

## MINNESOTA

**DISCLAIMER:** The views, statistical analysis, findings, and opinions expressed herein are not necessarily those of the Office of Minority Health, the Office of Public Health and Science nor the Department of Health and Human Services. The National Health Law Program, Inc. (NHeLP), under contract #282-00-0026, reviewed and analyzed existing state policies related to collecting racial and ethnic data by managed care organizations and health insurers. The information in this draft report contains the findings of NHeLP and not that of the Office of Minority Health, the OPHS, nor the U. S. Department of Health and Human Services. The study was conducted between October 2000 and May 2001. The policies and/or data per state may have changed since that time. The findings that have been updated in this draft report are the U.S. Census data (updated so that all data is from the 2000 Census) and the Center for Medicare & Medicaid Services (CMS)/HHS Medicaid data (updated from the June 30, 2000 to the December 31, 2002 reports).

## MINNESOTA

### A. General and Health Demographics

<b>Total Population</b>	4,919,479
Percent Black Population	3.4
Percent American Indian and Alaskan Native Population	1.1
Percent Asian Population	2.9
Percent Native Hawaiian and Other Pacific Islander Population	0.0
Percent Hispanic Population (of any race)	2.9
Percent White Population	88.2
Other (some other race and two or more races)	1.5
<b>Language Use - 1990 census data</b>	
Percent Limited English Proficiency (LEP) Population	1.73 (3.65)
<b>Health Care Delivery Profile</b>	
Percent of Total Non-elderly Population Privately Insured (2000-01)	76
Percent of Total Population Enrolled in HMOs (2002)	26.9
Medicaid Enrollment (as of December 31, 2000)	556,386 (11.31%)
Medicaid Managed Care Enrollment	386,472 (69.46%)
Percent of Total Non-elderly Population Uninsured (2000-01)	8

### B. Collection and Reporting of Racial and Ethnic Data by Health Insurers and Managed Care Organizations

#### 1. Statutes, Regulations, Policies, and Other Written Materials

Minnesota uses the term “insurer” or “health plan company” to encompass health insurance companies and health maintenance organizations (HMOs).<sup>1</sup> The term managed care organization (MCO) is used to refer to an insurance company, HMO, or any other health plan company that

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<sup>1</sup> Minn. Stat. § 62A.011. HMOs “provide, either directly or through arrangements with providers or other persons, comprehensive health maintenance services, or arrange for the provision of these services, to enrollees on the basis of a fixed prepaid sum. . .” Minn. Stat. § 62D.02

“covers health care services delivered . . . through a preferred provider organization (PPO) or a network of selected providers.”<sup>2</sup> The Department of Commerce, Insurance Division has jurisdiction over health insurers. MCOs are jointly regulated by the Insurance Division and the Department of Health.<sup>3</sup>

Minnesota does not have any statutes or regulations that prohibit or mandate the collection or reporting of racial or ethnic data.

Minnesota requires approval by the Commissioner of Insurance of any policy of accident and sickness insurance that is issued in the state, or any application used in connection with such a policy.<sup>4</sup> The standards for disapproval do not include the collection of or inquiry into the applicant’s racial or ethnic background, but does include “any provision which [is] unjust, unfair, inequitable, misleading, [or] deceptive. . .”<sup>5</sup>

Minnesota has implemented an extensive data collection initiative which entails health plans and HMOs submitting data “to monitor and improve the efficiency and effectiveness of health care in Minnesota.”<sup>6</sup> The Commissioner of Health is charged with collecting and maintaining data that will “enable population-based monitoring and trending of the access, utilization, quality, and cost of health care services within Minnesota.”<sup>7</sup> In addition, the Commissioner must establish a data collection system that ensures the participation of health care providers and health plan companies, while promoting improvements in health care efficiency and effectiveness.<sup>8</sup> Some of the data collected and analyzed includes, but is not limited to: (1) health outcomes data; (2) health status; and (3) a patient’s functional status.<sup>9</sup>

The Commissioner of Health, along with health care providers, group purchasers, and consumers, constitute the Minnesota Health Data Institute (“Institute”).<sup>10</sup> The Institute is a coordinated effort between the public and private sectors to collect and analyze data in order to assess access to, quality of, and the utilization of health care services in Minnesota. As part of this initiative, the Institute must develop a “data collection plan that provides coordination for public and

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<sup>2</sup> Minn. Stat. § 62Q.01.

<sup>3</sup> The Department of Commerce examines the financial condition of health carriers and reviews policies, contracts, and rates. The Department of Health ensures that licensed entities comply with applicable laws and rules which address financial solvency, quality of care, access, complaints and appeals, and other important consumer rights.

<sup>4</sup> Minn. Stat. § 62A.02.1.

<sup>5</sup> Minn. Stat. § 62A.02.3. The Minnesota Department of Commerce has indicated that the state “would disapprove any form that requested racial, ethnic or primary language information.” Letter dated December 20, 2000 from John E. Gross, Minnesota Department of Commerce.

