family income 125 - 200 percent of federal poverty level

SOURCE: 1985 State Planning Agency Study

Health Insurance Pool for the Uninsured (Initial Phase)

		Pregnant Women	Children 0 - 5
	Obstretrical Care*	X	
B E N E F I T S	Well-Child Care		X
	Sick-Child Care		X
	Inpatient Visits		X
	Diagnostic Tests		X
	Surgery**		X
	Inpatient Days***		X

*Includes physician pre- and post-natal care, anesthesia, newborn exam, and hospital costs.

**Includes inpatient and outpatient surgery and anesthesia costs.

***Does not include initial newborn exam and hospital days.

SOURCE: Children's Defense Fund Right Start Proposal

WORK OF THE COMMITTEE

Charge to the Committee

Following is the text of the charge to the Health Care for the Uninsured Committee, as prepared by the Citizens League Program Committee and approved by the Citizens League Board of Directors:

How should accessible, efficient and effective health care be financed for persons who are involuntarily uninsured? Currently, Minnesota has a considerable number of people whose medical expenses are covered neither by government assistance programs nor by private insurance. Some of these people have made a conscious decision to assume the risks of not being covered; in effect, they are self-insured. But a substantial number of others would like to be covered but for a variety of reasons they don't have adequate resources. This can include persons with insufficient incomes to purchase insurance but who don't qualify for public assistance because their level of assets may be higher than permitted by the public assistance programs.

In the past health care providers often have provided care to persons unable to pay by increasing the bills paid by everyone else. Such cost-shifting is growing more unfeasible under new systems of health care reimbursement.

The committee should develop recommendations to provide the involuntarily uninsured with access to care, consistent with market principles that are helping control health care costs throughout the population. The committee should review plans developed by others to finance health care for the involuntarily uninsured. It should then recommend a specific plan based on these proposals, or it should be free to develop an entirely new plan.

If the committee feels its assignment is too broad, it may concentate on one or more sub-groups of individuals within the larger category of the involuntarily uninsured.

Committee Membership

The following persons participated in the committee on a regular basis:

Jack Ebeler, chair
Ellen Benavides
Ron Brand
Keith Broady*
Robert Cardinal
Pat Davies
W.D. Chris Donaldson
John Drozdal
Mary Duroche
Johnelle Foley
Patricia Genereux
Sally Graven
Phil Griffin
Judith Hale
C. Joseph Howard*
David Hunt
Lawrence Kaplan
John Klein
Julianna LeBlond
Malcolm Mitchell
Charles Oberg
Christopher Reif
William Smith
K.C. Spensley
Marsha Studer
Robert Thompson
Peter Thoreen
Evelyn Van Allen
Lyle Wray

(*Dissented from the committee recommendation to offer a health insurance plan.)

Mary Ziegenhagen chaired the committee from January - August 1986. After she moved from the Twin Cities area, Jack Ebeler was appointed as chair of the committee.

Committee Work

The committee began its work on January 16, 1986 and met 36 times. The last meeting was held on February 12, 1987. The committee devoted its testimony stage to learning about who the uninsured are, the extent of their health needs, where they currently receive health care, and how care provided to them is paid for. The committee relied on testimony from resource people familiar with the subject as well as information contained in local and national publications.

Detailed minutes were kept of each committee meeeting. A limited number of copies of the committee's minutes and background materials are available from the League office.

Assistance to the Committee

Citizens League staff assistance to the committee was provided by Nancy Jones, Joanne Latulippe, and Marina Lyon.

Committee Resource Guests

Mila Aroskar, director, public health nursing, University of Minnesota
Sister Mary Madonna Ashton, commissioner, Minnesota Department of Health
Robert Baird, director of health care programs, Minnesota Department of Human Services
Senator Linda Berglin, chair, health and human services committee, Minnesota Senate
Roberta Droen, administrator, Shriners Hospital for Crippled Children
Mary Edwards, legislative assistant to Senator David Durenburger
Dr. Ed Ehlinger, director, personal health services, Minneapolis Health Department
Johnelle Foley, executive director, Minnesota Association of Public Teaching Hospitals
Robert Garland, chief financial officer and deputy director, Saint Paul Ramsey Medical Center
Phil Griffin, director of legislative and regulatory affairs, Physicians Health Plan
Michael Holmes, Cook Area Health Services
Linda Ingraham, director, Family Healthreach Consultants
John Ingrassia, supervisor, life and health section, Minnesota Department of Commerce
John Kingrey, director of government relations, Minnesota Hospital Association
Patricia Klauck, executive director, Minneapolis Children's Hospital
Jim Lehman, ad hoc committee on health care for the elderly, Minnesota Medical Association
Joe Lindsey, chief, medical administration service, Veterans Administration Medical Center
Tom Loftus, speaker, Wisconsin Assembly
Jan Malcolm, director of planning and government relations, MedCenters Health Plan
Walter McClure, president, Center for Policy Studies
Dan McLaughlin, administrator, Hennepin County Medical Center
Marianne Miller, Minnesota Department of Health
Richard Niemiec, vice president, underwriting and statistics, Blue Cross Blue Shield of Minnesota
Luanne Nyberg, Children's Defense Fund
Joan Olson, Blue Cross/Blue Shield of Minnesota, administrator, Minnesota Comprehensive Health Association
Brian Osberg, director of hospital and provider services, Group Health, Inc.
Christopher Reif, physician, Health Etc. Community Clinic
Michael Resnick, Adolescent Health Program, University of Minnesota
Dan Rode, associate director for finance, University of Minnesota Hospital
Mary Samoszuk, vice president of public affairs, Council of Community Hospitals
Darrell Shreve, health policy unit, Minnesota State Planning Agency
Vern Silvernale, Minnesota Hospital Association
K.C. Spensley, Community Clinic Consortium
Linda Stein, Ramsey County Public Health Department
Renee Trenary, Blue Cross/Blue Shield of Minnesota, administrator Minnesota Comprehensive Health Association
Sue Zuidema, director, Hennepin County Community Health Department

FOOTNOTES

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4. University of Minnesota Survey, and St. Thomas College Survey.
5. "Economic Characteristics of Households in the United States: Fourth Quarter 1983," U.S. Census Bureau, U.S. Department of Commerce, Washington, D.C. 1985, and "The Changing Face of the Uninsured," Katherine Schwartz, Urban Institute, paper presented at the Annual Meeting of the Association for Health Services Research, June 1984.
6. "An Evaluation of the 1981 AFDC Changes, Final Report," U.S. General Accounting Office, Washington, D.C., July 1985.
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12. State Planning Agency Study.
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35. "A New Direction in Social Policy" and remarks to Citizens League Breakfast meeting by Tom Loftus, Speaker, Wisconsin General Assembly, April 3, 1986.
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41. Ibid.
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APPENDIX A

Statistics in this section are drawn from Analysis of Health Insurance Coverage and Health Care Utilization and Expenditures in Minnesota for 1985. This report was prepared for the Minnesota State Planning Agency by ICF, Incorporated.

