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FISCAL FUTURES | A GUIDE TO MINNESOTA HEALTH CARE SPENDING

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CRITICAL ISSUES
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Minnesota Planning develops long-range plans for the state, stimulates public participation in Minnesota's future and coordinates public policy among state agencies, the Minnesota Legislature and other units of government.

The **Critical Issues Team** at Minnesota Planning examines emerging issues that could have a significant effect on Minnesota's governments, its people, economy and natural resources.

Fiscal Futures: A Guide to Minnesota Health Care Spending was prepared by Jay Fonkert and is available on the Minnesota Planning Internet site at www.mnplan.state.mn.us

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This report is one of a series of Minnesota Planning reports exploring important areas of state and local government spending.

- Government-paid health care
- Programs serving people with disabilities
- K-12 education
- Affordable housing
- Transportation

Each report will present background information to help readers participate in discussion of public policy issues that Minnesota will face over the next several years.

This and other reports in the *Fiscal Futures* series are not about the large deficits forecast for the Minnesota state budget in the current fiscal year or the 2004-05 biennium. They make no fiscal forecasts and do not recommend actions to balance the budget. Rather they provide background information that will help both citizens and policy-makers participate in important budget discussions and identify major challenges facing the state over the next decade.



INTRODUCTION

Health care consumes more government spending than anything except education, and threatens to increase its share at the expense of other government services.

- Health care programs account for nearly 20 percent of the state's general fund.
- Health care is expected to be the state's fastest growing spending area through the next two budget periods, growing 23 percent in the 2003-05 biennium and 16 percent in the 2005-07 biennium.

Expenditures for personal health care account for 10 percent of Minnesota economic activity and consume one-fifth of state and local government spending. Although health care is one of the largest single items of government spending, more than half of spending for personal health care flows through the private sector. While this report focuses primarily on costs paid through government, any successful health care finance policy must take into account the interplay between the private and public markets.

Health care, including prescription drugs, costs Minnesotans more than \$19 billion each year. Correspondingly, health care is a large part of the state's economy. Health care providers, including clinics, hospitals, nursing homes and home care providers, accounted for more than 10 percent of the state's jobs and payroll in 2000. In many communities, health care is the leading employer. These employment and payroll numbers do not include pharmacies or insurance industry employment.

One of the goals identified by citizens in *Minnesota Milestones*, the state's long-range plan, says simply: "Minnesotans will be healthy." Good health depends heavily on responsible individual behavior. However, there is wide consensus that government has a role in protecting good health and assisting those who cannot afford necessary health services and medical treatment.

Government's role takes two main forms:

- **Investing in public health.** Communicable diseases are a constant threat to communities. Government helps protect public health by ensuring safe drinking water supply, treating human waste, immunizing vulnerable populations and inspecting restaurants and food processing plants that could contribute to the spread of disease.
- **Assuring access to health and medical care.** Large, unexpected health care costs are beyond the means of most people. Public policies promote risk-sharing through private health insurance, but many people who are unemployed or in low-wage jobs cannot afford insurance. Several publicly financed programs, chief among them Medicaid (known as Medical Assistance in Minnesota), pay directly for the cost of care for people with very limited means or unusual health care expenses. Some of the cost of caring for people with neither health insurance nor government assistance ends up being borne by paying customers – both private and public.

The sluggish 2001-02 economy has pushed up enrollment in government health care programs for low-income people at the same time health care prices have continued to rise. Forty-five states reported taking actions in fiscal year 2002 to reduce spending for Medicaid, the single largest government health care program, and most states have additional cost-trimming plans for fiscal year 2003.

This report focuses mostly on the more than \$5 billion Minnesota governments spend each year to buy health care for low-income people. State and local governments also spend some \$650 million on public health programs, ranging from childhood immunization and preschool screening, to food industry inspections and general health education. Public health programs benefit the entire population and, by keeping the population healthy, may prevent future public and private health care costs. Most public health services are administered by cities and counties. In state government, the Minnesota

Department of Health acts largely as a public health department. The MDH does not directly pay for health care as does the Department of Human Services.

Unless otherwise noted, data on overall health care expenditures is from the Health Economics Program of the Minnesota Department of Health.

The Challenge

Even after dealing with its serious short-term budget problem, Minnesota will need to design and manage its health care programs in ways that are respectful both of the needs of people who cannot afford appropriate care on their own and taxpayers who, though willing to help pay for a health care safety net, want money left over for other important government services, as well as their own pockets.

In many ways, current programs have worked well, but because of the tendency for health care costs to rise faster than available revenues, policy-makers and citizens will have to carefully evaluate current arrangements and be willing to adopt reforms.

Several trends – including the aging of the population, rapidly rising drug costs, new expensive medical technologies and growing concentration in the health care industry – will challenge Minnesota's ability to continue providing the same level of care to people who need help. Minnesota will have to consider innovations that:

- Enhance competition in health care delivery markets
- Promote private sector health insurance coverage
- Increase consumer cost-consciousness when lower cost, equally effective treatments are available
- Assure availability of care for those who cannot afford it.

Reasonable people will disagree on the best strategies, but these will necessarily involve a mix of direct spending, financial incentives such as tax credits, and rules to enhance the benefits of private markets. And, in every decision they make,

policy-makers will have to beware of budget "tails" – long term fiscal impacts that can burden future budgets.

FISCAL FACTS

It is no surprise that health care financing is a major public policy issue. This section provides background information on health care expenditures and government programs that will help policy-makers and citizens participate in discussions about health financing issues in Minnesota.

HEALTH CARE SPENDING OVERVIEW

Most health care expenditures are paid from private sources, but government is a major payer for low-income people, people with disabilities and people who are medically needy because of very large medical bills. Minnesota spends more on health than most states.

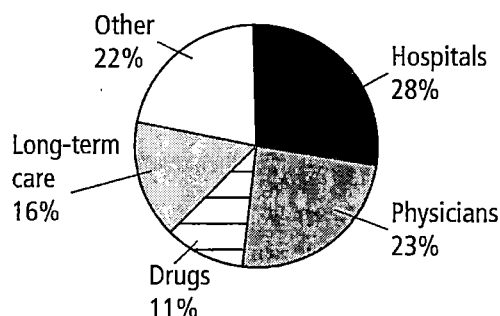
Government spending for health is dominated by programs that assist with the health care costs of low-income people. Most discussion of government spending focuses on these programs, of which Medical Assistance is the largest. While Medicare accounts for some 14 percent of all health care spending, it is not discussed in any detail here. Medicare is a federal insurance program that serves virtually all people 65 and older. In exchange for Medicare payroll taxes while working, most elderly are automatically enrolled in the Medicare Part A hospital insurance program. Enrollees have the option of paying a monthly premium for Part B Medicare insurance covering outpatient and physician services.

Hospital care and physician services are the largest health care expenditures

The Minnesota Department of Health estimates that hospitals and physicians account for 51 percent of Minnesota health care expenditures. Long-term care claims 16 percent and prescription drugs 11 percent.

