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Minnesota's Uninsured in 2017: Rates and Characteristics

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As noted in the companion issue brief to this analysis, Minnesota's uninsurance rate climbed significantly in 2017, undoing some of the success of the coverage expansion under the Affordable Care Act (ACA) through 2015.[1]

This issue brief uses data from the 2017 Minnesota Health Access Survey (MNHA) to provide additional context on uninsurance in Minnesota by:

1. Illustrating the persistent disparities in the rates of uninsurance across population groups; and
2. Describing Minnesota's uninsured population along key demographic characteristics, including their connection to the labor market.

The MNHA is a biennial telephone survey of the state population that is conducted in partnership between the Minnesota Department of Health and the University of Minnesota, School of Public Health State Health Access Data Assistance Center (SHADAC).

Disparities in Uninsurance Rates

Unlike in 2015 when the improvement in uninsurance rates was felt across the board – for virtually all demographic groups – in 2017 some groups maintained their coverage gains, while others lost ground. This means, the historical disparities that had been experienced by certain population groups in 2015 (and before) remained in place in 2017. The following Minnesotans had the highest rates of uninsurance again in 2017:

- Young adults, ages 18 to 34 (10.9 percent);
- Persons with incomes below 200 percent of the federal poverty guidelines (11.3 percent);
- People with a high school education or less (11.9 percent); and
- People of color and American Indians (13.9 percent).

These populations also tended to have lower access to employer sponsored (group) coverage. At the same time, obtaining health insurance on their own, either through public coverage or the individual market, presented its own challenges, both financially, and in terms of time, documentation needed and complexity in enrollment process. In the next section, we discuss which population groups in Minnesota maintained coverage gains, and where we saw disparities grow compared to two years earlier.

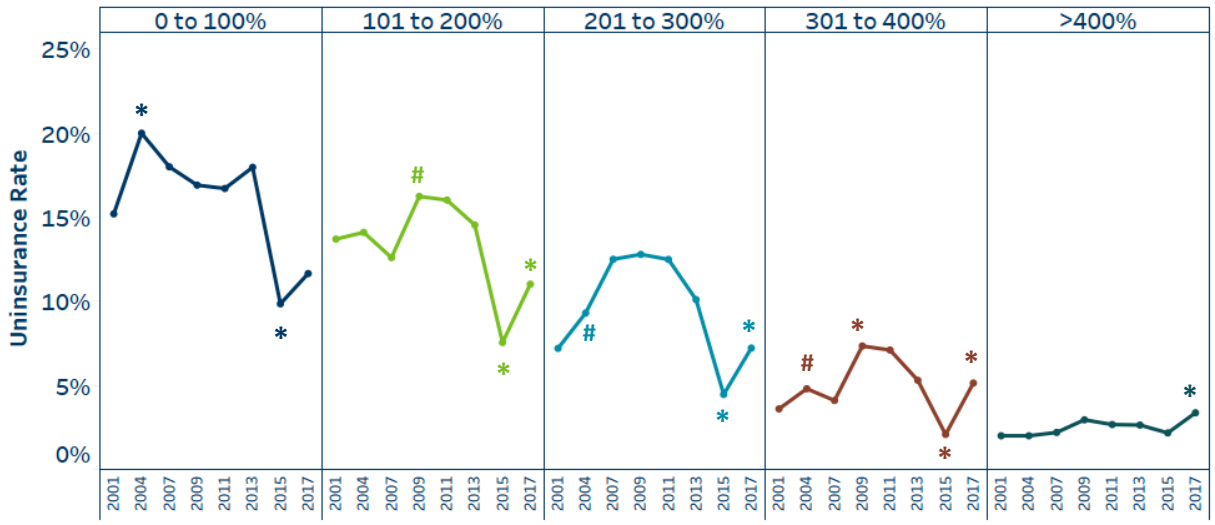
Income

Lower income Minnesotans have consistently had the highest levels of uninsurance among people of any income. While this was still the case in 2017, as shown in Figure 1, persons with the lowest incomes – people at or below 100 percent of the Federal Poverty Guidelines (FPG) – largely maintained coverage gains from 2015.[2] In contrast, uninsurance rates for people with incomes higher than 100 percent FPG saw increases toward or at 2013 levels.[3]

The particularly large increase in uninsurance, relative to 2015 levels, for people with higher incomes (300 percent of FPG or above), corresponds to losses in private market coverage that we documented elsewhere.[4] Nevertheless, their rates of uninsurance remained well below the state average (6.3 percent) and below that of people at any other income level.

