

Money Matters

A Publication of the Minnesota House Ways and Means Staff on Government Finance Issues

MinnesotaCare Financing 1995 Legislative Session/November 1995 Forecast

In 1992, the Minnesota Legislature enacted the MinnesotaCare program, then called Minnesota HealthRight. By July 1995, 88,123 low-income Minnesotans were enrolled, receiving low cost health coverage which they might not have had otherwise. Currently, families with children, earning less than 275 percent of the federal poverty level (FPL) and adults without children, who earn less than 125 percent of FPL are eligible. The program is expected to have a surplus of \$198 million at the end of the 1996-1997 biennium, and \$357 million at the end of the 1998-1999 biennium. (Cost estimates and enrollment figures are based on the November 1995 forecast.)

I. Eligibility for MinnesotaCare is based on Income and Family Status

To be enrolled in MinnesotaCare, a person must be in an eligible population group, have financial need, and lack health insurance. The income guidelines are based on federal poverty standards, and are adjusted for family size. When MinnesotaCare was first adopted, only families with children were eligible for the program. During the 1994 Legislative session, adults without children were added, at incomes under 125 percent of FPL. At this time, the Commissioner of Human Services has the authority to increase the limit to 135 percent of FPL, but as of October 1995, had not done so.

Potential enrollees must also not be otherwise insured for the covered services and must be permanent residents of Minnesota. Excluding those children with an annual family income less than 150 percent of FPL, applicants must not have had access to employer-subsidized insurance for the previous 18 months and must have been uninsured for four months. The 18-month delay requirement is exempted in three cases: 1) loss of employer-subsidized coverage due to involuntary layoff not due to employee misconduct, and the children of parents in this situation; 2) loss of coverage due to death or divorce, and; 3) loss of coverage as a child or dependant. Table 1 shows the number of enrollees in MinnesotaCare in fiscal year 1994, and the projected enrollment and the average number of enrollees per household for fiscal years 1995 through 1999.

Table 1
Enrollment in MinnesotaCare
(assumes eligibility for adults without children remains at 125% of FPL)

	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999
Monthly Average Enrollees	62,518	79,060	95,396	113,941	129,553	144,006
Avg. Enrollees Per Household	2.92	2.77	2.59	2.47	2.40	2.34

II. MinnesotaCare Revenues Exceed Expenditures through 1999

Revenues

MinnesotaCare is funded through a variety of taxes and fees. For 1996 and 1997, revenues will total \$373 million from seven sources. As shown in Figure 1, 78.3 percent of the revenue will come from the 2 percent tax on hospitals and other providers. The other main source of revenue for the program is premiums that are charged to program participants, which will account for \$40.5 million, or 10.9 percent, of the \$373 million in total revenue for fiscal years 1996 and 1997.

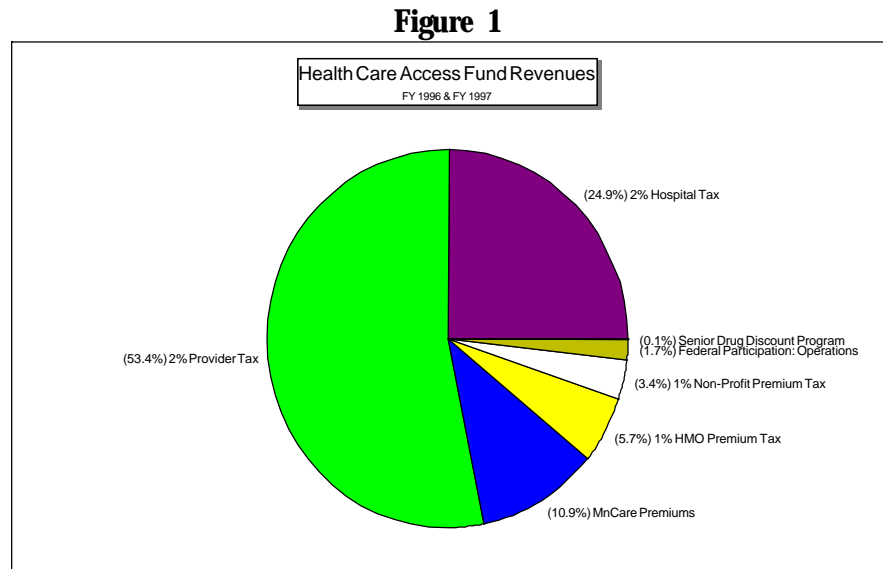


Table 2 is the detail on which Figure 1 is based, but it also includes revenues for fiscal years 1998 and 1999. It is clear from Table 2 that the 2 percent tax will continue to constitute the most significant component of revenues into the next biennium. Starting in fiscal year 1998, another large component of revenue will be interest income. During the 1995 session, the Legislature took action which required that interest earned on the balances in the fund be retained in the fund. For fiscal years 1998 and 1999, interest earnings will amount to more than \$29 million, approximately 6 percent of all revenues received in those two years.