Minnesota Health Care Expenditures, 2000

Total expenditures: \$19.2 billion



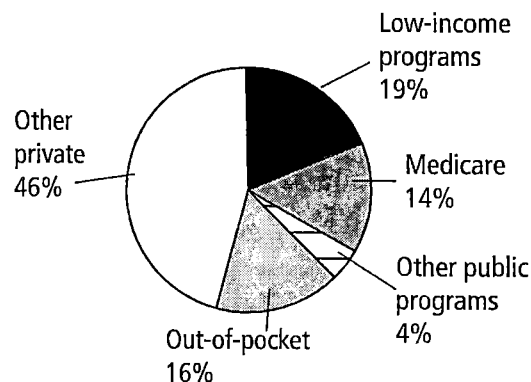
Source: Minnesota Department of Health

Although expenditures for prescription drugs have increased rapidly in recent years, physician and hospital services have contributed far more to overall spending increases. Prescription drug expenditures doubled between 1993 and 2000, but physicians and hospitals (both inpatient and outpatient services) accounted for more than half the increase in total health spending.

Private sources pay for 62 percent of health care costs

Private spending accounted for 62 percent of total health care expenditures in Minnesota in 2000, up from 57 percent in 1995. Private insurance through HMOs, traditional third-party insurers and self-insured programs paid for 39 percent of all spending, while 16 percent was paid by individuals out-of-pocket. Other forms of private insurance, including automobile insurance and worker's compensation, accounted for 7 percent. On the public expenditure side, low-income programs, including Medical Assistance, MinnesotaCare and General Assistance Medical Care were 19 percent of all spending. Medicare was another 14 percent. Both employee and employer contributions to health insurance premiums for government employees are counted as private spending because the health care payments they support are made by HMOs and other private insurers.

Payers for Minnesota Health Care, 2000



Source: Minnesota Department of Health

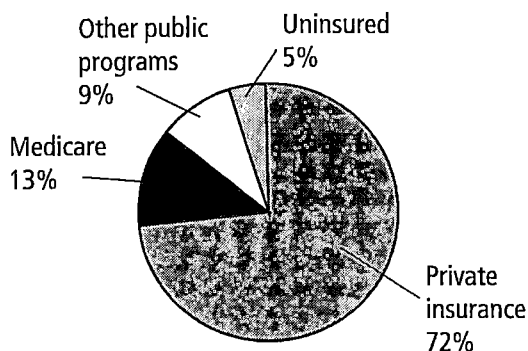
Nationally, it is estimated that about 33 percent of spending for health services and supplies in 2000 was borne directly by households. This one-third share includes individual policy premiums, employee contributions for health insurance, Medicare premiums and out-of-pocket expenses.

Private insurance meets the needs of most, but government programs protect low-income people and the medically needy.

Most people need health insurance to guard against the possibility of large, unexpected health care costs beyond what they could have saved for. At 95 percent, Minnesota has the second highest rate of insurance coverage in the nation. Nearly three-quarters are covered by private insurance, usually linked to their employment. Another 13 percent (nearly all of them elderly) are covered by Medicare, while 9 percent are covered by Medical Assistance and other public programs.

Based on a Minnesota Department of Health survey, young adults are least likely to be insured, while nearly all elderly have insurance through Medicare.

Minnesota insurance coverage by primary source, 2000



Source: Minnesota Department of Health

While Medical Assistance and other state-financed public programs cover only 9 percent of the population, these programs pay for 24 percent of all health care purchases. This is because public programs tend to cover people needing the most expensive care – namely, the elderly and disabled.

Employment-based policies dominate private health insurance coverage. Nationally, employer and employee contributions accounted for 94 percent of all private health insurance premiums in 2000. For employer-sponsored programs, employers paid 76 percent of premiums; employees paid 24 percent. In 1999, 16 million people under age 65 bought health insurance directly from insurance companies or through nonemployment groups.

Health care cost pressures are being felt in both the public and private sectors. Insurers expect the per capita cost of claims to rise 13 to 15 percent in 2003, according to an annual survey by the Segal Company, a national actuarial and consulting firm. Cost trends affect employer's decisions to offer insurance and employees' decisions to accept coverage. If rising costs result in more uninsured people, pressures on tax-supported programs could rise.

Minnesota spends more than most states

Minnesota ranked 17th in total per capita state and local government health spending in 2000, about 13 percent above the median state. This comparison is based on the most recent comprehensive, combined state and local spending data available from the U.S. Census Bureau.

Government spending for health care includes purchases of medical services for low-income and disabled people, expenditures for publicly owned hospitals and public health programs, but does not include contributions toward health insurance for government employees. The Census Bureau data is the best available for comparisons with other states because it includes both state and local governments. It is important to include both in interstate comparisons because each state divides spending responsibility between state and local governments differently.

State government accounted for three-fourths of total Minnesota spending; local governments (mostly counties) accounted for the other fourth. State government expenditures are heavily dominated by payments to vendors for low-income people, and state government accounts for virtually all spending for this purpose. On the other hand, local governments account for more than half of public health spending.

Minnesota was 10th per capita in payments to health care providers – mostly payments for services to low-income and disabled people, 27 percent above the median state. For other health spending, mostly public health services, Minnesota ranked only 27th.

**State and local government health expenditures,
1998-99 dollars per capita**

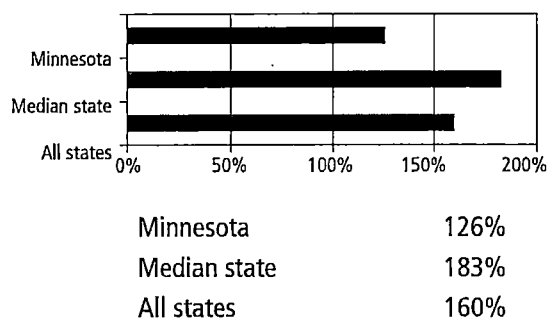
	ALL HEALTH PROGRAMS	PAYMENTS TO VENDORS	OTHER HEALTH (except hospitals)
Minnesota	\$994	\$645	\$136
Rank	17th	7th	27th
Percent of median state	111%	134%	99%

Note: "Other health" includes public health services, laboratories and other general health activities

Source: U.S. Census Bureau

Minnesota has ranked high in spending for many years, but had slower growth in payments to providers for low-income health care during the 1990s than most states. On a per capita basis, Minnesota's payments grew 126 percent from 1989 to 1999, compared to 160 percent for all states. Minnesota's growth rate ranked 38th.

**10-year growth in government payments to
health care providers
1989 to 1999**



Source: U.S. Census Bureau

The total cost to government of health care includes more than budget expenditures reported here. State and local governments contribute millions toward the cost of health insurance for their employees. The state Department of Employee Relations estimates that it will cost \$316 million to administer and provide health insurance benefits to 118,000 current and retired employees and their dependents in 2002.