TABLE 1. AGE Distribution of Minnesota's Uninsured Population

Age Group	Number Uninsured	Percent of All Uninsured
0 - 17	99,969	29.2%
18 - 24	80,429	23.5%
25 - 54	141,892	41.5%
55 - 64	19,936	5.8%

TABLE 2. Percentage of Uninsured by ETHNIC or RACIAL Identification

Race or Ethnic ID	Number Uninsured	Percent of Group Uninsured
White	333,316	8.1%
Black	6,062	11.7%
Hispanic	1,826	5.7%
Other	1,032	1.2%

TABLE 3. EMPLOYMENT Status of Minnesota's Uninsured Population (For Uninsured Minnesotans in 19-64 years of age)

Employed	Number Uninsured	Percent of Uninsured
All Year	92,049	26.9%
Part of the Year	79,198	23.1%
None of the Year	57,162	16.7%

TABLE 4. Uninsured Minnesotans by Employment Status

Status	Percent Uninsured At a Given Time	Percent Above the State Average (8.1%)
Student	11.9%	+ 47%
Employed Part Year Only	12.4	+ 53
Self-Employed	14.8	+ 83
Homemaker	15.5	+ 91
Unemployed	35.8	+342

TABLE 5. Percentage of OCCUPATION With Uninsured Employees

Employment Type	Number Uninsured	Percent of Occupation Uninsured
Non-Farm Laborer	14,172	15.3%
Farm	26,909	14.7%
Service	41,587	13.8%
Craft and Kindred	29,354	11.6%
Operatives	23,408	9.3%
Management and Sales	14,713	2.9%

TABLE 6. Uninsured Minnesotans by FAMILY INCOME

Family Income	Number Uninsured	Percent of All Uninsured
Below poverty line	105,890	30.9%
100-200 % of poverty	72,816	21.3%
200-400 % of poverty	127,451	37.2%
Over 400% of poverty	36,079	10.5%

TABLE 7. Uninsured Adult Minnesotans (25-54 Years) by Income

Family Income	Number Uninsured	% of Group	% Uninsured
Below poverty line	38,967	27.5%	41.9%
100-200% of poverty	25,058	17.7%	16.8%
200-400% of poverty	59,519	41.9%	9.6%
Over 400% of poverty	18,348	12.9%	2.3%

TABLE 8. Uninsured Minnesota Children (0-17 Years) by Income

Family Income	Number Uninsured	% of Group	% Uninsured
Below poverty line	38,015	38.0%	11.1%
100-200% of poverty	27,268	27.3%	8.0%
200-400% of poverty	29,228	29.2%	8.5%
Over 400% of poverty	5,458	5.5%	1.6%

APPENDIX B

TABLE 1. 1983 No-Charge Patients by Major Diagnostic Categories

25.4%	Pregnancy and Childbirth
17.5%	Normal Newborns and Other Neonates
42.9%	Subtotal of Above
12.0%	Diseases of the Musculo/Skeletal/Connective Tissue
7.5%	Diseases and Disorders of the Nervous System
20.0%	Other Diseases and Disorders
82.4%	TOTAL OF ALL ABOVE

Source: 1983 COCH Metropolitan Uncompensated Care Study

TABLE 2. 1983 Self-Pay Patients by Major Diagnostic Categories

18.3%	Newborns
14.9%	Childbirth
33.2%	Subtotal of Above
8.5%	Diseases and Disorders of the Digestive System
6.2%	Diseases and Disorders of the Nervous System
6.0%	Mental Disorders
21.7%	Other Diseases and Disorders
75.6%	TOTAL OF ALL ABOVE

Source: 1983 COCH Metropolitan Uncompensated Care Study.

APPENDIX C

Metropolitan Community Clinic Patient Population Insurance Status

38 %	No Insurance
16 %	Medical Assistance
3 %	Medicare
37 %	Other Insurance
7 %	Don't Know

Source: Community Clinic Consortium, May 1985 Survey

APPENDIX D

TABLE 1. Hennepin County Public Health Department
Insurance Status of Prenatal Patients

Medical Assistance	16 %
Private Insurance	18 %
No Insurance	66 %

TABLE 2. Hennepin County Public Health Department
Insurance Status of Child Health Clinic Patients

None	57 %
Insurance - No Outpatient	28 %
Medical Assistance	8 %
Insurance - Some Outpatient	8 %

APPENDIX E

TABLE 1. Minnesota Jobs Bill Program
Summary: Utilization of Services by Type of Visit

September 1983 - June 1985

Type of Visit	Number of Visits	Percent of Total Medical & Dental Visits
Dental		
Emergency Dental	1,145	9.5
Medical:		
Routine	1,620	13.4
Acute Problems	1,613	13.4
Pregnancy	1,143	9.5
General Medical	947	7.8
Chronic Problems	675	5.6
Well Child	333	2.8
Accidents	217	1.8
Other	4,386	36.3
TOTAL	12,079	100.0%

TABLE 2. Minnesota Jobs Bill Program
Medical and Emergency Dental Care for the Unemployed

Encounters by Age and Sex
January 1984 - December 1984

Age Group	Sex		Total	Percent of Total
	Male	Female		
0 - 4	749	817	1,566	58.0
5 - 9	85	65	150	5.6
10 - 14	45	40	85	3.1
15 - 19	33	42	75	2.8
20 - 34	187	339	526	19.5
35 - 44	99	72	171	6.3
45 - 64	51	75	126	4.7
Over 65	0	3	3	
TOTAL	1,249	1,453	2,702	100%

TABLE 3. Minnesota Jobs Bill Program
Medical and Emergency Dental Care for the Unemployed

Encounters by Age and Sex
January 1985 - December 1985

Age Group	Sex		Total	Percent of Total
	Male	Female		
0 - 4	297	270	567	9.5
5 - 9	258	222	480	8.1
10 - 14	108	137	245	4.1
15 - 19	154	306	460	7.7
20 - 34	1,094	1,483	2,577	43.4
35 - 44	488	402	890	15.0
45 - 64	337	362	699	11.8
Over 65	12	12	24	0.4
TOTAL	2,748	3,194	5,942	100%

TABLE 4. Minnesota Jobs Bill Program
Medical and Emergency Dental Care for the Unemployed

Number of Encounters, Fee for Service, and
Payment for Services Rendered
September 1983 - December 1985

Type of Service	Number of Encounters	Total Fee For Service	Average Fee For Services	Total Payment For Services	Average Payment	Payment Percent
Medical	8,367	$319,744.37	$38.21	$201,848.13	$24.12	63%
Emergency Dental	775	28,128.95	36.30	19,514.20	25.18	69%
TOTAL	9,142	$347,873.32	$38.05	$221,362.33	$24.21	64%

APPENDIX F

TABLE 1. Metro vs. Non-Metro Distribution of Dollars Hospitals with Active Hill-Burton Program

Fiscal Year 1984:

Area	Number of Hospitals	HB $ FY	% of Gross Revenues
Metro	13	$2,428,877	0.34
Non-Metro	39	$4,548,459	1.02
TOTAL	52	$6,977,336	0.61
Fiscal Year 1985:			
Metro	13	$3,838,199	0.52
Non-Metro	36	$4,666,620	1.04
TOTAL	49	$8,504,819	0.72

Source: 1984 Hospital Survey, MN Department of Health

TABLE 2. Minnesota Hospitals Participating in Hill-Burton by Year

Fiscal Year	Number
1986	39
1987	29
1988	26
1989	25
1990	22

(One respondent's end date is unknown.)

Source: 1984 Hospital Survey, MN Department of Health

APPENDIX G

TABLE 1. General Assistance Medical Care (GAMC) Qualification

* Minnesota resident

* Net income not exceeding the following:

Family Size	Annual Income	Monthly Income
1	4,164	347
2	5,208	434
3	6,336	528
4	7,392	616
5	8,292	691

If an applicant's income exceeds the limits, he or she may qualify on a "spend-down" basis. A "spend-down" is similar to an insurance deductible -- the client is responsible for bills up to the spend-down amount, and the program will pay for the rest. The amount of the spend-down is determined by taking the net income exceeding the GAMC standard for a 12-month period and dividing by two to arrive at the six-month spend- down amount.

* Real property--Homestead is excluded; non-homestead property is excluded if equity in all real property is less than $15,000. If equity is greater than $15,000, then non-home- stead property must be producing income not in excess of limits, be offered for sale, or waived by the county board in which assistance is sought.

* Personal property--not to exceed $1,000 per person applying for assistance. (Household goods, personal items, clothing, one automobile, and one burial plot per person are not counted.)