<sup>6</sup> Minn. Stat. § 62J.301.2.

<sup>7</sup> *Id.* § 62J.301.3(1).

<sup>8</sup> *Id.* § 62J.301.3(5).

<sup>9</sup> *Id.* § 62J.301.4(a).

<sup>10</sup> Minn. Stat. § 62J.451.1.

private sector data collection efforts related to the performance measurement and improvement of the health care delivery system.”<sup>11</sup> In addition, the Institute must identify the health data needs of consumers, groups purchasers, providers, and the state.<sup>12</sup>

The Institute also must develop a consumer survey which assesses the level of consumer satisfaction with their health care delivery system.<sup>13</sup> The Institute polls consumers from all types of health care delivery systems, including HMOs, preferred provider organizations (PPOs), and indemnity insurance plans (*e.g.*, Blue Cross/Blue Shield).<sup>14</sup> In order to effectuate the survey, health plans must provide the Institute with "roster data" which includes, among other things, the patient's name, gender, and birth date, but not race or ethnicity.<sup>15</sup> The survey may include information on overall satisfaction, health outcomes, communication, and access to care.<sup>16</sup>

## 2. Discrimination

Minnesota has a general civil rights statute that prohibits discrimination because of race, color, and national origin with regard to access to public accommodations and public services.<sup>17</sup> It is not clear whether access to health care services or health insurance is a “public accommodation” as defined by statute and there is no case law that has addressed this issue.<sup>18</sup>

In addition, the Department of Insurance requires health plans to accept all individuals for enrollment in a manner "which does not discriminate on the basis of race . . ."<sup>19</sup> With regard to its unfair trade practices law, Minnesota does not explicitly prohibit discrimination on the basis of race when issuing or continuing to issue a health insurance policy. The insurance statute only provides that there must not be any "discrimination between individuals of the same class of essentially the same hazard" when setting policy rates.<sup>20</sup>

## 3. Confidentiality

HMOs are prohibited from disclosing any information pertaining to the diagnosis, treatment, or health of an enrollee, or any application obtained from any person.<sup>21</sup> Exceptions to this prohibition include: (1) the express consent of the enrollee or applicant; (2) a statute or court order

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<sup>11</sup> Minn. Stat. § 62J.451.3(1).

<sup>12</sup> Minn. Stat. § 62J.451.4(1).

<sup>13</sup> Minn. Stat. § 62J.451.6b(a).

<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

<sup>17</sup> Minn. Stat. § 363.12.1(3)-(4).

<sup>18</sup> Minn. Stat. § 363.01.33.

<sup>19</sup> Minn. Stat. § 62D.10.3

<sup>20</sup> Minn. Stat. § 72A.20.9. Interestingly, this same statute does forbid discrimination on the basis of race when issuing motor vehicle insurance. *See id.* § 72A.20.23(e).

<sup>21</sup> Minn. Stat. § 62D.145.2.

for the production of evidence; (3) a claim or litigation between the person and the provider or HMO; and (4) authorization by another statute.<sup>22</sup> Any information that is released to the Commissioner of Insurance to carry out statutory or regulatory purposes must not identify any particular patient by name or contain any unique personal information.<sup>23</sup>

In addition, the Minnesota Health Data Institute must ensure that all individually identifiable data collected remains confidential.<sup>24</sup> Moreover, the Institute must create indecipherable patient identifiers to prevent identification of individual patients in order to enable the release of otherwise confidential data to researchers, providers, and group purchasers.<sup>25</sup>

Finally, an insurer must not disclose any “personal or privileged” information about an individual collected or received in connection with an insurance transaction.<sup>26</sup> Disclosure is allowable in conjunction with: (1) written consent by the individual; (2) a need by an insurance company in order to detect criminal activity or to perform administrative functions; (3) a need by a medical care institution for the purpose of verifying coverage or benefits; and (4) a release to a law enforcement or government authority.<sup>27</sup>

### **C. Collection and Reporting of Racial and Ethnic Data by Other Health Care Entities**

#### **1. Department of Human Services**

##### **a. Statutes, Regulations, Policies and Other Written Materials**

The Minnesota Health Care Programs, which include Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare programs (SCHIP and Medicaid managed care), are administered by the Department of Human Services (DHS). Approximately 500,000 Minnesotans receive health coverage through the Minnesota Health Care Programs, and the majority of their care is provided through contracting managed care organizations.<sup>28</sup>

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<sup>22</sup> *Id.* § 62D.145.2(2)-(4), (7).

<sup>23</sup> *Id.* § 62D.145.2(1).

<sup>24</sup> Minn. Stat. § 62J.451.3(4).

<sup>25</sup> Minn. Stat. § 62J.451.6a.

<sup>26</sup> Minn. Stat. § 72A.502. Personal information is “any individually identifiable information . . . from which judgments can be made about an individual’s character, habits, health . . . or any other personal characteristics” including name and address. Privileged information is “information that (i) relates to a claim for insurance benefits or a civil or criminal proceeding . . . , and (ii) is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding. . .” Minn. Stat. § 72A.491.