The stable rate of coverage for Minnesotans below the poverty line represents a considerable success. It is likely due to both the affordability of state public programs, and the addition of a new access point (MNsure) along with the related in-person support to help navigate available coverage options. As our survey results show, this has likely contributed to more public program enrollees maintaining coverage for a full year than was seen in the past.[5]

Figure 1. Uninsurance Rates by Household Income



Source: Minnesota Health Access Surveys, 2001-2017
* Indicates statistically significant difference from previous year shown at 95 percent level.
# Indicates statistically significant difference from previous year shown at 90 percent level.
Note: Household Income is standardized as a percent of the Federal Poverty Guidelines (FPG), which change each year. Respondents provided 2016 income for this survey; for a single person 100 percent FPG is $11,880 per year, and 400 percent FPG is $47,520 per year; for a family of four, 100 percent FPG is $24,300 per year, and 400 percent FPG is $97,200 per year.

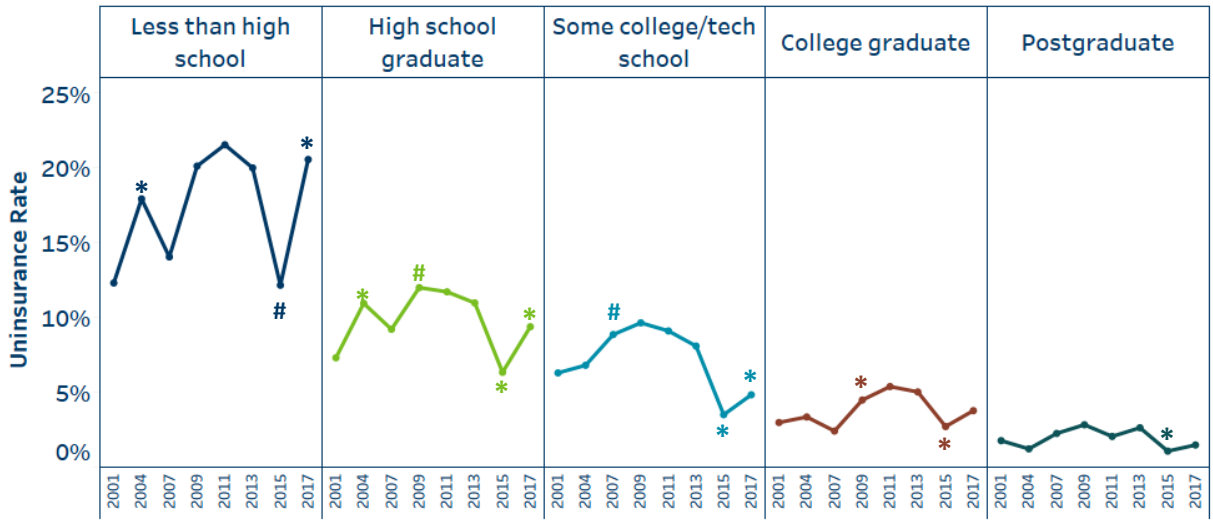
Education

Similar to income, educational attainment and coverage trends generally track closely, again in opposite directions: the likelihood of being uninsured falls with increasing educational attainment.

In contrast to the income dynamics just noted, rates of uninsurance in 2017 *increased* for people with the lowest educational attainment (all categories below a completed college education), while staying unchanged for Minnesotans who were college graduates or held postgraduate degrees. People with lower education levels were less likely to have access to insurance through employers or directly purchase individual coverage.