Table 2
Health Care Access Fund Revenues
(\$ in thousands)

	1996	1997	1998	1999
2% Hospital Tax	\$44,800	\$47,900	\$51,900	\$56,200
2% Provider Tax	\$95,700	\$103,400	\$112,700	\$122,300
MNCare Premiums	\$18,198	\$22,295	\$26,103	\$29,917
1% HMO Tax	\$7,142	\$14,165	\$15,300	\$16,400
1% Non-profit Tax	\$4,320	\$8,370	\$9,000	\$9,700
Federal Financial Participation	\$3,184	\$3,104	\$2,941	\$2,832
Senior Drug Discount Program	\$170	\$250	\$250	\$250
Investment Income	\$0	\$0	\$12,109	\$17,005
DOER Loan Payback	\$0	\$0	\$3,075	\$0
TOTAL	\$173,514	\$199,484	\$233,378	\$254,604

Expenditures

MinnesotaCare expenditures include grants, transfers and administrative expenses. Grant expenditures are those made on actual medical services. In Figure 2, the section entitled "statutory grants" is the required minimum spending on medical services, which is equal to premiums paid by enrollees. "Direct grants" is the remainder of spending on medical services.

In the past, the largest transfer was a transfer to the General Fund to cover Medical Assistance (MA) and General Assistance Medical Care (GAMC) costs incurred due to the MinnesotaCare program. This transfer was instituted to cover

possible spillover (or "radiation") effects from MinnesotaCare on MA and GAMC. The 1995 Legislature eliminated this transfer, primarily because there were no indications that the expected effects were occurring to a significant degree. Figure 2 shows that during the 1996-1997 biennium, 77.8 percent of the \$234 million in expenditures from the Health Care Access Fund will be made on grants, representing \$182 million in spending on health care services.

MinnesotaCare administrative funds are provided mainly to the Departments of Human Services and Health, but also to the University of Minnesota, the Legislature and the Departments of Administration, Commerce and Revenue. However, it should be noted that not all of the non-grant and transfer dollars account for "administration" of the program. Other non-grant expenditures include support of the insurance reform part of MinnesotaCare, regulatory functions, studies and pilot programs. The bulk of the administrative money for the subsidized insurance program is spent in the Department of Human Services, and accounts for approximately 10.8 percent of all Health Care Access Fund Expenditures.

III. Health Care Access Fund Maintains Solvency

Since the Health Care Access Fund began receiving revenue during the 1993 fiscal year, it has always had a positive balance, as required by law. The language of Minnesota Statutes 256.9352, subdivision 3 states that "the commissioner [of Human Services] shall...ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium." As Figure 3 shows, between fiscal years 1993 and 1999, the Health Care Access Fund will have revenues that exceed expenditures. Figure 4 indicates how much revenues will exceed expenditures during that period. As the graphs show, the annual surplus is projected to approach \$80 million by the end of fiscal year 1999. As the annual surpluses of revenues exceed expenditures, the cumulative fund surplus will increase. By fiscal year 1999, the cumulative surplus in the fund is expected to exceed \$357 million.

