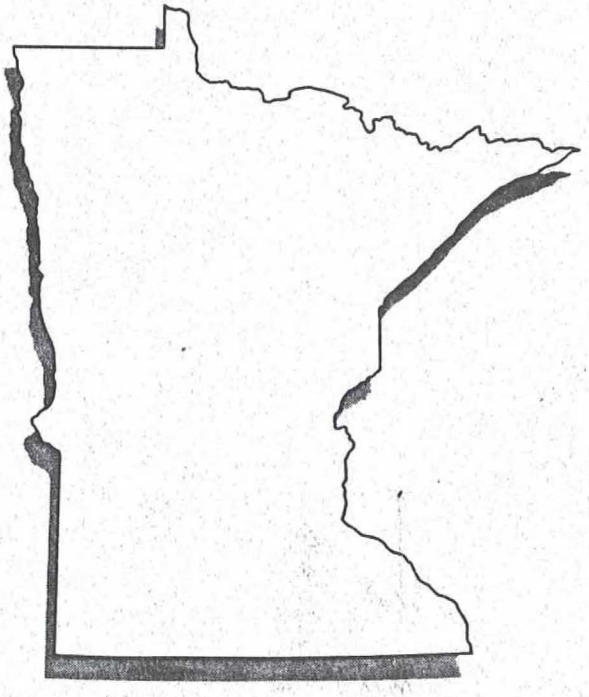
The Minnesota Health Care Access Commission

Final Report to the Legislature



January, 1991

Pursuant to 1989 Laws, Chap 327, ection 2, subd 4

THE MINNESOTA HEALTH CARE ACCESS COMMISSION

Final Report to the Legislature

January 1991

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SYNOPSIS

Despite the view that health care is an essential service, hundreds of thousands of Minnesotans do not have access to basic care. Access and cost pressures on the health care system are mounting, but Minnesota can respond with the recommendations of the Health Care Access Commission. We urge the state to do so.

The Commission was charged to develop and recommend to the legislature a plan to provide access to health care for all state residents. Through public hearings, surveys and other research, the Commission found that:

- Access to health care is a major problem in Minnesota---370,000 Minnesotans are uninsured for all or part of the year, and 366,000 have individually-purchased policies which often provide inadequate coverage.

- Inadequate or no health coverage leads Minnesotans to delay or forego needed health care, or face barriers or denials when they do seek care.

- High costs are a problem throughout the state, and leave many Minnesotans with high unpaid medical bills.

- Access problems are worse in greater Minnesota, where a higher percentage of residents are uninsured and inadequately insured.

- Current insurance practices discriminate against women, older Minnesotans, and people with handicaps or health problems.

- Despite these problems, access to health care in Minnesota is achievable. Compared to most other states, Minnesota has better state health coverage programs, a lower uninsurance rate, and a better foundation of HMOs and managed-care organizations.

The Commission's recommendations to place Minnesota's health care system on the right track are driven by these findings. The recommendations are interdependent---a piecemeal approach would cost more in the long run than the comprehensive reforms recommended in this report.

1. Ensure universal and equitable access to care. The Commission recommends that all Minnesotans have basic health care coverage. A new state program will provide subsidized coverage for low-income people. Cost containment will focus on managing care and limiting costs, rather than on simply cutting or denying coverage. Fewer minor problems will become major because coverage will ensure adequate preventive care and early medical interventions.

2. End discrimination in health care financing. The Commission recommends that health care costs be shared by all members of society, rather than being based on individual health care needs, age or sex. We recommend: (a) ending the practice of coverage denials and exclusions based on health status and preexisting conditions, and (b) using "community rating," under which an insurer or HMO sets a single premium rate for all individuals and small groups.

3. Control health care costs. The Commission recommends control of health care costs through: (a) a substantially expanded role for managed-care organizations, (b) applied research to improve health care delivery, (c) improvements in the state's abilitities as a health care purchaser, (d) a special pool to manage high-cost cases, (e) incentives and education to encourage healthy lifestyles and appropriate use of the health care system, and (f) establishment of a statewide limit on health care spending.

4. Consolidate state health care programs. The Commission recommends that most of the state's health care programs be consolidated in a new Department of Health Care Access. This consolidation will reduce overlap and duplication, improve service to citizens, reduce costs and complexity for health care providers, and enhance the state's purchasing leverage.