Further analysis is needed to better understand the interplay between educational attainment and income, and its impact on health insurance. However, the complexity of either enrolling in public programs or purchasing individual health insurance is often higher and takes more time than enrolling in group coverage through an employer. The level of documentation required, as well as the array of choices, especially in the individual market, only highlights the complexity of the health insurance system. This makes shopping for health insurance and maintaining it challenging.[6] It may also affect policy-holders' ability to benefit from insurance coverage and color their view of the value health insurance; national research indicates that both income and education are related to health insurance literacy.[7]

Figure 2. Uninsurance Rates by Education



Source: Minnesota Health Access Surveys, 2001-2017
* Indicates statistically significant difference from previous year shown at 95 percent level.
# Indicates statistically significant difference from previous year shown at 90 percent level.
Note: For children, education is defined as that of the parent.

Race and Ethnicity

Structural barriers in access to education, employment and wealth accumulation lead to persistent inequities for people of color and American Indians. Persistent disparities in access to health insurance and health care co-exist with these and other constraints and result in poorer health outcomes.[8]

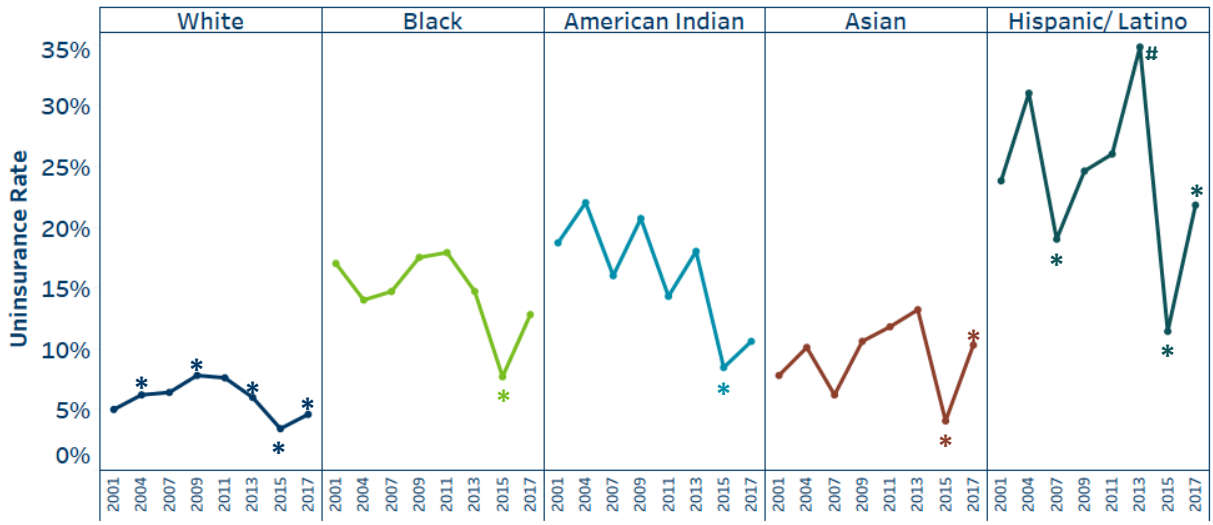
As shown in Figure 3, the uninsured rate in 2017 rose across all race and ethnic groups, but the growth in the rate for Blacks and American Indians in Minnesota did not rise to the level of

statistical significance.[9] As in the past, disparities in uninsurance by race and ethnicity persisted in 2017 and grew, in fact, for some population groups because of the difference in the magnitude of change:

- Whites saw a statistically significant increase as compared to 2015. Still, the uninsured rate of 4.6 percent remained lower than other groups and 2013 levels.
- The rate for Hispanics or Latinos nearly doubled relative to 2015 (to 21.8 percent). It too remained below 2013 levels, but represents the highest rate for any group in Minnesota.
- Asians in Minnesota saw their uninsurance rate climb two and a half times, to 10.3 percent.