* (Real or personal property transferred or given away without adequate compensation in the 24 months preceding application for GAMC is presumed to have been done with the intention of qualifying for GAMC. The value of such property is counted against the resource limits for the period of time determined by the local agency. There are provisions for the applicant, disqualified for GAMC because of such a property transfer, to appeal the decision.)

TABLE 2. General Assistance Medical Care
Cases, Persons, and Payments -- Fiscal Years 1981-1985

Fiscal Year	Monthly Average Cases	Monthly Average Persons	Total Net Annual Dollars	State Dollars	County Dollars
Actual					
1981	12,575	12,944	$52,231,201	$47,008,081	$5,223,120
1982	10,581	10,819	$38,840,601	$34,956,181	$3,884,020
1983	9,780	9,961	$31,971,231	$28,774,108	$3,917,123
1984	13,713	14,106	$35,588,347	$32,029,512	$3,558,835
1985	19,713	20,367	$57,906,419	$52,115,777	$5,790,642

Caseload and Payment Projections -- Fiscal 1986 and 1987
(Forecast of September 30, 1985)

Fiscal Year	Monthly Average Cases	Monthly Average Persons	Total Annual Dollars	State Dollars	County Dollars
1986	20,713	21,400	$70,856,000	$63,771,000	$7,086,000
1987	20,316	20,990	$75,577,000	$68,019,000	$7,558,000

SOURCE: Minnesota Department of Human Services

TABLE 3. General Assistance Medical Care Program Benefits

a. Inpatient hospital care
b. Outpatient hospital care
c. Eye examinations
d. Physician services
e. Chiropractic services
f. Podiatric services
g. Dental care
h. Prescription drugs and supplies necessary to administer them (e.g. syringes)
i. Medicare-certified rehabilitation agencies
j. Medical transportation
k. Laboratory and X-ray services
l. Hearing aids and prosthetic devices
m. Equipment necessary to give insulin and check blood sugar levels
n. Day treatment for mental illness at community mental health centers

TABLE 4. Minnesota General Assistance Medical Care Expenditures by Type of Care State Fiscal Years

Category of Service	1981 Amount	%	1982 Amount	%	1983 Amount	%	1984 Amount	%	1985 Amount	%
Inpatient Hospital Services	$32,046,407	61.4	$26,553,846	68.4	$21,868,636	68.4	$23,236,118	65.3	$36,327,780	62.7
Nursing Home Care	545,893	1.0	70,792	0.2	4,608	0.0	(1,656)	0.0	(70)	0.0
Intermediate Care	998,388	1.9	212,216	0.5	(2,473)	0.0	(3,109)	0.0	(3,274)	0.0
Physician Services	8,047,557	15.4	5,825,345	15.0	4,260,043	13.3	5,233,235	14.7	8,503,347	14.7
Outpatient Hospital or Clinic	3,530,906	6.8	2,858,303	7.4	3,212,065	10.0	2,049,216	5.8	4,910,543	8.5
Home Health Care	118,689	0.2	19,609	0.1	(236)	0.0	49	0.0	308	0.0
Nursing Services	7,986	0.0	874	0.0	0	0.0	0	0.0	1,412	0.0
P.T., O.T., S.T. & Rehab Services	114,752	0.2	12,103	0.0	625	0.0	16,514	0.0	50,582	0.1
Dental Services	2,581,353	4.9	1,315,636	3.4	908,071	2.8	1,560,229	4.4	2,265,192	3.9
Independent Lab and X-Ray	22,925	0.0	8,932	0.0	813	0.0	1,397	0.0	71,759	0.1
Prescribed Drugs	1,938,492	3.7	1,411,369	3.6	1,392,538	4.4	2,487,246	7.0	3,699,646	6.4
Optometric Services	498,431	1.0	106,030	0.3	677	0.0	195,207	0.5	344,234	0.6
Family Planning	183,228	0.4	163,503	0.4	107,057	0.3	140,557	0.4	236,309	0.4
Mental Health/Psychology	713,700	1.4	234,977	0.6	238,285	0.7	313,392	0.9	363,773	0.6
Medical Supplies	388,681	0.7	106,997	0.3	1,711	0.0	283,242	0.8	538,497	0.9
Diagnostic Screening Services	332	0.0	147	0.0	0	0.0	0	0.0	0	0.0
Ambulance and Other Medical Transportation	376,186	0.7	305,347	0.8	253,598	0.8	340,034	1.0	631,993	1.1
Other Practitioners	207,553	0.4	46,858	0.1	(472)	0.0	488	0.0	323	0.0
Health Insurance/HMO	62,805	0.1	67,840	0.2	127,848	0.4	210,664	0.6	611,381	1.1
Other Services	(153,062)	(0.3)	(480,123)	(1.2)	(402,163)	(1.3)	(474,476)	(1.3)	(647,316)	(1.1)
TOTAL	$52,231,202		$38,840,601		$31,971,231		$35,588,347		$57,906,419	

APPENDIX H

TABLE 1. Average Number of Persons Receiving Medical Assistance FY 1981-85

Year	Monthly Average Number
1981	135,472
1982	134,906
1983	135,520
1984	149,219
1985	158,865

TABLE 2. Minnesota Medical Assistance
For Recipients Concurrently Receiving Categorical Aid
Calendar Years 1981-85

Year	Total State	Total Urban	Total Rural
1981	$276,777,198	$139,986,756	$136,790,442
1982	308,028,172	153,696,756	154,332,029
1983	327,172,390	161,055,382	166,117,008
1984	361,358,496	182,453,749	178,904,747
1985	363,910,943	184,158,327	179,752,616

Minnesota Medical Assistance
For Recipients Receiving Medical Assistance Only
Calendar Years 1981-85

Year	Total State	Total Urban	Total Rural
1981	$429,686,176	$204,267,445	$225,418,731
1982	493,764,509	233,269,214	260,495,295
1983	548,244,338	257,669,223	290,575,115
1984	601,245,480	282,958,452	318,287,028
1985	621,705,773	289,257,252	332,448,521

TABLE 3. Medicaid Services by State

MEDICAID SERVICES STATE BY STATE

December 1, 1980

BASIC REQUIRED MEDICAID SERVICES. Medicaid recipients receiving federally supported financial assistance must receive at least these services: inpatient hospital services, outpatient hospital services, rural health clinic services; other laboratory and X-ray services; skilled nursing facility services and home health services for individuals 21 and older, early and periodic screening, diagnosis, and treatment for individuals under 21, family planning, and physician services. Federal financial participation is also available to States electing to expand their Medicaid programs by covering additional services and/or by including people eligible for medical but not for financial assistance. For the latter group States may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart.

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

● CN[2]
✦ Both CN and MN[3]