The public cost of health care also includes the revenue government foregoes due to the deductibility of insurance premiums and medical costs. Current law allows employers to deduct from their taxable income contributions they make to an employee's health insurance premiums and excludes these contributions from the employee's taxable income. Starting in 2003, self-employed individuals may deduct all of their health insurance expenses. In addition, any individual may claim an itemized deduction for insurance premiums and medical expenses exceeding 7.5 percent of adjusted gross income.

The Congressional Budget Office estimates that exempting employer-paid premiums from income taxes cost the federal government about \$120 billion in 2001. In 2000, the Minnesota Department of Revenue estimated that the cost of these "tax expenditures" would rise from \$407 million in fiscal year 2000 to \$491 million in fiscal year 2003.

GOVERNMENT SAFETY-NET PROGRAMS

With passage of the Medicare and Medicaid programs in the 1960s, the federal government created a health care safety net for people who could not afford private health insurance. The federal government pays for at least half the cost of Medicaid. Most states, including Minnesota, have supplemented Medicaid with state-financed programs for needy people who do not qualify for Medicaid. Whenever possible, states have designed programs to qualify for federal matching funds, thus stretching state dollars.

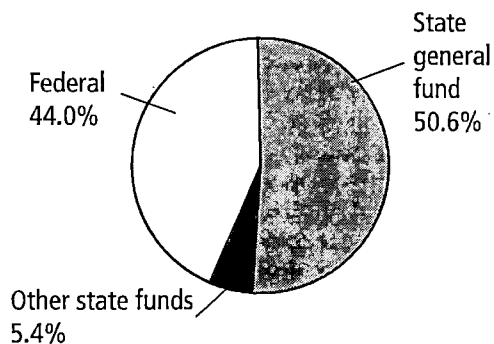
A combination of federal and state programs pay for health care services

Medical Assistance, Minnesota's version of the federal Medicaid program, is the workhorse of Minnesota's health care finance programs, but the state rounds out its coverage for low-income and medically needy people with several state-financed programs, such as MinnesotaCare, General Assistance Medical Care and the Prescription Drug Program.

For more background on Minnesota programs, see the Minnesota Department of Health report, *Health Care Coverage and Financing in Minnesota: Public Sector Programs* (January 2003).

Overall, federal funds cover 44 percent of Minnesota's health care expenditures and state funds cover 56 percent. Most federal funding comes through the 50 percent federal reimbursement for Medical Assistance expenditures. Most state money comes from the general fund. The exception is MinnesotaCare, which receives most of its funding from the health care access fund, a dedicated fund outside the state's general fund financed by a tax on insurance premiums and health care providers.

Health care expenditures, fiscal year 2002 Federal and state shares



Source: Minnesota Department of Finance

Spending for Medical Assistance and other programs that help low-income people purchase health and medical services is part of the Department of Human Services budget. The DHS budget groups programs into two main categories: basic health care grants and continuing care grants. Basic health care grants include the parts of Medical Assistance, General Assistance Medical Care and MinnesotaCare that pay for doctor visits, hospitalization, medications, medical equipment and other primary and preventive health care services. Also included here is the state's prescription drug program.

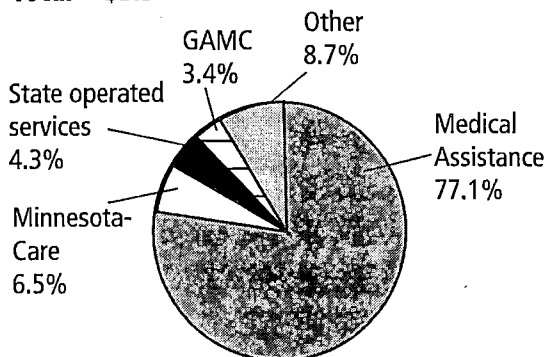
Continuing Care grants include the parts of Medical Assistance that pay for chronic health care services and long-term living assistance in nursing homes and alternative home care settings, as well as a variety of smaller grant programs for mental health, chemical dependency, community social services and other health services. The physical care of people in nursing homes and other long-term care settings is included in the basic health care part of the budget.

These two broad sets of programs comprise more than 94 percent of DHS spending for health care programs. State operated services, which includes state-owned and managed hospitals and nursing homes, account for about 4 percent, with the balance accounted for by management and policy administration.

The lion's share of Minnesota's expenditures to pay for health care of low-income and disabled people flows through the Medical Assistance program. GAMC and MinnesotaCare extend similar benefits to people not eligible for Medical Assistance. MinnesotaCare is also partially financed with federal Medicaid funds, as well as premiums paid by enrollees.

Minnesota state government health care expenditures, fiscal year 2002

Total = \$5.3 billion



Note: Includes federal and state funds
Source: Minnesota Department of Finance

In the state's biennial budget, Medical Assistance is divided into four parts, described below. Total fiscal year 2002 expenditures, including both state and federal funds, are indicated in parentheses.

Basic Health Care Grants for Families and Children (\$973.3 million). This part of Medical Assistance purchases medical services for low-income families, children and pregnant women. Federal and state funds reimburse health care providers for physician services, lab services, hospital care, dental care, prescription medications and other physical health services.

People become eligible for the program either as recipients of cash assistance from the Minnesota Family Investment Program (Minnesota's welfare program under the federal Temporary Assistance for Needy Families program) or by meeting income requirements. Pregnant women and children under age 2 are eligible with incomes below 280 percent of the federal poverty level. Others are generally eligible with incomes below 133 percent of the poverty level. The poverty level for a family of four was \$18,180 in 2002.

Basic Health Care Grants for the Elderly and Disabled (\$1.1 billion). A separate part of the Medical Assistance program serves the elderly and disabled. It pays for similar physical health services as provided to families and children. For most elderly and about 40 percent of people with disabilities, Medical Assistance is a supplement to Medicare. For those not eligible for Medicare, Medical Assistance pays the total cost of care.

Individuals with income at or less than 133 percent of the income level that qualified for AFDC welfare payments in 1996 qualify for Medical Assistance. Others can qualify if their medical bills exceed the difference between their income and the 133 percent income standard.

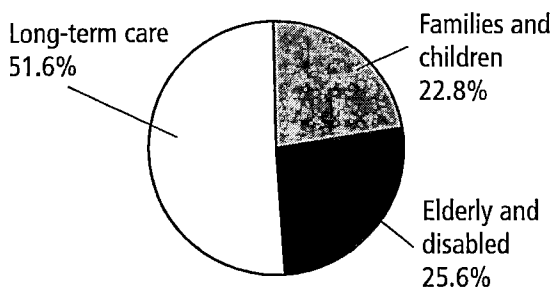
Long-Term Care Facilities (\$1.1 billion). This part of the Medical Assistance program pays for room and board, nursing services and living assistance for low-income people living in nursing homes and people with mental retardation living in intermediate care facilities. The cost of their physical health care is paid through the basic health care grants part of Medical Assistance.