The structural constraints for people of color and American Indians noted above likely contributed to the lower rates of coverage among these groups. For example, people of color and American Indians have lower levels of access to employer-sponsored (group) coverage. Nearly 79 percent of white, non-Hispanic Minnesotans are connected to an employer who offers health insurance coverage, while the equivalent rates for people of color and American Indians was 61 percent (data not shown). These disparities in offer rates persisted across income levels, so even at the highest income levels (400 percent FPG), offer rates were lower for people of color and American Indians.

Figure 3. Uninsurance Rates by Race and Ethnicity



Source: Minnesota Health Access Surveys, 2001-2017
* Indicates statistically significant difference from previous year shown at 95 percent level.
# Indicates statistically significant difference from previous year shown at 90 percent level.
Note: Respondents may select multiple race and ethnic groups; in this chart, those who selected multiple groups are included in each category they selected.

Age

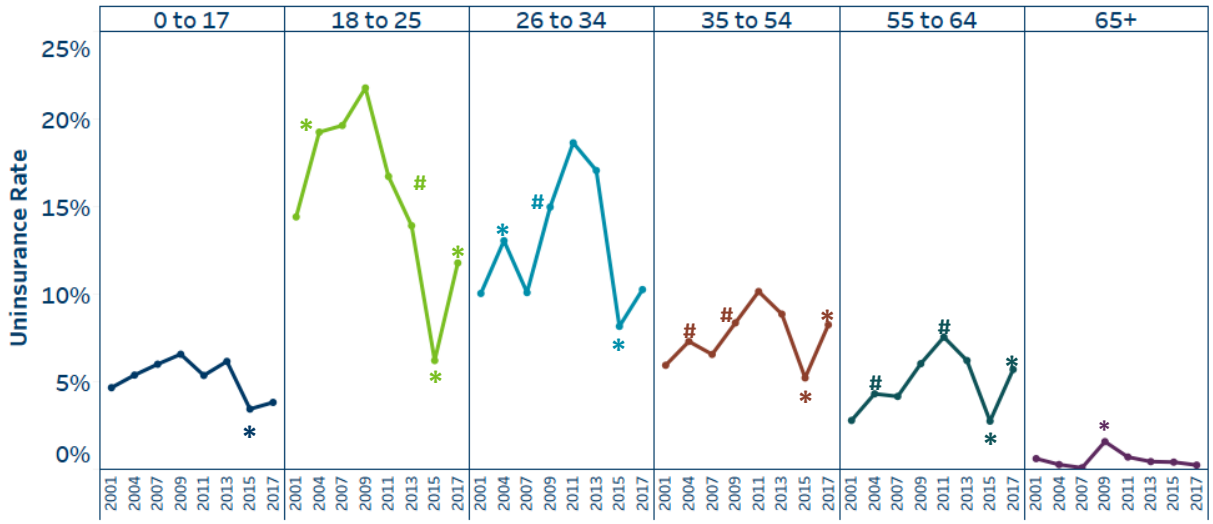
There are large differences between age groups in levels of coverage. Adults younger than 65 had the highest rates of uninsurance, while the rates for children and, particularly, adults age 65 and older – the Medicare eligible population – were the lowest (Figure 4).

As in previous years, adults aged 18 to 25 and 26 to 34 were the two age groups with the highest rates of uninsurance in 2017 (11.8 percent and 10.3 percent, respectively). Growth in uninsurance occurred for most adults under age 65, with the exception being young adults ages 26 to 34 years.

Young adults aged 18 to 25 had seen the most substantial decline in uninsurance following implementation of the Affordable Care Act (ACA). This was largely due to the provision that, beginning in 2011, allowed parents to maintain their children as dependents on their health insurance until age 26. This makes the rebound in uninsurance rates for young adults in 2017 somewhat surprising. While as a group young adults were less likely to have insurance through an employer compared to 2015 (data not shown), it is not clear whether that is due to changes in their *own* employment or in employment or coverage decisions by their parents – both paths to being connected to group coverage.