FMAP[1]	BASIC REQUIRED MEDICAID SERVICES SEE ABOVE		Optional Services in State Medicaid Programs: Podiatrists' Services	Optometrists' Services	Chiropractors' Services	Other Practitioners' Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing, and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitative Services	Services for Age 65 or Older in TB Institutions: A. Inpatient Hospital Service; B. SNF Services	C. ICF Services	Services for Age 65 or Older in Mental Inst.: A. Inpatient Hospital Services	B. SNF Services	C. ICF Services	Intermediate Care Facility Services	ICF for Mentally Retarded	Inpatient Psychiatric Service for Under Age 22	Christian Science Nurses	Christian Science Sanitoria	SNF for Under Age 21	Emergency Hospital Services	Personal Care Services	Total Additional Services	
71	●	Alabama		●									●		●	●											●	●						12	AL
50	●	Alaska		●				●				●				●								●			●	●	●			●	●	10	AK
61		Arizona																																	AZ
73	+	Arkansas		+	+	+		+	+				+	+	+	+					+	●	●	+	●	●	●	●			●	+	●	21	AR
50	+	California	+	+	+	+		+	+	+		+	+	+	+	+	+	+	+	+	+	+		+	●	●	●	●		+		+	+	30	CA
53	●	Colorado	●					●					●		●									●			●	●				●		12	CO
50	+	Connecticut	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+				●			●	●				●		24	CT
50	●	Delaware	●					●					●		●		●							●			●	●				●		10	DE
50	+	D.C.	+	+				+		+			+		+	+	+							●			●	●				●	●	19	DC
59	●	Florida		●		●			●			●	●	●	●	●					●			●			●	●	●		●	●		14	FL
67	●	Georgia	●			●		●					●		●						●	●	●		●	●	●	●			●			13	GA
50	+	Guam		+				+	+	+			+	+	+	+																		10	GU
50	+	Hawaii	+	+		+		+	+	+	+		+	+	+	+	+	+																20	HI
66	●	Idaho	●	●	●			●		●			●							●						●	●							12	ID
50	+	Illinois	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+		+	+	+	+	+	●	●			●	●		29	IL
57	●	Indiana	●	●	●		●	●	●	●	●	●	●	●	●	●	●		●	●				●			●	●	●		●	●		24	IN
59	●	Iowa	●	●	●	●		●	●	●	●		●	●	●	●	●	●	●	●				●			●	●	●		●	●		21	IA
54	+	Kansas	+	+	+	+	+	+	+	+	+		+	+	+	+						+	+	+	+	+	●	●			●	●		26	KS
68	+	Kentucky		+		+		+		+	+		+	+	+									+	+	+	●	●			●	●		17	KY
69	+	Louisiana			+			+					+	+	+									●			●	●				●		15	LA
70	+	Maine	+		+	●		+		+	+	+	+	+	+				+	+							+	●			+	●		23	ME
50	+	Maryland	+	+				+		+			+	+	+	+											+	●			+	●		15	MD
52	+	Massachusetts	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+				+	+	+	+	●	●			●	●		28	MA
50	+	Michigan	+	+	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+				+	+	+	+	●				●	●		24	MI
56	+	Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	●				●	●		31	MN
78	●	Mississippi							●				●		●									●			●	●			●				8	MS
60	●	Missouri		●					●				●	●	●	●	●	●	●	●				●			●	●				●			14	MO
64	+	Montana	+	+		+	+	+	+	+	+	+	+	+	+	+	+		+	+				+	+	+	+	●				●	●		26	MT
58	+	Nebraska	+	+	+	+	+	+	+	+			+	+	+	+								+	+	+	+	●				●	●		23	NB
50	●	Nevada	●	●	●	●	●	●		●	●	●	●	●	●	●				●				+			●	●				●	●		20	NV
61	+	New Hampshire	+	+	+	+	+	+					+		+	+	+		+					+		●	●	●				●	●		25	NH
50	●	New Jersey	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●	●	●			+		●	●	●	●			●	●		27	NJ
65	●	New Mexico	●	●		●	●	●	●	●	●	●	●	●	●					●				+			●	●				●	●		18	NM
50	+	New York	+	+		+	+	+	+	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	●	●				●			29	NY
68	+	North Carolina	+	+	+			+	+				+	+	+	+	+	+	+	+				+			+								19	NC
51	+	North Dakota	+	+	+		+	+	+	+	+		+	+	+	+	+	+	+	+				+			+								27	ND
50	+	N. Mariana Islands		+				+		+			+	+	+							+	+	+			+								16	NMI
55	●	Ohio	●	●	●	●	●	●	●	●	●	●	●	●	●	●								+			●	●			●	●			23	OH
64	+	Oklahoma	+						+				+		+									+			+								10	OK
66	●	Oregon	●	●	●	●	●	●	●	●			●	●	●	●	●			●				●			●	●			●	●	●		22	OR
56	+	Pennsylvania	●	+	+			+	●				●	●	●					●				+	+	+	+	●				●			16	PA
60	+	Puerto Rico				+		+	+	+	+	+	+				+	+	+	+															13	PR
58	+	Rhode Island	+	+					+				+	+	+	+											●	●			●				11	RI
71	●	South Caroline	●		●								●		●							●		●			●	●			●	●			11	SC
69	●	South Dakota			●			●	●	●	●		●	●	●					●				●	●	●	●	●			●	●	●		16	SD
69	+	Tennessee						+					+		+									+			+								14	TN
58	●	Texas	●	●	●								●	●	●	●				●		●		+	+	+	●	●			●	●	●		13	TX
68	+	Utah	+	+		+	+	+	+	+		+	+	+	+									+			+	+							18	UT
68	+	Vermont	+					+					+		+									+			+	+							10	VT
50	+	Virgin Islands						+	+	+	+	+	+	+	+																				9	VI
57	+	Virginia	+	+				+		+	+	+	+		+									+			+	+							17	VA
50	+	Washington	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+		+	+	+	+	+	+	+							28	WA
67	+	West Virginia	+	+	+	+	+	+		+	+	+	+	+	+							+	+	+			+	+							20	WV
58	+	Wisconsin	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+				+			+	+			+				27	WI
60	●	Wyoming								●					●					●							●								6	WY
●	20	●	14	14	10	9	6	12	11	10	7	7	19	11	16	12	6	3	4	11	9	2	2	14	8	11	24	23	12	1	7	19	18	5		
+	34	+	25	27	17	20	14	32	23	26	19	23	33	24	30	26	17	13	16	20	17	9	7	29	17	16	26	25	22	5	11	27	28	11		
	54	Total	39	41	27	29	19	44	34	36	26	30	52	35	46	38	23	16	20	31	26	11	9	43	25	27	50	48	34	6	18	46	46	16		

[1] FMAP-Federal Medicaid Assistance Percentage: Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act. Percentages, effective from October 1, 1979, through September 30, 1981 are rounded.
[2] Categorically Needy: People receiving federally supported financial assistance.
[3] Medically Needy: People who are eligible for medical but not for financial assistance.

TABLE 4. Minnesota Medical Assistance Expenditures
By Category of Service
State Fiscal Years (Ending June 30)