<sup>27</sup> *Id.*

<sup>28</sup> *See* Letter dated December 22, 2000 from Mary B. Kennedy, Medicaid Director, Department of Human Services.

The Minnesota Health Care Programs application attempts to collect racial and ethnic data when people apply for the various programs, but applicants are not required to provide this information. Once the information is collected, DHS forwards the information to contracting managed care organizations to assist them in providing better service to their enrollees.<sup>29</sup> In addition, state statisticians compile this information to provide data to policymakers regarding the various populations receiving care through the state health care programs.<sup>30</sup>

With regard to primary language, Minnesota has implemented several initiatives to ensure access to linguistically appropriate services for limited-English proficient consumers. The DHS asks applicants and recipients whether they need interpretation services, and if so for what language, at multiple points of the health care delivery system, including: (1) upon application; (2) upon choosing a health plan after acceptance into one of the state health care programs; and (3) annually as recipients renew their eligibility status for health care assistance.<sup>31</sup>

Moreover, health care eligibility workers are instructed to encourage recipients to provide primary language information. In turn, this information is reported to the recipient's chosen health plan upon enrollment, and updates are sent if the recipient indicates a change in primary language preference.<sup>32</sup> This information is used to help DHS meet its civil rights requirements under Title VI (see below).

#### b. Discrimination

DHS informs each applicant for and recipient of the Minnesota Health Care Programs that they have the right to fair treatment. The application for benefits and the renewal application state that a person cannot be treated differently because of his race, color, or national origin. In addition, the DHS Review Manual explicitly states that DHS is required under Title VI of the Civil Rights Act to provide all applicants/recipients equal access to the services it provides.<sup>33</sup>

#### c. Confidentiality

Because these programs are funded by taxpayers, summary data is considered public information and is made available to anyone who inquires.<sup>34</sup> Minnesota categorizes other data as either public or private. Public data may be disclosed to any person, without regard to the nature of that person's interest in the data.<sup>35</sup> Private data is only made available to the subject of the

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<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> DHS Review Manual, TE02.08.149.

<sup>34</sup> Minn. R. 1205.0700.1. *See also* Kennedy Letter.

<sup>35</sup> Minn. R. 1205.0300.2.

data or those granted access through statute or federal law.<sup>36</sup> No distinction is made by statute or regulation for race or ethnicity information.

2. Department of Health (DOH)

a. Statutes, Regulations, Policies and Other Written Materials

The DOH is one of Minnesota's largest data collectors and reporters. In order to promote effective public health practices and improve the health status of Minnesotans, this Department collects data regarding various conditions and diseases. Racial and ethnic data is collected and reported for the following conditions and diseases: (1) cancer;<sup>37</sup> (2) communicable diseases;<sup>38</sup> (3) lead poisoning;<sup>39</sup> (4) abortions;<sup>40</sup> and, (5) traumatic brain and spinal cord injuries.<sup>41</sup> In addition, the DOH reports racial information with regard to births, deaths and marriages.<sup>42</sup>

b. Discrimination

Minnesota's civil rights statute prohibiting discrimination on the basis of race and national origin with regard to access to public accommodations and public services applies to Department of Health services.<sup>43</sup> This offers some protection for those individuals whose racial and ethnic information is collected and reported by the Department of Health.

c. Confidentiality

Any data collected and maintained by the Department of Health is classified as private data under the state data practices laws. As private data, it is provided only to the subject patient or to other entities based on statutory exceptions.

**D. Observations**

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<sup>36</sup> Minn. R. 1205.0400.2.

<sup>37</sup> Minn. R. 4606.3304.1(I)-(J).

<sup>38</sup> Minn. R. 4605.7090(D)(3).

<sup>39</sup> Minn. Stat. § 144.9502.4(8).

<sup>40</sup> Minn. R. 4615.3600.2(A)(5).

<sup>41</sup> Minn. R. 4643.00302.(A).

<sup>42</sup> Although not statutorily required, Minnesota collects and reports racial information with regard to births, deaths and marriages in the *Minnesota Health Statistics Annual Summary*. See <http://www.health.state.mn.us/divs/chs/99annsum/index2.htm>.

<sup>43</sup> Minn. Stat. § 363.01.34. Public service is defined as "any public facility, department, agency . . . owned, operated or managed by or on behalf of the state of Minnesota . . ."

Minnesota does not have any statutes or regulations that prohibit or mandate the collection or reporting of racial or ethnic data.

Minnesota is one of the states that has no explicit prohibition against the collection of racial and ethnic data, but has an unwritten policy which leads the Department of Insurance to reject any policy form or application that requests racial, ethnic or primary language information.

By establishing the Minnesota Health Data Institute, the state has taken a major step in developing a data collection tool needed for racial and ethnic data collection. By enforcing its confidentiality protocols and policies, the Institute can serve as a central clearinghouse for racial and ethnic data, begin to use such data to improve health care delivery services to minorities, and still afford those groups protection against any misuse of the information so acquired.