On the positive side, insurance gains achieved in 2015 for children under age 18 were sustained in 2017. Children under 18 had higher limits on income thresholds for public programs than adults (up to 275 percent FPG), and they benefited from the more continuous public coverage seen in 2017. Yet, 50,000 children in Minnesota still lacked health insurance coverage in 2017.

Figure 4. Uninsurance Rates by Age



* Indicates statistically significant difference from previous year shown at 95 percent level.
\# Indicates statistically significant difference from previous year shown at 95 percent level.
Source: Minnesota Health Access Surveys, 2001-2017

Other Demographic Groups

Though much of this brief has focused on uninsured rates by age, income, education and race and ethnicity, disparities in uninsured rates are not limited to only those groups. Other notable differences between groups and trends in uninsurance in 2017 extend to gender, geography and nativity.

- Males had a higher rate of uninsurance than females, mirroring earlier trends prior to 2015.
- Uninsured rates for Minnesotans in the Twin Cities metropolitan area and in Greater Minnesota rose, but they remain at comparable levels to each other (6.4 percent and 6.1 percent, respectively).
- Similarly, both Minnesotans born in the United States and elsewhere saw increases in the uninsured rates in 2017. However, Minnesotans not born in the U.S. saw the difference in their coverage widen to 3.5 times that of US-born Minnesotans (18.0 and 5.2 percent, respectively).

Characteristics of the Uninsured

In this section we look at differences in the characteristics of the uninsured compared to the overall population. For example, rather than focusing on the fact that Whites have the lowest rates of uninsurance, in this section we document that Whites account for more than half of the uninsured (58.6 percent), because demographically, they account for a substantial majority of Minnesotans (78.2 percent). We also note, that they account for a disproportionally lower share of the uninsured, because they account for a smaller share of people without coverage than the overall population.

We highlight some differences in the distribution of the uninsured population in order to inform our understanding of the barriers to health care or insurance coverage. Appendix Tables 2 and 3 provide more complete data on demographic and employment characteristics of the uninsured compared to the state as a whole. The following sections focus on certain aspects of employment characteristics of the uninsured, as well as indicators of health status and confidence in getting needed care.

Employment Characteristics of the Uninsured

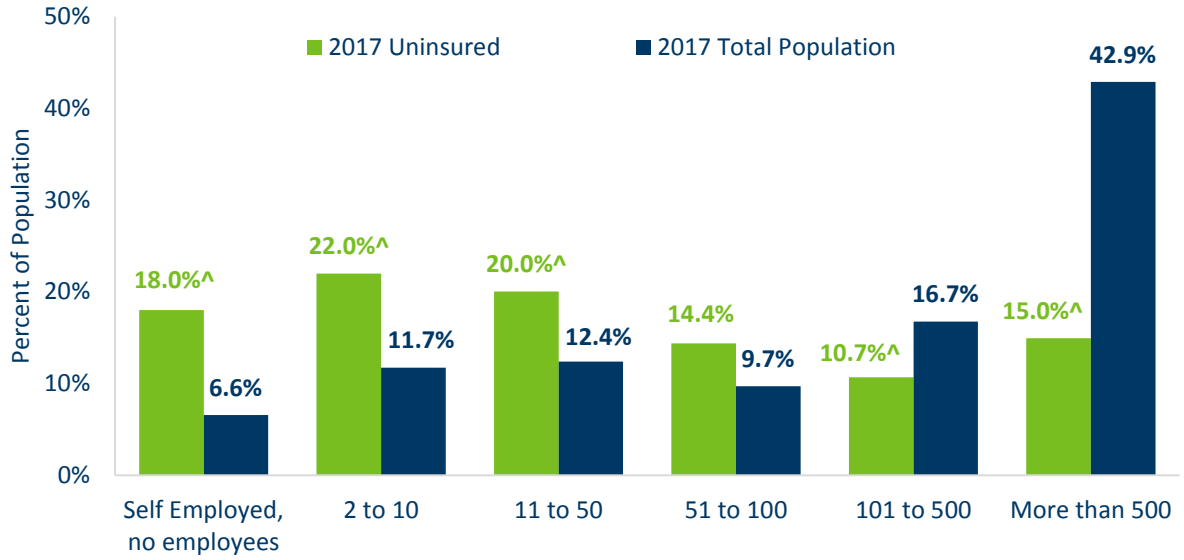
Because such a large share of Minnesotans used to get health insurance through an employer, there has been a long-held misconception that the uninsured do not work. That misconception has held steady even as the rate of employer-based coverage has fallen.