Category of Service	1980	1981	1982	1983	1984	1985	1986
Mandatory Services (Subtotal)	$288,491,225	$346,456,169	$401,905,224	$453,380,863	$489,190,810	$514,613,755	$516,593,113
Inpatient Hospital, General	79,181,818	90,210,650	108,351,306	129,936,223	135,955,622	135,659,012	123,442,504
Outpatient Hospital, General	13,148,545	14,684,258	16,988,117	20,792,713	12,118,711	18,406,456	20,707,502
Nursing Home, Skilled	161,652,275	198,780,976	232,214,767	256,867,630	290,232,697	305,250,950	312,111,893
Independent Lab/X-Ray	211,462	227,895	238,764	312,661	336,280	453,723	641,601
Family Planning Service	1,699,197	2,391,333	2,826,544	2,661,459	2,556,382	2,735,988	2,986,492
EPSDT	512,158	631,333	884,630	1,193,309	1,148,450	1,271,185	1,325,066
Physician/Osteopathic Service	32,085,770	39,529,724	40,401,096	41,616,868	46,842,668	50,836,441	55,378,055
Optional Services (Subtotal)	$277,877,696	$311,358,805	$347,685,722	$386,477,377	$434,917,794	$479,447,215	$503,856,489
Inpatient Hospital, T.B.	0	0	0	0	0	0	0
Inpatient Hospital, Mental	56	0	0	0	0	0	11
Crippled Children's Hospital/Convalescent	0	0	0	0	0	0	0
Mental Health Service	721,686	1,187,460	1,358,757	2,087,944	2,556,959	3,332,135	4,584,795
HMO	147,382	236,625	329,091	2,355,012	2,912,904	4,645,057	10,788,618
Rehabilitation Service	505,863	587,950	582,503	1,429,757	2,763,214	4,069,780	4,836,914
Nursing Home, T.B.	0	0	0	0	0	0	0
Nursing Home, ICF-MR	39,765,782	50,747,684	68,744,859	83,776,384	105,432,996	119,854,289	125,278,020
Nursing Home, ICF-I	91,198,360	106,940,638	114,792,490	115,797,865	120,807,188	124,741,356	118,218,568
Nursing Home, ICF-II	9,099,791	10,246,879	10,988,173	10,945,780	10,859,665	11,214,604	12,330,816
P.T., O.T., S.T., & Aud. in Nursing Homes	9,249,446	10,812,069	11,896,925	13,581,338	16,477,163	20,022,367	20,615,848
Home Health Service	2,599,771	3,231,283	3,267,160	4,148,518	5,002,284	6,095,026	7,559,570
Crippled Child Service	11,492	15,630	11,825	13,701	14,122	14,997	15,883
Buy-In/Health Insurance	1,938,614	2,213,176	2,300,993	2,684,989	3,193,580	3,617,990	3,755,185
Public Health Clinic Service	454,155	522,274	422,127	489,932	588,872	593,977	701,119
Recipient Recovery	(3,603,456)	(4,226,448)	(7,012,117)	(7,414,416)	(11,302,677)	(10,161,542)	(14,373,148)
State Institution, MR (ICF)	69,010,385	63,021,701	70,787,360	86,341,395	93,824,806	97,157,349	96,538,356
State Institution, MI-CD (Mental Hospital)	10,228,731	9,676,267	9,474,566	8,820,957	10,282,884	12,124,228	12,249,613
Prescribed Drugs	23,119,914	26,307,065	28,912,486	29,683,669	34,286,244	39,437,593	45,002,970
Medical Supplies	3,644,865	4,426,486	4,443,005	4,952,297	6,323,057	7,644,430	9,384,247
Ambulance Service/Medical Transportation	2,754,199	3,286,684	3,627,629	4,154,973	4,576,548	5,733,877	7,262,475
Dental Services	11,535,634	13,963,854	12,881,318	11,978,091	12,502,519	12,091,819	13,387,665
Optometric Services	1,813,581	2,256,863	2,048,270	1,552,332	1,351,349	1,507,092	1,660,976
Psychology	979,667	1,797,095	2,725,966	2,891,191	3,500,966	4,498,773	5,529,139
Nursing Services	1,240,921	1,995,290	3,146,871	3,682,673	5,064,692	6,101,504	6,848,594
Physical Therapy	203,366	292,636	216,709	262,849	299,407	393,039	352,594
Speech Therapy	236,070	480,072	429,882	392,486	497,497	425,642	185,227
Occupational Therapy	0	31,293	107,570	169,870	105,264	99,021	62,845
Podiatrist Service	491,796	530,149	553,379	361,192	307,935	344,783	295,268
Chiropractor Service	508,604	731,490	618,915	786,038	901,895	1,058,327	1,304,240
Audiologist	19,979	39,075	20,016	21,690	43,808	59,391	63,665
Osteopathic Service (Non-M.D.)	0	0	0	0	0	0	0
Waivered Services (MR)	N/A	N/A	N/A	N/A	N/A	377,156	5,142,237
Waivered Services (Elderly)	N/A	N/A	N/A	479,927	1,597,649	2,249,398	4,172,635
Other Services	1,042	7,565	8,994	48,943	145,004	103,757	101,544
All Services (Grand Total)	$566,368,921	$657,814,974	$749,590,946	$839,858,240	$924,108,604	$994,060,970	$1,020,449,602

TABLE 5. Medical Assistance Payments
Fiscal Years 1981-85

Year	Total Dollars	Federal Dollars	State Dollars	County Dollars
1981	$657,814,974	$366,008,252	$262,626,050	$ 29,180,672
1982	749,590,946	403,917,081	311,106,478	34,567,387
1983	839,378,312	440,526,723	358,966,430	39,885,159
1984	922,510,954	468,428,000	408,674,659	45,408,295
1985	994,060,969	517,682,101	428,763,348	47,615,520

Medical Assistance Payment Projections
Fiscal Years 1986 and 1987
(Forecast as of May 10, 1986)

Year	Total Dollars	Federal Dollars	State Dollars	County Dollars
1986	$1,055,525,000	$561,750,000	$444,376,000	$49,399,000
1987	$1,152,291,000	$615,439,000	$483,156,000	$53,697,000

APPENDIX I

Hennepin County Capitation Ratebook, F.Y. 1986
Non-Institutional Care

AFDC

ALL CATEGORIES:	Female	Male
0-14	44.11	44.11
15-49	116.84	68.51
50+	155.79	155.79

AGED

MEDICARE:

1) SSI/MSA:	Female	Male	2) Non-SSI/MSA:	Female/Male
65 - 74	139.41	162.19	All Ages	361.86
75+	130.11	138.41		

NON-MEDICARE:

1) SSI/MSA:	Female	Male	2) Non-SSI/MSA:	Female+Male
65 - 74	262.37	218.81	All Ages	607.69
75+	318.03	448.39		

BLIND

MEDICARE:

1) SSI/MSA:	Female + Male	2) Non-SSI/MSA:	Female+Male
All Ages	125.94		125.94

NON-MEDICARE:

1) SSI/MSA:	Female + Male	2) Non-SSI/MSA:	Female+Male
All Ages	250.01		250.01

DISABLED

MEDICARE:

1) SSI/MSA:	Female	Male	2) Non-SSI/MSA:	Female+Male
0 - 15	269.67	185.69	All Ages	555.84
15 - 49	258.49	156.05		
50 - 64	205.65	165.96		
65+	142.55	169.55		

NON-MEDICARE:

1) SSI/MSA:	Female	Male	2) Non-SSI/MSA:	Female+Male
0 - 15	159.85	380.27	All Ages	824.14
15 - 49	421.70	366.92		
50 - 64	473.04	583.17		
65+	212.15	939.68		

Hennepin County Capitation Ratebook, F.Y. 1986
Individuals in Institutional Settings

ICF-MR

MEDICARE:	Female + Male
All Ages	104.57

NON-MEDICARE:	Female + Male
All Ages	154.53

SNF, ICF I & II

AGED

1) MEDICARE:	Female	Male	2) NON-MEDICARE:	Female	Male
65 - 74	242.63	231.49		310.80	296.56
75 - 84	173.00	170.08		220.82	216.50
85+	133.70	147.00		156.53	172.01

BLIND

1) MEDICARE:	Female + Male	2) NON-MEDICARE:	Female + Male
All Ages	207.38		447.09

DISABLED

1) MEDICARE:	Female	Male	2) NON-MEDICARE:	Female	Male
- 64	339.08	309.09		545.54	495.95
65 - 74	260.97	233.87		422.15	376.92
75 - 84	243.09	284.55		324.59	381.87
85+	123.02	107.31		205.32	178.53

APPENDIX J

Minnesota Comprehensive Health Association (MCHA)

Year	Claims	Total Cost	Premium Income	State Cost	Loss Ratio
1983	22,510	$7,732,000	$4,082,000	$3,650,000	187.0%
1984	37,350	10,612,000	6,414,000	4,198,000	165.5%
1985	58,570	14,124,000	9,492,000	4,632,000	148.8%

Source: Minnesota Department of Commerce

APPENDIX K

Catastrophic Health Expense Protection Program (CHEPP)
Example of Eligibility

Family Income: $26,000

20 percent of first $15,000	=	$3,000
25 percent of $15,000-$25,000	=	$2,500
30 percent of amount over $25,000	=	$300
Total		$5,800

The family would be liable for the $5,800 worth of medical care*.
CHEPP would pay 90 percent of qualified medical expenses over $5,800.**

* The $5,800 would be over and above insurance reimbursement.
** Costs do not have to be paid, only owed.