Long-Term Care Facilities and Waivers (\$997.0 million). Minnesota has aggressively promoted alternative home- and community-based care to keep people out of expensive nursing homes and other institutions. These services are paid for with state and federal funds under a federal Medicaid program waiver. Covered services include home visits by nurses and home health aides, private duty nursing services, occupational and physical therapy and medical supplies and equipment.

Of the \$4.1 billion spent through the Medical Assistance program, a little more than half was for living assistance in long-term care settings. Long-term residential care for the elderly and disabled, together with physical health care expenses of the elderly and disabled, account for more than 75 percent of all medical assistance expenditures. Care for low-income families and children accounts for less than one-fourth of Medical Assistance expenditures.

Medical assistance grants, fiscal year 2002 (excluding management)

Total = \$4.1 billion



Note: Includes federal and state funds

Source: Department of Finance

Minnesota also pays health care expenses for low-income people through several other programs. In general, Minnesota uses Medical Assistance to cover children and pregnant women, as well as the elderly and disabled adults. MinnesotaCare, with federal matching funds, covers parents. MinnesotaCare, without federal matching funds, covers adults without children.

General Assistance Medical Care (\$182.2 million). GAMC is a state-funded program that buys medical care for low income people who are not eligible for Medical Assistance – generally working age adults without children. Individuals with earned income between 75 and 275 percent of poverty must enroll in MinnesotaCare (see below).

GAMC pays for most physical medical services, including dental care, drugs and public health nursing services. It does not cover nursing home or home health care.

MinnesotaCare (\$347.8 million). MinnesotaCare is a state-funded program that provides insurance coverage to low-income people whose incomes extend beyond Medical Assistance or General Assistance Medical Care limits. In general, eligibility includes pregnant women, children and parents with incomes below 275 percent of poverty, as well as childless adults below 175 percent of poverty.

MinnesotaCare pays for most physical medical care services, including mental health services and most prescription drugs, as well as dental care for pregnant women and children. It does not cover care in nursing homes or intermediate care facilities, as well as non-preventive dental services for people with incomes greater than 175 percent of the federal poverty line.

Prescription Drug Program (\$5.1 million).

After a \$35 monthly deductible, the state-financed Prescription Drug Program pays prescription drug costs for people 65 and older with limited assets and incomes at or below 125 percent of poverty, but who are not eligible for Medical Assistance. The program is necessary because Medicare does not cover prescription drug costs. Average monthly enrollment in 2001 was 5,554.

Alternative Care Grants (\$63.2 million).

Alternative Care Grants is a state-funded program that pays for at-home services and long-term care services for low-income elderly people who are at risk of requiring nursing home care under Medical Assistance. Eligibility is limited to people 65 or older who need a nursing facility level of care and have income and assets inadequate to pay for more than 180 days of care.

Minnesota Comprehensive Health Association.

MCHA is a state-sponsored program that offers coverage to individuals who cannot obtain coverage from other sources. The insurance pool is funded through premiums and assessments on HMOs and other insurance companies. The legislature has periodically used the Health Care Access Fund to reduce assessments necessary to make up the difference between premium revenue and costs.

In addition to these programs, the state also funds health care-related expenses through a variety of other programs, including mental health grants, group residential housing and community social services grants.



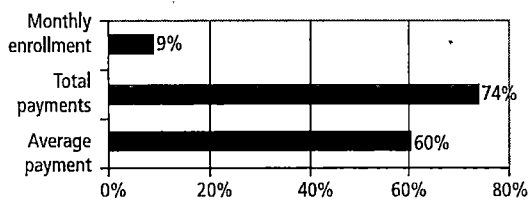
Medicaid use drives state health spending

Medical Assistance is Minnesota's single largest health care purchasing program. In June 2002, Medical Assistance served 409,000 people, up from 381,000 a year earlier. Enrollment has risen since 2000 due to program expansions and a sluggish economy, but is still at or below levels of the mid-1990s.

Over the past 10 years, average monthly enrollment has increased only 9 percent, but total annual payments have grown 123 percent, or 74 percent after adjusting for inflation. Total Medical Assistance spending has grown mostly because the average monthly payment per recipient has risen 105 percent, or 60 percent after adjusting for inflation. Average monthly payments have increased at least 4.5 percent each year since 1997, with a 10 percent increase in 2002.

Medical assistance spending and enrollment, 1992-2002

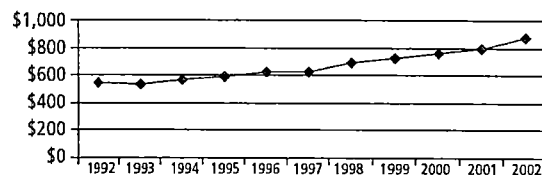
Percent change (adjusted for inflation)



Source: Department of Human Services

Medical assistance: average monthly payment per enrollee

1992	\$549
1993	\$532
1994	\$570
1995	\$587
1996	\$625
1997	\$629
1998	\$690
1999	\$727
2000	\$764
2001	\$799
2002	\$879



Note: Adjusted for inflation; in 2002 dollars

Source: Department of Human Services

Under Medicaid, the federal government reimburses from 50 to 80 percent of state costs for medical services to low-income people. The federal share varies inversely with per capita income. Minnesota and 11 other higher income states receive the minimum 50 percent federal share. The lowest-income state, Mississippi, receives a 76.6 percent federal match. Federal reimbursement rates are recalculated each year based on population and personal income estimates. Minnesota's federal matching rate fell from 54 percent in federal fiscal year 1997 to 50 percent in fiscal year 2002.

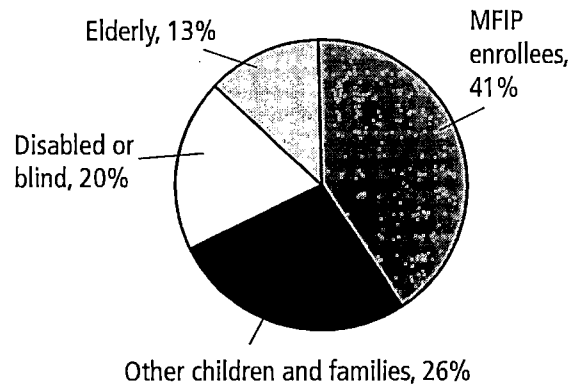
The prospect of a dollar in federal aid for every dollar of state spending makes it attractive to expand Medical Assistance spending, but the federal matching arrangement means that every dollar reduction in state spending results in two dollars less in health care services for needy people.

The Department of Human Services categorizes eligible recipients into five groups. The largest group in 2001, at 41 percent, was recipients of MFIP cash assistance. Other low-income families with children and pregnant women accounted for another 26 percent of all eligible recipients. The disabled or blind were 20 percent and the elderly were 13 percent.