The Minnesota Health Access Survey has helped to consistently demonstrate that the uninsured are employed at rates comparable to the rest of the population (75.8 percent and 72.1 percent, respectively in 2017). In addition, Appendix Table 3 shows that the uninsured work multiple jobs at about the same rate as the overall population and work full time at comparable rates.[10]

Sizable differences exist, however, in the types of jobs the uninsured hold and the size of employers they work for. For example:

- Uninsured Minnesotans are three times more likely to be temporary or seasonal employees than Minnesotans overall (27.4 percent and 9.7 percent, respectively). These types of jobs are less likely to provide access to employer-sponsored coverage. People with temporary or seasonal jobs may also find it more difficult to maintain coverage through public programs or receive tax credits as their income may fluctuate throughout the year and between years.
- Minnesota's uninsured are nearly twice as likely to be self-employed than Minnesotans overall (22.0 percent and 12.5 percent, respectively). Options for health insurance are more limited for those who are self-employed, as they have to seek coverage on their own in the individual market and, because of their income, are less likely to be eligible for premium support (25.0 percent of self-employed uninsured have incomes over 400 percent FPG, making them ineligible for federal premium support, while that is the case of only 12.2 percent of those employed by others).
- As shown in Figure 5, a greater share of the uninsured in Minnesota (60.0 percent) work for employers with 50 or fewer employees compared to Minnesotans overall (30.7 percent). Such small employers offer health insurance coverage at lower rates than larger employers. As a result of their smaller size, they may also be more susceptible to having to absorb premium increases than employers with larger risk pools.
- The uninsured have a radically lower likelihood to receive paid sick leave (36.1 percent) than their insured counterparts who are employed (75.4 percent). Lacking paid sick leave has been shown to contribute to poorer health status and the spread of illness to coworkers and customers.[11]

Figure 5. Employer Size of Minnesotans and Uninsured Minnesotans, 2017



Source: Minnesota Health Access Surveys, 2017
^ Indicates statistically significant difference from total population at the 95% level
Note: For children, refers to employer size of parent.

Demographics, Health and Confidence in Getting Care

The demographic profile of the uninsured has remained essentially unchanged since 2001. In 2017, as in the past, the uninsured were disproportionately more likely to:

- Have a high school degree or less (57 percent);
- Be adults aged 18 to 64 (85 percent);
- Be born outside the US (25.7 percent); and
- Have incomes below 200 percent of poverty.

Finally, the uninsured as a group were also disproportionately people of color and American Indians. In 2017, they comprised 43.9 percent of the uninsured, while accounting for just 19.3 percent of the state's population; though as shown in Appendix Table 2, the proportion of the uninsured who identify as American Indians or Asians was not statistically different than their proportion of the overall state population.[12]

Given the barriers to care that people who are uninsured face, along with structural constraints that contribute to health inequities, it is not surprising that compared to the population overall, the uninsured in 2017 were more likely to:

- Report fair or poor health (21.6 percent and 12.7 percent, respectively);
- Experience more unhealthy days related to their mental health (4.6 days in the last 30 days as compared to 2.9 days);
- Lack confidence in getting needed care (38.2 percent vs. 9.9 percent); and
- Report forgoing care due to costs (46.0 percent compared to 21.0 percent).