APPENDIX L

Total Cholecystectomy
(Gallbladder Operation)

Hospital	Total $	Avg. Admission Severity	7 Day Average Complication Rate
A	$4,906	1.57	4.7%
B	$2,900	1.46	2.5%
C	$5,390	1.39	9.1%
D	$3,585	1.38	3.4%
E	$6,008	1.38	3.2%
F	$2,756	1.33	1.9%
G	$4,916	1.28	6.7%
H	$3,374	1.17	1.9%
I	$3,129	1.13	4.3%

Explanation: Hospital D and E admitted a patient with the same level of severity (1.38). Seven days later the patients were improving at about the same rate (3.4% vs. 3.2%). Even through there is no measurable difference in the result to the patient, the difference in cost is almost $2500.

Source: Medi-qual Systems, Inc., 1986

APPENDIX M

TABLE 1. MINNESOTA MANDATED HEALTH INSURANCE BENEFITS

1. The RIGHT of terminated employees to remain part of the insurance group for up to twelve months after termination. The employee is required to pay for the actual benefit after termination.
2. Immediate coverage for adopted children.
3. Coverage of handicapped dependents and/or spouse.
4. Immediate coverage of newborns for 31 days or until enrollment.
5. Ability of disabled to continue group insurance for two or more years (more if totally disabled) -- the employer is not responsible for paying the premium.
6. Limited outpatient, mental health, and alcoholic benefits.
7. Continuation of benefits to survivors.
8. Emotionally handicapped children.
9. Ambulatory mental health services.
10. Free standing ambulatory surgical centers.
11. DES related conditions.
12. Conversion privileges for insured former spouses and children.
13. Reconstructive surgery.
14. Coverage for phenylketonuria treatment (condition found during infancy).

Source: Minnesota Statutes, Section 62A.

TABLE 2. ADDITIONAL "QUALIFIED HEALTH PLAN" MANDATED BENEFITS

1. Coverage equal to at least 80 percent of the cost of covered serivces in excess of an annual deductible which does not exceed $150, $500, or $1,000 per person. The coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage shall be subject to a maximum lifetime benefit of not less than $250,000.

2. Covered expenses shall be the usual and customary charges for the following services when prescribed by a physician:

a. hospital services;
b. professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at the physician's direction;
c. drugs requiring a physician's presciption;
d. services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under Medicare;
e. services of a home health agency if the services would qualify as reimbursable services under Medicare;
f. use of radium or other radioactive materials;
g. oxygen;
h. anesthetics;
i. prostheses other than dental;
j. rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;
k. diagnostic X-rays and laboratory tests;
l. oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;
m. services of a physical therapist;
n. transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment;
o. benefits for well baby care, subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations; and
p. a second opinion from a physician on all surgical procedures expected to cost a total of $500 or more in physician, laboratory and hospital fees, provided that the coverage need not include the repetition of any diagnostic tests.

Source: Minnesota Statutes, Section 62E.06

APPENDIX N

Examples of Individual Health Insurance Coverage and Rates

Blue Cross and Blue Shield of Minnesota

AWARE CARE

Monthly Rates

(Effective 4/1/86)

Applicant Age _____
Spouse Age _____
Number of Children (under 19)_____

STEP 1:

BASE AMOUNT

a. Enter your base rate from the Step 1 table based on age, sex and deductible chosen (deductible must be the *same for all family members*): $ _____

b. Enter your spouse's base rate based on age and sex: $ _____

c. Enter rate for children. $ _____

Base Amount Total: $ _____

		Deductible					
AGE		$150	$300	$500	$1,000	$1,500	$2,000
Under 30	M	$36.96	$29.45	$18.82	$14.68	$11.88	$ 9.83
	F	56.96	45.62	29.22	23.12	18.73	15.49
30 - 34	M	40.09	31.96	20.67	16.03	12.99	10.74
	F	61.85	49.63	31.96	25.04	20.29	16.78
35 - 39	M	46.85	37.33	23.77	18.51	14.99	12.40
	F	73.87	59.39	38.35	29.79	23.32	19.29
40 - 44	M	57.13	45.51	28.80	22.39	18.13	14.99
	F	80.96	65.08	41.99	31.86	25.80	21.35
45 - 49	M	72.47	57.86	36.92	28.41	23.02	19.05
	F	95.68	76.81	49.96	38.25	30.98	25.62
50 - 54	M	91.15	72.84	46.15	35.67	28.89	23.89
	F	113.97	91.55	59.63	45.86	37.15	30.73
55 - 59	M	110.86	87.66	57.47	44.14	35.78	29.58
	F	134.13	106.86	70.11	54.03	43.75	36.19
60 - 64	M	148.49	105.24	78.03	60.30	48.84	40.38
	F	176.53	140.64	92.94	71.65	58.02	48.00
**65+	M	213.62	160.97	113.69	88.75	71.87	59.47
	F	243.72	176.04	129.76	100.00	81.01	66.99
CHILDREN							
1 Child		47.00	34.29	20.71	15.90	12.87	10.66
2 Children		94.00	68.58	41.42	31.80	25.74	21.32
3 or more		141.00	102.87	62.13	47.70	38.61	31.98

STEP 2:

NONSMOKER DISCOUNT

You may reduce your AWARE CARE rates if you and/or your spouse have **not** smoked tobacco within the past 36 months. The nonsmoker discount does not affect the rate for children.

If applicable, enter amount of your rate reduction from the Step 2 table: $ _____

Enter amount of spouse's rate reduction if applicable: $ _____

Nonsmoker Discount Total $ _____

AGE		$150	$300	$500	$1,000	$1,500	$2,000
Under 30	M	$ 1.83	$ 1.46	$ .94	$ .73	$ .59	$ .48
	F	2.82	2.25	1.45	1.14	.92	.77
30 - 34	M	2.75	2.19	1.41	1.10	.89	.73
	F	4.25	3.40	2.19	1.72	1.40	1.16
35 - 39	M	3.21	2.56	1.63	1.27	1.02	.85
	F	5.07	4.08	2.64	1.97	1.60	1.32
40 - 44	M	5.93	4.73	2.99	2.32	1.88	1.55
	F	8.40	6.75	4.36	3.31	2.68	2.22
45 - 49	M	9.40	7.50	4.79	3.68	2.99	2.47
	F	12.40	9.96	6.48	4.95	4.02	3.32
50 - 54	M	16.27	13.01	8.24	6.37	5.16	4.27
	F	20.35	16.35	10.65	8.19	6.64	5.49
55 - 59	M	19.76	15.65	10.26	7.88	6.38	5.28
	F	23.95	19.08	12.52	9.65	7.81	6.46
60 - 64	M	32.00	22.68	16.83	13.00	10.53	8.70
	F	38.05	30.32	20.04	15.44	12.50	10.35
**65+	M	46.04	34.70	24.50	19.13	15.48	12.82
	F	52.53	37.93	27.96	21.55	17.46	14.44

STEP 3:

ALCOHOL AND CHEMICAL DEPENDENCY COVERAGE OPTION

Alcohol and Chemical Dependency Treatment is covered under the AWARE CARE plan unless you and your family decline this coverage. If you decline the coverage, you will receive a rate reduction and such declination is effective for all covered members under the *AWARE CARE Contract*.