5. Address the special access needs of rural Minnesota. The Commission recommends that the state ensure adequate access to health care in rural areas through a combination of financial support, technical assistance, regulatory changes, and reimbursement changes.

ACKNOWLEDGEMENTS

This report is the product of 15 months of work, from October 1989 through December 1990, by Health Care Access Commission members, staff, contractors, volunteers and other interested persons. Hundreds of people contributed their time and expertise to the Commission's work through its public hearings, research projects, and formal deliberations and meetings. The following organizations and individuals deserve special recognition for their contributions.

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The Commission staff provided a variety of services in support of the Commission's work, ranging from meeting preparation to issue paper drafting to research coordination. All staff members made significant contributions to the preparation of the final report.

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1. TESTIMONY.

The Commission owes special thanks to the over 300 people who offered testimony at one of the 19 public hearings held in various cities around Minnesota. The Commission's understanding of health care access and affordability was enriched by these contributions, especially from those who shared with us their personal experiences with the health care system.

2. LOCAL COORDINATORS.

The public hearings would not have been possible without coordinators in each city to assist with the many necessary arrangements.

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F. VOLUNTEER CONSULTANTS.

Volunteer consultants assisted the work of the Commission in many ways, including serving on committees and task forces, making presentations at Commission meetings, providing valuable background information, and undertaking special projects on the Commission's behalf.

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G. SUPPORT SERVICES.

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In addition, the following people provided critical support services at many stages of the Commission's work.

United HealthCare
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State Planning Agency
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Chapter 1
SUMMARY

A. INTRODUCTION AND BACKGROUND.

1. HEALTH CARE IN MINNESOTA: A SYSTEM IN NEED OF REFORM.

Despite the view that health care is an essential service, hundreds of thousands of Minnesotans do not have access to health care. They lack health care coverage altogether or have large deductibles which leave them uncovered for routine health care. For small businesses, the self-employed and many retirees, health care has become unaffordable and unfairly priced. Their insurance coverage is characterized by unpredictable premium increases, rigid underwriting requirements and limited, if any, coverage for primary and preventive care.

Unlike education or other essential services, health care continues to be viewed as a private commodity, inaccessible to many and inequitable in costs. As a result, insurance rates and coverage are a product of where you live in the state, where you work, your health, age and sex. The insurance rate for a 30 year old female is likely to be twice that of a 30 year old male; for people over age 60, the premium is easily three or four times that of a 25 year old. For people diagnosed with diabetes, high blood pressure or some form of disability, health coverage may be restricted to exclude treatment of that condition---the treatment most important to such people's health, or denied altogether.

Furthermore, the quality or comprehensiveness of health care benefit packages varies dramatically. The state permits the sale of plans with comprehensive benefits and very little or no copayments, as well as policies with $1000 and larger deductibles. We know that it is cost-effective to treat people with primary and preventive care rather than waiting for minor problems to become major ones. Yet we only demand that those services be covered by health maintenance organizations and accept less from all other private plans. Government-supported health programs pay for expensive hospital care for uninsured Minnesotans who "spend down" their incomes to program eligibility levels, but do not pay for primary and preventive care which might have prevented the need for hospital care.

Therefore, we face the consequences. Infant mortality rates in the Twin Cities vary for those with private insurance (6 per thousand) and those without (31 per thousand). Over 11,000 people were denied care in Minnesota last year and 50,000 reported they delayed seeking medical care for serious symptoms such as chest pain because they were uninsured. In Minnesota we already pay for the health care of the uninsured, in many cases for expensive hospital or emergency room care when early, less expensive care would have sufficed.

These costs do not disappear; many of the costs are passed on by hospitals and doctors to those who can pay, and result in higher insurance premiums and higher taxes for all Minnesotans. Last year an estimated $150 million of uncompensated care was provided in Minnesota, and these unpaid bills raised the price of insurance premiums and the cost of public programs. In the metropolitan area alone, over $20 million in local government property tax revenues goes to pay for these costs.

We have a patchwork series of health care policies and programs which result in high costs, no participation for many, and marginal health care outcomes for our citizens. We cannot continue to conduct business as usual and expect health care to become more affordable, more accessible,

more equitable, better managed or directed toward more cost-effective care. We need to move forward with reform and significant change. Only when we begin to treat health care as a public interest and guarantee for all Minnesotans will we accomplish the efficiencies and effectiveness of a good health care system. The result will be a health care system which provides health care in a rational and humane way.