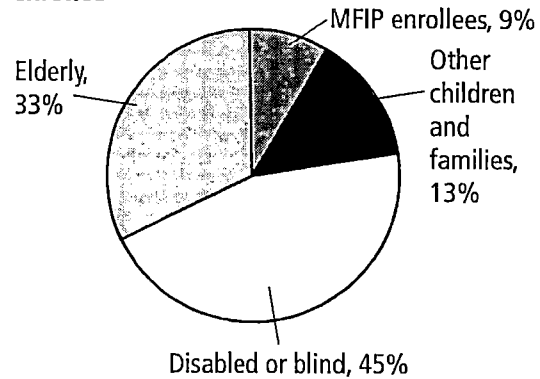
While welfare recipients and other low-income children and families and pregnant women accounted for two-thirds of Medical Assistance enrollees, they accounted for only 23 percent of Medical Assistance payments. Conversely, the elderly and people with disabilities were one-third of enrollees, but they benefited from 78 percent of payments.

Medical assistance enrollees and payments by type, 2001

Medical assistance enrollees by type



Medical assistance payments by type of enrollee



Source: Department of Human Services

Welfare recipients in the MFIP program account for a disproportionately small share of Medical Assistance spending. They received only 19 percent of payments for basic care and less than 1 percent of payments for long-term care.

The elderly and disabled account for a disproportionate share of payments for basic care, but it is the high cost of long-term care that makes the elderly and disabled the biggest beneficiaries of Medical Assistance payments. The elderly and disabled each account for about half of all long-term care spending. The elderly receive 72 percent of payments for care in long-term care facilities, while the disabled consume about 83 percent of home-based and community care payments under the long-term care waiver program.

In 2001, the average monthly cost of basic care was \$678 for the disabled or blind, and \$468 for the elderly. Basic care costs for welfare recipients were only \$166. The monthly costs of long-term care are much higher. Payments for long-term care facilities averaged nearly \$2,800 for the elderly and more than \$6,000 for the disabled. Home- and community-based care cost less per recipient – \$831 for the elderly and \$2,894 for the disabled. The difference suggests that home- and community-based care saves money, but it may reflect the fact that those still in institutional care settings are among the most expensive to care for.

Medicaid options pose policy choices for states

Each state's Medicaid program is unique. States have choices about who to cover, what services to pay for and how much to pay providers for each service.

To receive federal reimbursement, a state's program must cover a required set of services for categories of people who are automatically eligible under federal law. In addition, the federal program offers reimbursement for a range of other services and populations if a state opts to include them in its program. All states participate in the minimum program, but vary widely in their coverage beyond

the minimum. Minnesota covers more services for more people than most states.

Although legally optional, many services, such as prescription drugs and nursing home care for the elderly are covered by all states. Nearly two-thirds of all Medicaid spending in the U.S. is for optional beneficiaries and services. According to the Kaiser Commission on Medicaid and the Uninsured, more than 80 percent of Medicaid spending on the elderly is optional, as is two-thirds of spending on people with disabilities.

Eligibility. States are required to provide coverage for most individuals who receive federally assisted income maintenance payments. In Minnesota, this includes people who receive welfare payments through the Minnesota Family Investment Program (MFIP). All states must provide coverage to the following groups of people:

- Low-income families with children that were eligible for AFDC in 1996.
- Pregnant women with income and assets below eligibility limits, and their newborn child up to age 1.
- All children under age 19 in families below 133 percent of poverty. (Before 2002, coverage was required only for children born after September 30, 1983.)
- All current and some former recipients of federal Supplemental Security Income.
- All recipients of foster care and adoption services under Title IV-E of the federal Social Security Act.
- All Medicare recipients with incomes below poverty (Medicaid assistance for payment of Medicare premiums, deductibles and cost-sharing). Very low-income Medicare recipients are eligible for Medicaid benefits, which cover services such as outpatient prescription drugs that are not covered by Medicare.

In addition, states may receive federal matching funds if they choose to serve additional people at higher income levels. These include:

- Infants and pregnant women up to 185 percent of poverty.
- The medically needy – individuals with incomes too high to otherwise qualify, but who can “spend down” to qualifying income levels by deducting medical expenses from their income.
- Recipients of state supplemental income payments.
- Individuals receiving long-term care in medical institutions or community settings, if their income is below 300 percent of the federal SSI payment level.
- Working disabled – individuals with disabilities whose income is too high to otherwise qualify.

States can also expand eligibility beyond these optional groups through demonstration and statutory provisions that allow use of less restrictive methodologies for calculating income and assets.

Coverage. All states must provide a range of mandatory services:

- Hospital (inpatient and outpatient) services
- Physician services
- Medical and surgical services of dentists
- Nurse practitioner services
- Nurse-midwife services
- Family planning services and supplies
- Laboratory and X-ray services
- Rural health clinic and Federally Qualified Health Center services
- Early screening for children
- Nursing facility and home health services for adults

States may also receive federal matching funds for a range of optional services, including dental services, many specialists, social work and psychologist services, private duty nursing, eyeglasses, prescribed drugs and Intermediate Care Facilities and Mentally Retarded services (ICF/MR).

How much to pay. States set their own provider payment rates for specific services, with a limitation that the federal government will pay its share only for fees at or below the amount Medicare would pay for the same service. States can set lower rates as long as the reduction does not compromise consumer choice or quality. As a practical matter, states must negotiate rates that will keep providers in the Medicaid market.

While the state can limit spending growth by covering fewer people, paying for fewer services or limiting growth in rates paid providers for particular services, each of these strategies may save less than expected and have other unforeseen consequences. People denied coverage may still require hospital care at public expense. In addition, some observers believe that restraining Medical Assistance reimbursement rates can cause insurers to negotiate higher rates from private buyers.

Minnesota covers more people and pays for more services than most states

Minnesota serves more people and pays for a broader range of services than most states. In a study of 13 states, Urban Institute researchers characterized Minnesota’s Medicaid program as having “liberal eligibility policies and a rich set of benefits.” Minnesota covers people at higher income levels than most states and is one of only a handful of states to cover all optional services.

Minnesota’s rank as a generous Medicaid state must be tempered by the fact that it ranks in the bottom half of states in terms of the percentage of its residents covered by Medicaid. Between 8 and 9 percent of Minnesotans are covered by Medicaid, compared to 12 percent or more in several southern states, according to data compiled by the Kaiser Commission on Medicaid and the Uninsured. The smaller portion of Minnesota’s population covered by Medicaid reflects the state’s relatively smaller poor population, compared to other states.

Between Medicaid and MinnesotaCare, the state covers children, their parents and pregnant women with family income up to 275 percent of the federal poverty level.

For all ages of children, Minnesota has one of the highest income cut-offs for Medicaid eligibility. Minnesota qualifies children ages 0-2 up to 280 percent of poverty, ranking behind only Missouri and Vermont, which provide benefits to children up to 300 percent of poverty. Minnesota has the second highest income cut-off for pregnant women at 275 percent of poverty. Only California is higher, at 300 percent.