a. Enter amount of rate reduction for yourself from the Step 3 table: $ _____

b. Enter amount of rate reduction for spouse: $ _____

c. Enter amount of rate reduction for children: $ _____

Alcohol & Chemical Dependency Coverage Option Discount Total: $ _____

AGE		$150	$300	$500	$1,000	$1,500	$2,000
Under 30	M	$ 2.56	$ 2.03	$ 1.30	$ 1.01	$ .82	$ .69
	F	3.95	3.17	2.02	1.61	1.30	1.07
30 - 34	M	2.75	2.20	1.42	1.10	.90	.74
	F	4.24	3.40	2.20	1.72	1.40	1.16
35 - 39	M	3.21	2.57	1.62	1.27	1.03	.85
	F	5.08	4.07	2.63	1.98	1.59	1.32
40 - 44	M	3.77	3.00	1.90	1.48	1.19	.99
	F	5.35	4.30	2.77	2.10	1.70	1.41
45 - 49	M	4.69	3.75	2.39	1.83	1.48	1.24
	F	6.21	4.97	3.23	2.48	2.00	1.66
50 - 54	M	5.71	4.56	2.89	2.23	1.81	1.49
	F	7.12	5.72	3.72	2.86	2.32	1.92
55 - 59	M	8.92	5.48	3.59	2.76	2.24	1.86
	F	8.38	6.68	4.38	3.38	2.73	2.25
60 - 64	M	8.96	6.35	4.70	3.64	2.95	2.44
	F	10.65	8.48	5.61	4.33	3.50	2.90
**65+	M	12.89	9.71	6.86	5.36	4.34	3.59
	F	14.71	10.63	7.84	6.04	4.90	4.04
CHILDREN							
1 Child		3.42	2.50	1.52	1.16	.93	78
2 Children		6.84	5.00	3.04	2.32	1.86	1.56
3 or more		10.26	7.50	4.56	3.48	2.79	2.34

Enter Base Amount Total from Step 1 $ _____
If applicable: Enter the Nonsmoker Discount from **Step 2** $ _____
If applicable: Alcohol and Chemical Dependency Coverage Option Discount. Enter from *Step 3* $ _____
Total of Discounts from Steps 2 & 3 (Subtract from Base Amount Total above) $ _____
YOUR MONTHLY AWARE CARE RATE: $ _____

*Rates will change as you reach a new age table (e.g., age 44 to age 45)
**Available only to applicants who are not entitled to Medicare.

F2370-R3 (4/86)

AWARE CARE provides **$1,000,000 of lifetime protection** for you and each family member covered under your plan. It's protection that is with you everywhere...at home...across town...across the country...or on the other side of the world.

After your deductible is paid, AWARE CARE covers 80% of the first $5000 of eligible expenses—then 100% of all eligible expenses over $5000 during each calendar year. Coverage includes:

Acute care benefits:

- semiprivate room 365 days per year (private room if medically necessary)
- special care units (coronary care, intensive care, etc.)
- ancillary medical supplies
- hospital outpatient services and surgical centers
- diagnostic, X-ray, and laboratory services
- physician, surgeon, and chiropractor services
- private-duty nursing by a licensed registered nurse
- therapy by physical, speech, or inhalation therapist
- prescription drugs
- ambulance
- pregnancy or pregnancy-related conditions:
  - through the first 18 months of the contract and after the subscriber has paid the first $5000, AWARE CARE will pay 100% of the remaining covered expenses
  - beginning with the 19th month, AWARE CARE will pay 50% of the covered expenses up to $5000 after the annual deductible is met—thereafter 100% of all eligible expenses are covered to the end of the calendar year

***Care in a skilled nursing facility* (nonacute):**

- 120 days per calendar year
- semiprivate room (private room if medically necessary)
- all necessary services and supplies

Home health care:

- 180 visits per calendar year
- approved health agency team services
- all necessary services and supplies

The PHP Individual Plan

Your Benefit Summary

PHP Physician Services:	
Visits to physician offices	100%
Tests, X-rays, and immunizations	100%
Hospital visits by a PHP physician	100%
Surgical care	100%
Eye and hearing exams	100%
Well-baby care	100%
Routine exams	100%

Supplemental Services:	
Physical therapy (outpatient)	100%
Private-duty nursing by registered nurse	80%
Home health services	80%
Prosthetics	80%
Durable medical equipment	80%
Ambulance services	80%

Prescription Medications

You pay $4.50 for each prescription or refill – written by a PHP physician and filled at a PHP pharmacy – for up to a 34-day supply of medication consistent with the PHP Drug Formulary.

Services through PHP Hospitals

Inpatient: 80% for unlimited number of days for medically necessary admissions, with a maximum copayment of $900 per member per calendar year (Reconstructive surgery limitations apply.)

Outpatient: $25 member copayment for emergency room or PHP hospital services when you cannot be treated in a PHP physician's office. No copayment is required if you are admitted to the hospital for the same condition within 24 hours. No copayment applies for scheduled outpatient surgery and diagnostic tests when the hospital does not make a facility charge.

Maternity Services

100% coverage for pre- and postnatal care from a PHP physician. 80% coverage for hospital services for mother and child with a maximum member copayment of $900 per member per calendar year.

Emergency Medical Services Received from Non-PHP Providers

80% coverage for the first $2,500 of expenses per calendar year. 100% thereafter when it is not medically possible to reach a PHP provider or hospital.

Mental Health and Chemical Dependency Services

Outpatient: The PHP member pays $10 per visit for individual therapy and $5 per visit for group therapy. Maximum coverage is 30 visits per calendar year. All care must be provided or authorized in advance by the Metropolitan Clinic of Counseling.

Inpatient: 80% coverage for up to 30 days per calendar year for mental health and 73 days for chemical dependency treatment. PHP members must be evaluated and treated by the Metropolitan Clinic of Counseling.

Reconstructive Surgery

Surgical and all other services received during hospitalization for Reconstructive Surgery:

1. To correct a congenital anomaly resulting in a functional defect of the body – 80% coverage with a maximum member copayment of $1,500 per hospital stay.
2. For surgery incidental to or following surgery resulting from injury, sickness or disease – 80% coverage with a maximum member copayment of $1,500 per hospital stay.

Basic Dental Coverage

The following basic dental care is covered at 100%:

Diagnostic Services: Initial Oral Examination – (#D0110)

Periodic Oral Examinations/2 per year – (#D0120)

A $15 charge will apply for each appointment not kept or cancelled at least 24 hours prior to the time of the scheduled visit – (#D9998)

X-rays, bitewings/1 per year – (#D0274 or #D0272)

Preventive Care: Teeth Cleaning/2 per year – (#D1110/adult) (#D1120/children)

Fluoride Treatments/1 per year – (#D1230/children only)

Discounts on other dental services, too. In addition to 100% coverage for preventive and diagnostic services, your PHP dentists will give you a 10% discount on other services normally performed by them. As long as you receive the services through a PHP general dentist and make payment at time of service, this discount is allowed. Payment is due at time of service unless other arrangements are made with your dentist.

The following services are not covered:

Dental

- Prescription drugs prescribed by a PHP dentist

Medical

- Physical exams for insurance or employment purposes
- Cosmetic procedure or plastic surgery
- Experimental/unproven procedures
- Surgical procedures intended primarily for treatment of morbid obesity. This includes gastric bypasses and jejunal bypasses
- Invitro fertilization

This summary of benefits is only an outline for your general information. All benefits for members are subject to the provisions of the contract between you and PHP.

RATE TABLE

AGE	SEX	MONTHLY RATE
Under 30	M	$ 42.35
	F	$ 62.98
30-34	M	$ 48.95
	F	$ 67.10
35-39	M	$ 51.70
	F	$ 71.78
40-44	M	$ 61.60
	F	$ 77.00
45-49	M	$ 77.00
	F	$ 95.00
50-54	M	$ 88.50
	F	$ 98.00
55-59	M	$110.00
	F	$115.00
60-64	M	$125.00
	F	$130.00
CATEGORY		
One Child		$ 40.15
2 Children		$ 80.30
3 + Children		$120.45

FAST FACTS
AWARE Gold Individual

Blue Cross and Blue Shield of Minnesota

No other plan offers as many benefits or advantages in health care protection.*

	AWARE Gold Individual (full program— $0 deductible)	AWARE Gold Individual ($500 hospital deductible)
AWARE Gold Physicians' Services Office visits	100% covered	
Well-baby care	100% covered	
Eye & ear examinations	100% covered	
Immunizations & vaccinations	100% covered	
Maternity care	100% covered (after 18 months of consecutive coverage)	
Surgery	100% covered	
In-hospital medical visits	100% covered	
Anesthesia	100% covered	
Laboratory tests & X rays	100% covered	
Hospital Coverage Outpatient	100% covered for medical emergencies and other services listed in the contract (certain nonemergency care subject to a $25 copayment)	
Inpatient	100% covered	member pays a $500 deductible each year; then Blue Cross and Blue Shield of Minnesota pays 80% of the first $5000 of eligible expenses and 100% thereafter for the rest of the calendar year

*This is only an outline of coverage. For most service rendered within the network, 100% coverage will be available for the benefits described. Please see the contract for specific description of benefits.