Figure 2

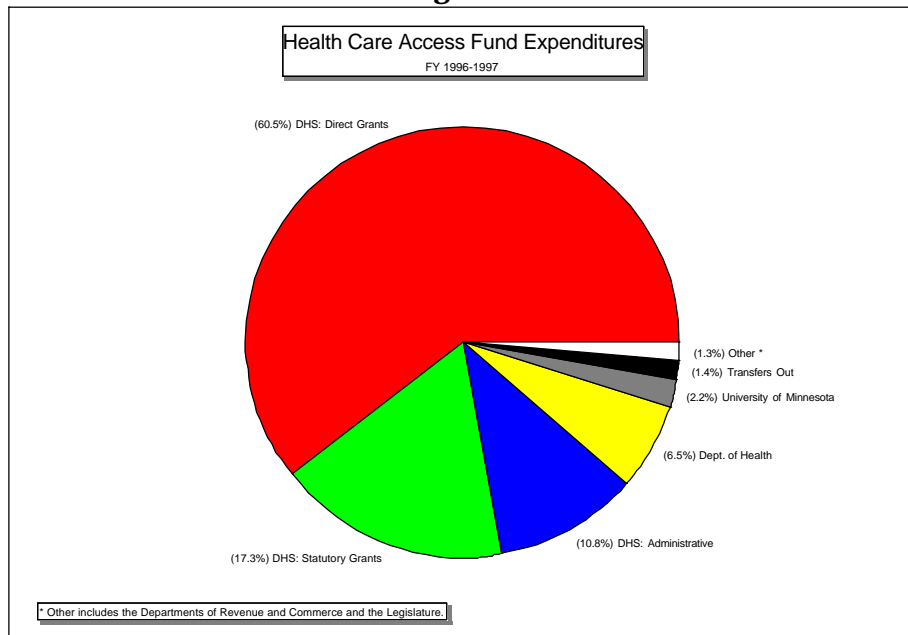
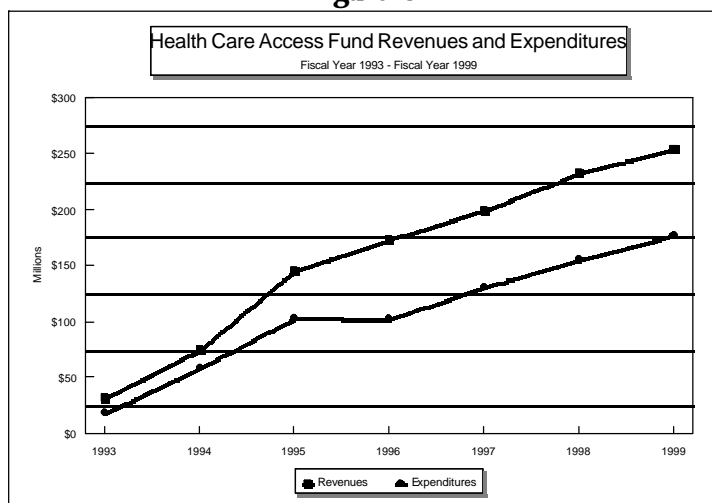
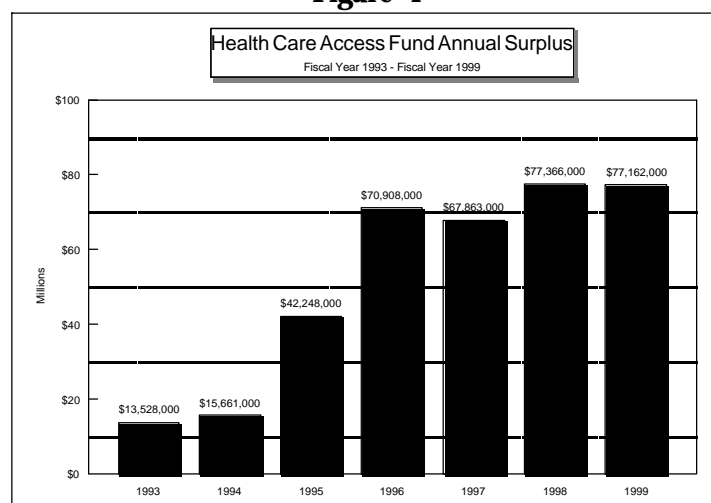


Figure 3**Figure 4**

IV. Eligibility Changes are Financially Possible

When the MinnesotaCare program was first passed in 1992, as Minnesota HealthRight, all Minnesota citizens who had annual family incomes below 275 percent of FPL were included as eligible. However, those in families without children were scheduled to become eligible at a later date than those with children. Prior to the expansion of eligibility to adults without children, because of a more pessimistic forecast the 1994 the Legislature chose to revise the enrollment eligibility of adults without children into a two-stage process, where those with incomes up to 125 percent of FPL would be eligible for enrollment on October 1, 1994, and those with incomes up to 275 percent of FPL would be eligible for enrollment on October 1, 1995.

During the 1995 session, again because of funding questions, the eligibility question was raised for adults without children. The 1995 Legislature decided that while single adults with incomes up to 125 percent of FPL would remain eligible, there would not be an automatic increase in eligibility for those with incomes higher than that as required. Instead, the Commissioner of Human Services was required by statute to review the current Health Care Access Fund balance, including expected revenues and expenditures, and, taking into consideration Federal budget actions, make a determination if expansion for adults without children up to 135 percent of FPL was compatible with existing financial management constraints, which require that expenditures from the Health Care Access Fund not exceed revenues to the fund. As of October 1995, the Commissioner had not expanded eligibility, primarily due to lack of action on the Federal level.