States have lower cutoffs for Supplementary Security Income recipients and the medically needy. Minnesota ranks in the top half in income cut-offs for the medically needy; 16 states do not serve the medically needy at all. Minnesota qualifies SSI recipients at 70 percent of poverty; most states qualify SSI recipients at 74 percent of poverty. Minnesota is one of several states that exercises an option to use 1972 standards instead of the federal SSI standards to determine eligibility for the disabled. Those that do so must also allow disabled individuals to "spend down" into Medicaid eligibility by deducting incurred medical expenses from income.

Eligibility levels as percent of poverty, 2002

	Children Under Age 5	Pregnant Women
Minnesota	280%	275%
Minnesota rank	3rd	2nd
High state	300%	300%
	(Missouri and Vermont)	(California)
Low state	133%	133%

Source: Henry J. Kaiser Family Foundation

According to the Department of Human Services, Minnesota's annual payments (federal and state funds) per enrollee increased from \$5,112 in 1992 to \$10,260 in 2002. Even after adjusting for inflation, payments per enrollee increased 35 percent.

Recent comparative data on spending per enrollee is not available. However, in federal fiscal year 1998, Minnesota ranked seventh in benefits paid per Medicaid enrollee, 38 percent above the median state. Minnesota's ranking has probably not changed much. Using expenditure data collected by the National Association of State Budget Officers and data from state Medicaid enrollment reports, Minnesota ranked sixth in spending per enrollee in fiscal year 2002. Minnesota's spending was about 33 percent above the median state.

Minnesota's spending per enrollee is particularly high compared to other states for care of the elderly and the blind and disabled. Minnesota's 1998 spending per enrollee for the elderly was \$19,427, or 67 percent above the rate for all 50 states. Minnesota's spending per blind or disabled enrollee was \$17,636 or 150 percent above the national rate.

Minnesota's high spending reflects its less restrictive eligibility standards and comprehensive service coverage. This means a higher bill for taxpayers, but it also means that more needy people receive more care than in other states. An argument can be made that at least some of Minnesota's higher Medicaid spending saves taxpayer money in the long run because it reduces charity care and pays for timely care that prevents the need for more expensive care later.

Minnesota has recently expanded Medicaid coverage on several fronts:

- An increase in income standards for elderly, blind and disabled individuals from 70 to 100 percent of poverty.
- Elimination of the asset test for pregnant women and children.
- Extension of benefits to all employed people with disabilities, regardless of income.
- Increase in the income limit for children to 170 percent of poverty.
- Increase in the income level for parents to 100 percent of poverty.

Minnesota has also secured Medicaid matching funds for adults with children enrolled in MinnesotaCare under a waiver from the federal government. The income limit for federal matching funds was raised to 275 percent of poverty in 2001.

When the federal government offered matching funds for the State Children's Health Insurance Program, it required that federal funds be used for new programs rather than supplementing existing programs. Because Minnesota already received Medicaid matching funds for children up to 275 percent of poverty in MinnesotaCare, the state had little opportunity to claim new SCHIP funds. In 1998, Minnesota received approval for a small "placeholder" program to prevent the state from losing its allotted SCHIP funds. Minnesota's SCHIP program offers coverage to about 20 children under age 2 in families with incomes between 275 and 280 percent of poverty.

Minnesota's total Medicaid spending (including federal funds) has generally grown more slowly than that of the nation as a whole, based on Urban Institute estimates. From 1995 to 1998, Minnesota's long-term care spending grew only 1.4 percent per year, compared to a national rate of 6.5 percent. Minnesota's expenditures per enrollee, although high, also grew more slowly than the national rate. More recent data from the National Association of State Budget Officers indicates that Minnesota's Medicaid spending growth rate accelerated in 2000 and 2001, and surpassed the national growth rate. Minnesota's growth fell back below average in fiscal year 2002.

Minnesota has promoted alternative care, but nursing home use remains high

Minnesota has aggressively promoted home- and community-based care as an option to institutionalization. The state operates six home- and community-based care waiver programs under Section 1115 of the Social Security Act.

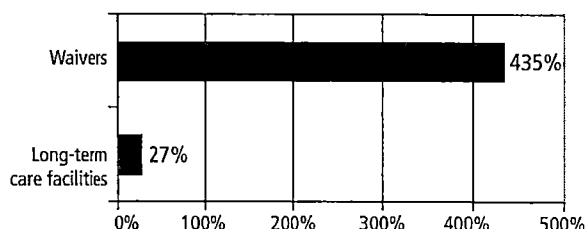
The elderly and disabled tend to have more serious and long-lasting health problems, and require many kinds of living assistance beyond medical care.

These services are commonly referred to as long-term care, which is defined as "assistance given over a sustained period of time to people who are experiencing long-term inabilities or difficulties in functioning because of a disability."

Traditionally, long-term care was provided in institutions, including nursing homes. The availability of funding through the federal Medicaid program spurred a dramatic increase in the number of nursing homes starting in the 1960s. By 1980, nearly 9 percent of Minnesotans over age 65 were in nursing homes, the highest rate in the nation. Since then, the high cost of nursing home care and changing consumer expectations has propelled a shift toward home- and community-based care. Minnesota was granted a waiver from the federal government in 1983 to use Medicaid funding for home- and community-based care.

Almost all of the increase in long-term care expenditures has gone to home- and community-based services funded under the state's waiver programs. Waiver program payments increased 435 percent between 1991 and 2001, compared to an increase of only 27 percent in payments directed to long-term care facilities.

Growth in long-term care payments, 1991-2001



Note: Waiver spending includes home- and community-based care.

Source: Department of Human Services

The share of long-term care payments made through the waiver program increased from 14 percent in 1991 to 41 percent in 2001, and is projected to grow to 55 percent in 2005. Medical Assistance payments for long-term care facilities actually declined 9 percent between 1996 and 2001, and are projected to fall another 4 percent by 2005.

There are concerns about how much more money can be saved through home- and community-based care. Per enrollee costs are higher in nursing homes, but this is likely in part because many of the remaining nursing home residents are high-cost patients who need the 24-hour supervision and care of a nursing home. For care of these patients, nursing homes benefit from some economies of scale, although other factors such as higher labor costs may offset any advantage. For many people, the most important advantage of alternative care arrangements is improved quality of life, compared to living in a nursing home.

Concerns about worker shortages, quality issues in assisted living and low reimbursement rates for both home and institutional care led to creation of a joint legislative-executive branch task force that recommended 48 strategies for long-term care reform to the 2001 Legislature. In response, the Legislature required counties to conduct assessments of gaps in their long-term care systems and produce development plans for addressing gaps. The task force also established several benchmarks for measuring the state's progress. The benchmarks include measures of the supply of senior housing and nursing home beds, as well as the percentage of the less disabled elderly still in nursing homes and the more disabled elderly being served in home- or community-based care.