No benefits will be paid during the first two (2) years of coverage for any preexisting condition for which a covered family member received medical advice or treatment 90 days before the date that person is first covered under the AWARE Gold contract.

	AWARE Gold Individual (full program— $0 deductible)	AWARE Gold Individual ($500 hospital deductible)
Outside-the-Network Coverage Non-AWARE Gold doctor	member pays a $200 deductible; then Blue Cross and Blue Shield of Minnesota pays 80% of the first $3000 in eligible expenses and 100% thereafter for the rest of the calendar year	
Emergency physician care	100% covered	
Emergency outpatient care	100% covered	
Emergency inpatient hospital	100% covered	member pays a $500 deductible; then Blue Cross and Blue Shield of Minnesota pays 80% of the first $5000 of eligible expenses and 100% thereafter for the rest of the calendar year
Authorized, nonemergency hospital admissions**	100% covered	same as emergency inpatient hospital above
Other Benefits No paperwork	no paperwork or claims to file when member uses an AWARE Gold doctor or hospital	
Prescriptions, drugs	$4.50 copayment for each prescription	
Nonsmoker discount	reduced rates for member who has not smoked tobacco for past 36 months	
Chemical dependency option	benefits can be waived with accompanying reduction in rates	

**There is a $250 copayment for each unauthorized hospital stay outside of Minnesota in nonemergency situations. This condition applies to both AWARE Gold Individual plans.

Blue Cross and Blue Shield of Minnesota

AWARE Gold Individual

Applicant Age _____
Spouse Age _____
Number of Children (under 19) _____

STEP 1:

BASE AMOUNT

a. Enter your base rate from the Step 1 table based on age, sex and deductible chosen (deductible must be the same for all family members): $ _____

b. Enter your spouse's base rate based on age and sex: $ _____

c. Enter rate for children. $ _____

Base Amount Total: $ _____

STEP 2:

NONSMOKER DISCOUNT

You may reduce your AWARE Gold Individual rates if you and/or your spouse have not smoked tobacco within the past 36 months. The nonsmoker discount does not affect the rate for children.

If applicable, enter amount of your rate reduction from the Step 2 table: $ _____

Enter amount of spouse's rate reduction if applicable: $ _____

Nonsmoker Discount Total: $ _____

STEP 3:

ALCOHOL AND CHEMICAL DEPENDENCY COVERAGE OPTION

Alcohol and Chemical Dependency Treatment is covered under the AWARE Gold Individual Plan unless you and your family decline this coverage. If you decline the coverage, you will receive a rate reduction and such declination is effective for all covered members under the AWARE Gold Individual Contract.

a. Enter amount of rate reduction for yourself from the Step 3 table: $ _____

b. Enter amount of rate reduction for spouse: $ _____

c. Enter amount of rate reduction for children: $ _____

Alcohol & Chemical Dependency Coverage Option Discount Total: $ _____

Monthly Rates*

(Effective 4/1/86)

Age		AWARE Gold full program $6 deductible	AWARE Gold [illegible] $6 deductible
Under 30	M	$50.26	$36.88
	F	73.13	56.25
30 - 34	M	55.85	43.02
	F	83.91	64.53
35 - 39	M	66.99	53.78
	F	93.25	71.72
40 - 44	M	88.99	66.90
	F	106.32	81.76
45 - 49	M	109.36	84.11
	F	124.25	95.59
50 - 54	M	141.89	109.14
	F	141.89	109.14
55 - 59	M	173.40	133.40
	F	188.15	129.35
60 - 64	M	230.64	177.41
	F	208.67	160.50
**65 +	M	329.46	253.43
	F	302.02	232.32
[illegible]	1 Child	43.53	33.44
	2 Children	87.06	66.88
	3 or more	130.59	100.32

Age		AWARE Gold full program $6 deductible	[illegible] $6 deductible
Under 30	M	$ 2.33	$ 1.79
	F	3.39	2.60
30 - 34	M	3.55	2.76
	F	5.39	4.14
35 - 39	M	4.49	3.45
	F	5.99	4.61
40 - 44	M	8.47	6.51
	F	10.35	7.96
45 - 49	M	13.31	10.24
	F	15.13	11.64
50 - 54	M	23.85	18.34
	F	23.85	18.34
55 - 59	M	29.14	22.42
	F	28.26	21.74
60 - 64	M	46.88	36.06
	F	42.41	32.62
**65 +	M	66.96	51.51
	F	61.39	47.22

Age		[illegible]	[illegible]
Under 30	M	$ 3.26	$ 2.51
	F	(4.74)	3.65
30 - 34	M	3.55	2.76
	F	5.39	4.14
35 - 39	M	4.56	3.45
	F	5.99	4.61
40 - 44	M	5.39	4.14
	F	6.59	5.07
45 - 49	M	6.66	5.12
	F	7.56	5.82
50 - 54	M	8.35	6.42
	F	8.35	6.42
55 - 59	M	10.20	7.85
	F	9.89	7.61
60 - 64	M	13.13	10.10
	F	11.88	9.13
**65 +	M	18.75	14.42
	F	17.19	13.22
CHILDREN	1 Child	2.90	2.19
	2 Children	5.80	4.38
	3 or more	8.70	6.57

Enter Base Amount Total from Step 1 $ _____
If applicable: Enter the Nonsmoker Discount from Step 2 $ _____
If applicable, Alcohol and Chemical Dependency Coverage Option Discount. Enter from Step 3 $ _____
Total of Discounts from Steps 2 & 3 (Subtract from Base Amount Total above) $ _____
YOUR MONTHLY AWARE GOLD INDIVIDUAL RATE: $ _____

*Rates will change as you reach a new age table (e.g., age 44 to age 45)
**Available only to applicants who are not entitled to Medicare.

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WHAT THE CITIZENS LEAGUE IS

The Citizens League has been an active and effective public affairs research and education organization in the Twin Cities metropolitan area since 1952.

Volunteer research committees of League members study policy issues in depth and develop informational reports that propose specific workable solutions to public issues. Recommendations in these reports often become law.

Over the years, League reports have been a reliable source of information for governmental officials, community leaders, and citizens concerned with public policy issues of our area.

The League depends upon the support of individual memberships and contributions from businesses, foundations and other organizations throughout the metropolitan area.

Citizens League

708 South 3rd Street
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RESEARCH and REPORTS

- Citizen committee research and debate develops new policy ideas which often become law.
- Experts equip the committees with facts and judgments.
- Comprehensive reports make the rounds, inform the public and frequently shape the debates.

PUBLICATIONS

- *Minnesota Journal* - twenty-two issues of engaging public affairs news, analysis and commentary — news you can't find anywhere else.
- *CL Matters* – an update of the League's community activities, meetings and progress on issues.
- *Public Affairs Directory* – a listing of agencies, organizations and officials involved in the making of public policy.

ACTION and IMPLEMENTATION

- Citizens communicate the League's work to the community and public officials, precipitate further work on the issues and get things to happen.

LEADERSHIP BREAKFASTS

- Public officials and community leaders meet with League members in locations throughout the metropolitan area to discuss timely issues.

SEMINARS

- Single-evening meetings offer debate and education covering pending public issues — an opportunity to become fully informed about and have an impact on issues that affect you.

INFORMATION RESOURCES

- A clearinghouse for metropolitan public affairs information and a resource of educational materials and speakers for the community

Public affairs
research and education
in the Minneapolis-Saint Paul
metropolitan area

Citizens League

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