People without health insurance reported having one or more chronic health conditions at about the same rate as people with private health insurance (25.5 percent and 29.3 percent, respectively). But lack of coverage affects timely access to needed services and, as the literature documents, actual health outcomes.[13]

Conclusions

Minnesota has historically maintained high rates of health insurance coverage compared to the rest of the United States. Under the surface, though, not all Minnesotans have benefited from this positive picture. Our past work has documented considerable and persistent disparities in insurance coverage by race and ethnicity, income, age and education, as well as their impact on access to health *care*. The Minnesota Health Access Survey has been an essential tool for documenting these dynamics and studying their impact.

Findings from 2017 suggest that most disparities persisted and that, although some gains from 2015 were maintained, other gaps worsened. Because of the strong association between access to affordable health insurance coverage and access to health care services, these disparities influence financial well-being (coverage is designed to financially protect people at times of poor health), impact the ability to obtain timely needed care and affect continuity of care. This then layers on top of other social stressors that Minnesotans experience.

Many of the disparities are direct outcomes of structural factors or are affected by them in considerable ways:

- For example, the lower rates of coverage for people of color and American Indians is a result, in part, of lower offer rates for employer coverage across all income categories. This hamstrings these Minnesotans' ability to obtain coverage that is the most prevalent and most affordable among private market options.
- Similarly, young adults have higher rates of uninsurance, because early in their career they tend to work for employers that offer fewer non-wage benefits, and their incomes and preferences may not align well with obtaining protection offered by health insurance. This keeps people who, on average, are healthier out of the risk pool and exposes them to high costs for potential acute care needs just as they begin their independent lives.

There are some tools in place that can help reduce disparities. Premium subsidies for income-eligible people on the individual market help buy down the cost of coverage, and subsidized public program insurance offers free or steeply discounted coverage for lower-income individuals. As noted in the companion brief to this analysis,[14] we estimate that slightly more than half of the uninsured in 2017, or about 178,000 Minnesotans, were eligible for public program coverage; another 22.7 percent, or 75,000, likely qualified for premium subsidies under the ACA.

The reasons for why these groups of Minnesotans did not take up subsidized coverage is multi-faceted. As noted, while cost is a factor influencing take-up of private coverage, the evidence about people eligible for public programs is more mixed. On the one hand the data reveals concerns about costs and benefits, which does not seem to align with the actual design of public programs. On the other hand, respondents express uncertainty about being eligible and worry about the ability to scale the enrollment process. This highlights challenges with understanding the program, how to obtain more information and, perhaps with assessing the value of holding coverage in general. This seems to be the case despite the progress Minnesota made in this area by establishing an insurance exchange that includes multiple resources to assist with shopping and enrolling in coverage.

In addition, that so many income-eligible people in Minnesota continue to lack coverage may mean that having health insurance coverage simply ranks below other factors in complex lives, or that the enrollment tools offered and the communication about the benefits of coverage are not sufficiently suited to individuals' needs or circumstances. Additional research, including qualitative investigations, may help us better understand these challenges and design strategies that reduce disparities in coverage or otherwise guarantee access to timely, affordable, high quality health care. This can bring us closer to the aspirational goal that all Minnesotans enjoy equal opportunity to reach their best health.

Methodological Notes

The Minnesota Health Access (MNHA) surveys are stratified random digit dial telephone surveys, designed to produce stable estimates for regions of the state and the most populous demographic groups. In 2017, landline and cell phone interviews were completed with 12,436 respondents, and had a margin of sampling error of 1.51 percent. Additional information on the MNHA surveys can be found in the methodological notes of the companion brief.[15]

Appendix Tables are available, which provide additional relevant data for this brief, including values for Figures 1 to 4.

Endnotes

[1] Minnesota Department of Health, Health Economics Program and School of Public Health, University of Minnesota, (2018, February). *Minnesota's Changing Health Insurance Landscape: Results from the 2017 Minnesota Health Access Survey.* Retrieved from: http://www.health.state.mn.us/data/economics/docs/mnha2017primfind.pdf.

[2] Unless otherwise noted, differences between estimates over time or across population groups that are identified in this issue brief are generally statistically different at the 90 percent confidence level.