2. LEGISLATIVE ACTION ON THE HEALTH CARE PROBLEM IN 1989.

The legislature recognized in 1989 that this system is unacceptable. The legislature found that it represents a woefully inefficient method for providing care for the uninsured and represents an added cost to employers now providing health insurance to their employees. The legislature was concerned that inaction would continue to harm the health of uninsured and inadequately insured Minnesotans, increase the uncompensated care burden, and increase the economic stress on employers and existing state programs---particularly the Minnesota Comprehensive Health Association (MCHA) and the Medical Assistance program.

Because of its interest in addressing this problem, the legislature formed the Health Care Access Commission in 1989 to develop and recommend to the legislature a plan to provide access to health care for all state residents. In developing the plan, the legislature asked the Commission to conduct significant new research to develop solid estimates of the number of persons affected and the cost of the plan. The legislature did not charge the Commission to add to the list of previous studies, but to develop a detailed blueprint for legislative action. Specifically, the Commission is charged to:

- Develop and recommend to the legislature a plan to provide access to health care for all state residents.

- Develop new estimates of the number of uninsured Minnesotans.

- Explore potential insurance options for a new health care access program, including the size and makeup of risk groups, and the program's relationship with other public programs.

- Study alternatives for financing the state share of the program's costs, and the extent to which costs could be shared by program participants.

- Identify cost savings that would result from the program.

- Recommend incentives to ensure that employers continue to provide employee health benefits, based on an analysis of federal laws (such as ERISA) which affect state programs.

- Develop a system to administer the new state program, including eligibility, enrollment, premium collections, outside contracting, staff requirements, and other related matters.

- Develop a cost containment policy for the program, including health care delivery management techniques and limits on health care provider reimbursement.

- Recommend what benefits should be covered by the program, including copayments and maximum coverage amounts.

- Recommend changes to health care and insurance laws that will improve health care access.

3. THE HEALTH CARE ACCESS COMMISSION.

The Health Care Access Commission was appointed September 1, 1989. The Commission membership is comprised of fifteen public members appointed by the Governor representing consumers, business, health care providers, unions, and insurers; the Commissioners of Human Services, Health, Employee Relations and Commerce; three Senators and three Representatives.

A. New research.

The Commission developed its recommendations through conducting significant new research, statewide public hearings and extensive deliberations. To develop solid program design and cost estimates, the following new research was commissioned:

- A Household Survey of health coverage and lack of Insurance in Minnesota. The survey in-

cluded over 10,000 Minnesotans, and was conducted through the Division of Health Service Research and Policy, University of Minnesota School of Public Health, and the Department of Medicine, Hennepin County Medical Center.

- An Employer Survey of employer-provided health benefits in Minnesota. The survey included over 1,100 employers, and was conducted by Anderson, Niebuhr & Associates, a St. Paul survey research firm.

- Legal research on relevant state and federal laws, especially the federal ERISA law, conducted by Ropes & Gray, a Massachusetts-based law firm, and the Minnesota Attorney General's Office. Ropes & Gray had done previous work of a similar nature in support of a health care access commission in Massachusetts.

- Actuarial research to develop accurate cost estimates of the Commission's benefit recommendations, conducted by Milliman & Robertson, an actuarial consulting firm.

B. Public hearings.

Public hearings were an important means for the Commission to gather information, receive suggestions, and answer questions from people affected by the problem of health care access. The Commission held nineteen public hearings across the state in the following cities. Over 700 Minnesotans attended the hearings.

Public Hearings Conducted by the Health Care Access Commission

City	Date
Fergus Falls	June 5th
Moorhead	June 6th
Crookston	June 7th
Willmar	July 11th
Marshall	July 12th
Worthington	July 13th
Duluth	August 1st
Eveleth	August 2nd
Winona	August 7th
St. Paul	August 16th
Mankato	August 29th
Minneapolis--south	September 13th
Brainerd	September 27th
Blue Earth	October 16th
Rochester	October 17th
Minneapolis--south	October 24th
Minneapolis--north	October 25th
St. Cloud	November 1st
State Capitol	December 18th

C. Deliberations.

Extensive deliberations by the Commission and its committees resulted in the Commission's recommendations. For each policy issue considered by the Commission, background papers and formal issue papers were prepared and adopted by the Commission over the course of 1990. The following are the formal issue papers developed by the Commission through its program committees.