Given the level of annual surpluses being generated in the Health Care Access Fund, there is sufficient revenue for the expansion suggested by the 1995 Legislature, assuming that enrollment would increase to 135 percent of FPL on October 1, 1996, **given current Federal funding** levels for MA. Decisions on the Federal level will have an impact on MA, and other programs, which could in turn have implications for MinnesotaCare. Table 3 shows the projected net cost of increased enrollment up to the 125 percent level, the current annual and cumulative surplus amounts, and the change in the cumulative surplus and the annual surplus due to added costs, if eligibility were to be increased up to 135 of FPL for adults without children.

Table 3
Health Care Access Fund Surpluses
Change with Increased Eligibility for Adults without Children
(\$ in thousands)

	1996	1997	1998	1999
Cost of Expansion to 135%	\$3,205	\$13,137	\$21,228	\$29,049
Current Cumulative Surplus	\$124,634	\$197,796	\$280,669	\$357,289
Net Cumulative Surplus with Expansion	\$121,429	\$184,659	\$259,441	\$328,240
Current Annual Balance	\$70,908	\$67,863	\$77,366	\$77,162
Net Annual Balance with Expansion	\$70,953	\$64,644	\$66,640	\$59,482

V. Health Care Reform Waiver Increases Funds for MinnesotaCare

The other source of a financial impact on the Health Care Access Fund during the 1995 session was the adoption of enabling legislation which allowed the Department of Human Services to implement a waiver of §1115 of the Federal Social Security Act, which was approved in late April of 1995. The waiver has broad implications for both the MA and the MinnesotaCare program, as it creates increased flexibility for Minnesota to expand access to health care in these two programs, exempts the state from various federal requirements and allows the two programs to be more closely integrated.

The financial impact of the waiver is felt primarily in the MinnesotaCare program by the contribution of the federal government toward the cost of health care services provided to children and pregnant women who are enrolled in MinnesotaCare. The federal government pays 54 percent of the cost of services for these enrollees, while the state pays 46 percent. In addition, the federal government pays 50 percent of all administrative costs related to those enrollees. Federal funds into the Health Care Access Fund are expected to exceed \$36 million during the 1996-1997 biennium.

VI. General Fund Savings Due to MinnesotaCare

As noted earlier, the 1995 Legislature eliminated the transfer of funds from the Health Care Access Fund to the General Fund. Between fiscal year 1993 and fiscal year 1995, more than \$41 million had been transferred into the General Fund. This transfer was made to compensate the General Fund for costs in MA and GAMC that would not have existed without MinnesotaCare. During the initial implementation of the program it was speculated that these costs would be incurred in MA and GAMC as people found out about public health programs because of MinnesotaCare. However, actual experience has not verified this expected effect. In fact, it has been determined that, primarily in MA and Aid for Families with Dependant Children (AFDC), another General Fund program, there have been significant **savings** to the General Fund.

In AFDC there are significant savings due to a reduction in expected caseloads. In general, reduced caseloads have come as families with employment, but without employer-sponsored health care or the ability to purchase private health insurance, have been able to keep their jobs and still have health insurance, through MinnesotaCare. Instead of quitting their job, for example, to enroll in MA, they have kept their jobs, and enrolled in MinnesotaCare. It appears that the ability to enroll in MinnesotaCare makes employment a workable alternative to AFDC and MA. Table 4 shows the state, county and federal budget savings in MA and AFDC due to the existence of the MinnesotaCare program. For the 1996-1997 biennium, for example, MinnesotaCare will generate nearly than \$69 million in savings to the state General Fund, and a total over \$116 million to the state, the counties and the federal government.

Table 4
Savings Resulting from MinnesotaCare
 Fiscal Years 1995-1999
 (\$ in millions)

	1995	1996	1997
State Savings			
Aid for Families with Dependant Children	\$18,880	\$25,967	\$30,387
Medical Assistance	\$3,625	\$5,623	\$6,924
Subtotal State General Fund Savings	\$22,505	\$31,590	\$37,311
Federal and County Savings (MA and AFDC)			
Federal Savings	\$14,265	\$19,537	\$22,877
County Savings	\$1,605	\$2,211	\$2,615
Total Savings, All Units of Government	\$38,375	\$53,338	\$62,803

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