[3] Family income is measured as a percent of the Federal Poverty Guidelines, which allows for comparison across years. A family of four in 2016 was considered to be in poverty if their income was at or below $24,300 per year. Source: US Department of Health and Human Services (2016, January 25). Annual update of the HHS poverty guidelines. *Federal Register*, *81*(15), 4036-4067. Retrieved from https://www.gpo.gov/fdsys/pkg/FR-2016-01-25/pdf/2016-01450.pdf

[4] Minnesota Department of Health, Health Economics Program and School of Public Health, University of Minnesota, (2018, February). *Minnesota's Changing Health Insurance Landscape: Results from the 2017 Minnesota Health Access Survey.* Retrieved from: http://www.health.state.mn.us/data/economics/docs/mnha2017primfind.pdf.

[5] Minnesota Department of Health, Health Economics Program and School of Public Health, University of Minnesota, (2018, February). *Minnesota's Changing Health Insurance Landscape: Results from the 2017 Minnesota Health Access Survey.* Retrieved from: http://www.health.state.mn.us/data/economics/docs/mnha2017primfind.pdf.

[6] Paez, K.A., Mallery, C.J, Noel, H., Pugliesse, C., McSorley, V.E., Lucado, J.L. & Ganachari, D. (2014). "Development of a Health Insurance." *Journal of Health Communication*, 19(sup2): 225-239.ng Consumer Ability to Choose and Use Private Health

[7] Long, S. K., Shartzer, A., & Politi, M. (2014, October 27). *Low levels of self-reported literacy and numeracy create barriers to obtaining and using health insurance coverage.* Retrieved from Urban Institute, Health Reform Monitoring Survey Website: http://hrms.urban.org/briefs/Low-Levels-of-Self-Reported-Literacy-and-Numeracy.html

[8] Bailey, ZD, Krieger, N, Agenor, M, Graves, J, Linos, N & Basset, MT. (2017)" Structural racism and health inequities in the USA: evidence and interventions." *The Lancet*, 389(10077): 1453-1463.

[9] This is driven in part by the size of sampling error associated with estimates in 2015 and 2017 for numerically small groups (the uninsured represent a small number of individuals in the sample, of which Blacks and American Indians account for just a portion).

[10] See Minnesota Department of Health, Health Economics Program (2016, February) *Health Insurance Coverage in Minnesota: Results from the 2015 Minnesota Health Access Survey*. Retrieved from http://www.health.state.mn.us/data/economics/docs/coverage/healthinscovmnhas2015brief.pdf; and The Kaiser Family Foundation (2017 November). *Key Facts about the Uninsured Population*. Retrieved from http://files.kff.org/attachment/Fact-Sheet-Key-Facts-about-the-Uninsured-Population.

[11] Alarcon, G., Call, K. T., Hagge, S., & Simon, A. B. (2017, June). *Offering paid sick leave to employees improves health in Minnesota.* Presented at the AcademyHealth Annual Research Meeting, New Orleans, LA.

Appendix Table 2 provides data from 2015 and 2017. Data back to 2001 is available on the Minnesota Health Access Survey Interactive Web Tool at: https://mnha.web.health.state.mn.us/Welcome.action.

[13] Minnesota Department of Health (2014, February). *Advancing Health Equity in Minnesota*. Retrieved from http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf.

[14] Minnesota Department of Health, Health Economics Program and School of Public Health, University of Minnesota, (2018, February). *Minnesota's Changing Health Insurance Landscape: Results from the 2017 Minnesota Health Access Survey.* Retrieved from: http://www.health.state.mn.us/data/economics/docs/mnha2017primfind.pdf.

[15] Minnesota Department of Health, Health Economics Program and School of Public Health, University of Minnesota, (2018, February). *Minnesota's Changing Health Insurance Landscape: Results from the 2017 Minnesota Health Access Survey.* Retrieved from: http://www.health.state.mn.us/data/economics/docs/mnha2017primfind.pdf.

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