The most recent comparative data places Minnesota's nursing home utilization rate at 6.8 percent of the over-65 population in 1999, compared to the national rate of 4.3 percent. Using a different methodology, the Minnesota Department of Human Services calculates a Minnesota utilization rate of 6.1 percent in 1998 and 5.5 percent in 2000. According to DHS, Minnesota's rate has dropped from a high of 8.4 percent in 1984.

FISCAL FUTURES

Minnesota has chosen to spend more than most states to assure access to health care for people who need help. The added expense to taxpayers must be balanced against the benefits, including appropriate care for people, alternatives to institutional care, and less need for uncompensated "charity" care. However, an aging population, demand for new and expensive medical treatments and diagnostic technology, and health provider cost pressures all will make it difficult to sustain Minnesota's high level of assistance without cutting other popular programs or raising taxes.

Minnesota's public health care system receives high marks on several counts. Its uninsurance rate is less than half the national average. The state has a high level of employer-sponsored insurance and Minnesota's broad coverage of the low-income population through public programs contributes to an overall low incidence of uncompensated care.

Minnesota's health care markets have been relatively stable compared to other states, with fewer hospital closures, no health plan exits and no declines in employer-sponsored health insurance coverage. However, there has been a decline in direct enrollment in HMOs as employers turn increasingly to self-insurance to control costs. Self-insured companies escape having to comply with mandated benefits, and by contracting with health care plans as third-party administrators rather than as health plans, they avoid paying taxes on health insurance.

Minnesota faces difficult challenges over the next several years:

- How to pay for care of a growing elderly population.
- How to further reduce nursing home use, while assuring sufficient home- and community-based care.
- How to fund MinnesotaCare. Current funding from provider taxes, gross insurance premium taxes and enrollee premium taxes are projected to be insufficient by 2006.

- How to alleviate health care worker shortages.
- How to control rapidly rising costs of drugs.

CONTINUING COST PRESSURES

By their sheer magnitude in government budgets and their tendency to outpace general economic growth, health care expenditures will continue to strain budgets for years to come. Increased health care needs of an aging population and public demand for the benefits of new, expensive treatments will propel health care spending in general, and put increased pressure on government programs that buy health care for low-income and disabled people.

Public and private health care spending in Minnesota accelerated after 1998, following several years of modest growth averaging about 5 percent per year. Minnesota health care expenditures jumped 8.3 percent in 1999 and 10.5 percent in 2000. After adjusting for inflation, the 2000 increase was still more than 6 percent.

Researchers for the Kaiser Commission on Medicaid and the Uninsured report that nationwide Medicaid spending on acute care grew 10.1 percent per year between 1998 and 2000, outpacing the 7.4 percent annual growth in long-term care spending. Acute care includes in- and out-patient hospital services, physician and lab services and prescribed drugs. Expanded coverage of children and families accounted for much of the growth in acute care spending.

The fastest growing areas of acute care were drugs (20 percent increase per year) and the price of pre-paid care delivered by HMOs and other managed care organizations (16 percent increase per year). According to the Kaiser Commission researchers, some of this increase reflected an increase in managed care enrollments, but also the higher costs managed care plans had to pay for hospital services and drugs.

State Medicaid administrators attribute the rise in drug costs to both higher use and higher prices. Medicaid is particularly susceptible to rising drug

costs because it covers a population that is generally in worse health than privately insured populations, and serves large numbers of elderly and disabled individuals who rely on the program for prescription drugs. However, because of their large share of the pie, hospital and physician bills still are a bigger driver of health care expenditures than prescription drugs.

A recent article in the journal *Health Affairs* reports that health care spending has risen even more sharply since 2000. Per capita health care spending jumped 10 percent in 2001. Increased use of hospitals drove hospital spending. Prices charged by hospitals increased 3.6 percent in 2001, but utilization increased 8.0 percent. Rising utilization reflects a retreat from tightly managed care. Growth in hospital spending also reflected rising labor costs due to labor shortages, as well as stronger hospital leverage in negotiations with health plans. Both hourly wages and the number of hours worked by hospital employees rose sharply.

The *Health Affairs* article concluded that health spending grew more slowly during the first half of 2002, probably reflecting the effect of higher copayment requirements and a sluggish economy on demand. They think it is possible that growth may continue to slow for several years. First, they believe that much of the recent surge in spending reflected the cost of a one-time retreat from managed care. In addition, they believe that, while insurance companies are currently in the "hard phase" of the underwriting cycle when insurers emphasize premium increases and profits over competing for market share, they will eventually move back to the "soft phase" of the cycle when they become more aggressive in attempting to expand market share.

However, the Congressional Budget Office estimates that Medicaid expenditures nationwide will grow 9 percent per year between 2003 and 2012. Little growth is expected in enrollment of children, but elderly enrollment is expected to increase about 1 percent per year, and enrollment of the blind and disabled between 2 and 3 percent per year.



The Kaiser Commission researchers believe four forces will push Medicaid spending upward:

- Wage pressures and drug costs will boost hospital costs. States are reluctant to reduce reimbursement rates to hospitals because many are so reliant on Medicaid revenues.
- Savings from managed care have been exhausted. Many managed care plans have left Medicaid because of concerns over reimbursement rates and the increased difficulty of negotiating favorable prices from hospitals and physicians because of provider consolidation.
- Expenditures for prescription drugs will continue to rise as enrollment of the elderly and disabled grows. These groups are the heaviest users of prescribed drugs.
- Labor shortages and concerns over quality of care will create pressures for increased spending for long-term care.

LABOR SHORTAGES

Severe labor shortages are driving up health care costs. In a tight labor market, employers have to pay higher wages to attract and maintain employees. Salaries and benefits account for 51 percent of hospital operating costs and 71 percent of operating costs of skilled nursing facilities. Nationally, hospitals reported a 7.6 percent increase in wages between 2000 and 2001.

About 58,000 registered nurses and 17,000 licensed practical nurses were employed in Minnesota in 2001. The Minnesota Department of Economic Security reported a 7 percent vacancy rate for RNs and a 9.4 percent vacancy rate for LPNs. According to the Minnesota Health and Hospital Partnership, the annual turnover for LPNs was nearly 15 percent.

For the first time since 1995, wage rates in the health services industry grew faster in 2000 than wages for all industries combined. Wage growth was expected to accelerate further in 2001, perhaps as a result of severe nursing and other staff shortages. The *Health Affairs* article speculates that the long-standing pattern of health care wages rising more rapidly than other industries has returned.

Despite all kinds of new technology, the labor needs of the health care industry have not declined a great deal. In fact, new technologies often require new supplies of highly trained workers.

COSTS OF GROWING ELDERLY POPULATION

The elderly consume a disproportionate share of health care paid for by government, raising fears that their growing numbers could strain budgets. The elderly comprised 13 percent of Medical Assistance enrollees in 2001, but accounted for 33 percent of all Medicaid payments.

The State Demographer expects Minnesota's over-65 population to more than double between 2000 and 2030, increasing by nearly 700,000 people. The older population will grow both because people are living longer and because a large bubble of baby boomers will pass age 65 over the next two decades. The most rapid growth in the over-65 group will come after 2015, as the peak of the baby boom population passes age 65. The over-85 population is also expected to grow rapidly, yet at slower rates than during recent decades. Even though people are living longer, lower birthrates from the 1920s and 1930s will help hold down the number of people moving into extreme old age over the next couple of decades.

If people live longer, but also stay healthy longer, they might not need significantly more health care than today's elderly. However, their sheer numbers might strain the state's ability to pay for their care, especially if a smaller proportion of the population is working and paying taxes.

Increases in the older population will actually be more modest in many agricultural rural areas because of the small size of the middle-aged population living there now. The older population is actually falling in some counties.

SPENDING CHOICES

Minnesota has both a short-term and long-term health care cost problem. In the short term, weak revenues and rapidly rising health care costs point



to a serious health care funding problem. The November 2002 fiscal forecast from the Department of Finance anticipates health care spending will grow 23 percent during the 2004-05 biennium and 16 percent during the following two-year budget period. In the long term, health care price increases and a growing elderly population in need of long-term care are likely to push expenditures up faster than revenues. Although measures to improve efficiencies may produce some savings, Minnesota will have to make difficult choices about who should get government-paid health care and how much care they should get.

A sharp focus on controlling spending is warranted simply because health care is expensive and it competes with education, housing and other highly valued services for tax dollars. Growth in government spending for health care is a function of trends in demographics, health care prices, demand for new treatments and drugs and decisions about how much health care to buy; that is, the numbers of people eligible and the range of services provided to them. Demographics and health care inflation are largely beyond Minnesota's control, leaving decisions about eligibility and coverage the most obvious levers for controlling costs.

However, cuts in public programs could lead to higher costs later when people denied care develop more serious problems, or merely shift costs to the private sector, as health care providers try to recover costs by charging more to paying customers – mostly insurance companies.

To cope with large short-term deficits, most states are proposing cost-cutting measures for their Medicaid programs. In the long term, states will inevitably also have to look seriously at what kinds of care they buy, and how many people they serve. Otherwise, states will have to raise taxes or curtail spending on education, highways and other government services in order to pay for health care.

Even small reductions in eligibility or coverage are difficult because of their human consequences. Conversely, when cuts in benefits, or even delays

in planned expansions are proposed, policy-makers must consider:

- Who will be denied care?
- What care won't people receive?

Unless they find new revenue or cut into other programs, policy-makers will over the next few years have to consider limiting the number of people served, the range of health care services they can receive at government cost, or the amount government will pay health care providers for specific services. Reductions in any of these areas will affect the health and economic status of people, as well as the economic viability of hospitals, nursing homes and others that are heavily dependent on government payments.

Some general strategies that might help control the costs of government-supported programs include:

- Lower income and asset limits for eligibility of adults without children.
- Tighter annual payment limitations for hospitalization.
- More frequent eligibility review to move people off public programs faster.
- More use of deductibles and co-pays.
- Measures to encourage use of lower-priced drugs.

Most states have already faced pressures to curtail growth in Medicaid spending as state revenues have contracted during the 2001-02 economic slowdown. In a survey of states, the Kaiser Commission on Medicaid and the Uninsured found that 45 states took actions to reduce Medicaid spending in fiscal year 2002, and most have additional plans to curtail spending in the current fiscal year. The most common strategy was prescription drug cost controls: 32 states in 2002 and 40 states in 2003. More than half the states plan to reduce or freeze provider payment rates this year, while more than a dozen states plan to reduce benefits, restrict Medicaid eligibility or increase beneficiary co-payments for services other than prescription drugs.

The most common cost-saving actions in 2002 were restricting Medicaid reimbursement to drugs on a state-approved list and reductions in payments for drugs, either through application of greater discounts or enforcement of a maximum allowable cost for generic drugs.

A total of 22 states reported benefit cuts either in fiscal year 2002 or fiscal year 2003. Fifteen states passed benefit reductions for 2003. Eight reduced dental benefits for adults; others made cuts in home health services, podiatry, chiropractic services, eyeglasses, psychological counseling or translator services.

Eighteen states planned eligibility cuts in 2003. Three states enacted cuts that will eliminate coverage for large numbers of people.

- Missouri cut more than 32,000 people by lowering the threshold at which parents become eligible from 100 percent of poverty to 77 percent of poverty, reducing transitional coverage for people moving from welfare to work, and by making it more difficult for people to qualify as medically needy.
- Nebraska cut 25,000 people – half adults and half children – by reducing continuous eligibility and changing the way income is calculated.
- Massachusetts eliminated coverage for 50,000 long-term unemployed people effective April 1, 2003.

Other states have shortened coverage for post-partum pregnancy care, increased asset or income-reporting requirements, made it harder for people to “spend-down” to eligibility, and shortened the eligibility period for people transitioning from welfare to work.

These are the kinds of cuts Minnesota may have to consider in both the short- and long-term. They are also the kinds of cuts that cannot be taken lightly because of their impact on people.

Cutting spending will not always save money in the long run. Reductions in government-paid health care

can lead to more uncompensated “charity” care or undercut the financial footing of small, often rural, hospitals. Other kinds of strategies – including regulatory and tax code changes – may save as much money over the long haul. The challenge for Minnesota policy-makers, even after they solve the state’s short-term budget problem, will be to use all the tools available to them to see that all people get the care they need at a price Minnesotans can afford.

GLOSSARY

Home- and community-based care. Minnesota uses a federal waiver to provide health care and related services to people living at home or in other non-institutional settings in their communities.

Long-term care. Health care and living assistance given over a sustained period of time to people who are experiencing long-term disabilities or difficulties in functioning because of a disability or chronic health condition. Long-term care can be provided in institutions such as nursing homes, or in homes or other non-institutional settings.

Medicaid. A federal grant-in-aid program that reimburses states for 50 percent or more of the cost of health care services for low-income, disabled and medically needy people. In Minnesota, programs financed with federal Medicaid money are known as Medical Assistance.

Medically needy. The medically needy are people whose health care expenses are so large that, when subtracted from their income, reduce their income below an amount that makes them eligible for Medical Assistance.

Poverty. Poverty status is determined by a federally established income level, which varies by family size. The poverty level for a family of four was \$18,180 in 2002. Medical Assistance and other programs use the relationship of an individual’s income to the poverty line to determine eligibility for assistance.



Waivers. Section 1115 of the federal Social Security Act allows the Secretary of Health and Human Services to grant waivers to Medicaid rules allowing states to receive Medicaid funding for alternative programs that serve people who would not otherwise be eligible for Medicaid. Minnesota's home- and community-based care programs operate under waivers.

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