Health Care Access Commission Issue Papers

A. Universal coverage (research priorities).
B. Employer role (research priorities).
C. Open participation (research priorities).
D. Health care delivery.
E. Outreach and enrollment.
F. Underwriting, rating and reinsurance.
G. Eligibility terms and incentives.
H. Data and research initiatives.
I. Individual subsidies.
J. New program structure, current program changes.
K. Benefit design.
L. Geographic access.
M. Non-participant revenues.
N. Costs, revenues and savings.
O. Pace and timing of implementation.

As charged by the Legislature, the Commission has issued two reports. An Interim Report to the Legislature was issued in February 1990. The Commission's Final Report to the Legislature was issued in January 1991.

B. FINDINGS AND RECOMMENDATIONS.

1. KEY COMMISSION FINDINGS.

The following are some of the highlights of the Commission's findings from its research and public hearings.

A. Access to health care is a major problem in Minnesota.

• 370,000 Minnesotans are uninsured for all or part of the year---8.6 percent of the state's population.

• An additional 366,000 Minnesotans, 8.5 percent of the population, have individual insurance marred by high premium costs, high deductibles and stringent insurance underwriting policies which can result in policy denials, cancellations or pre-existing condition exclusions.

• 11,000 Minnesotans were refused health care last year because they lacked health insurance.

• 50,000 Minnesotans delayed seeking health care for serious or moderately serious conditions, such as chest pain or an ear infection, because they lacked heath insurance.

B. Insurance practices contribute to the problem.

• A further 900,000 Minnesotans covered by small businesses are also vulnerable to high and unpredictable premium cost increases and stringent underwriting, resulting in denial or cancellation of coverage or onerous limitations on coverage for preexisting conditions.

• The current insurance practices of experience and table rating, denials, cancellations and pre-existing condition exclusions discriminate against women, older Minnesotans, and Minnesotans with health problems and disabilities. These practices contribute significantly to the health care access problem.

• Minnesotans who work for small businesses or are self-employed generally pay significantly more for their health care coverage than Minnesotans who work for larger companies.

C. High costs are a problem throughout the system.

• The uninsured and individually insured in Minnesota have large out-of-pocket expenditures, averaging $425 per year. Many uninsured Minnesotans with high medical bills make payments on them over long periods of time, and in many cases face the stress and embarassment of debt collection pressures.

• The current health care system is unaffordable for many Minnesotans. One in three uninsured Minnesotans have unpaid medical bills, averaging $826. One in five individually insured Minnesotans have unpaid medical bills, averaging $1207.

• These unpaid medical bills are borne as uncompensated medical care by Minnesota hospitals and doctors, an estimated $150 million in 1990, and by all Minnesotans in insurance premium increases and higher taxes for state and local health care programs.

• High administrative expenses inflate health care costs. Health care providers face very high administrative costs. Both public and private health coverage programs are responsible for multiple regulations and duplication. National estimates indicate that doctors' offices employ as many clerical workers as health care personnel, and that 18 percent of hospital expenditures go for administrative costs. In Minnesota, HMO administrative expenses range from 9 to 16 percent of total premiums.

D. Access problems are worse in greater Minnesota.

• People who live in greater Minnesota are harder hit by the health care access problem. Health insurance is more expensive for small business and self-employed people, such as farmers, the mainstays of rural economies. Many rural residents are underinsured---forty percent of farmers spend 10 percent or more of their incomes for health care. Greater Minnesota has a higher percentage of uninsured Minnesotans than the statewide average.

• In greater Minnesota, most people with health insurance do not have health insurance coverage

for primary and preventive health care and face high deductibles. This lack of coverage makes it difficult for rural primary care providers to maintain a stable economic base. Rural areas face shortages of primary care providers.

E. Access to health care in Minnesota is achievable.

• Minnesota is well positioned to respond successfully to the health care access problem. Although a significant number of Minnesotans are forced to delay or forego needed care for financial reasons, Minnesota has a lower rate of uninsurance than every other state, except for Hawaii.

• Unlike most states, Minnesota has reduced the number of uninsured citizens by establishing public programs with sound eligibility standards and adequate benefits for low-income people. Minnesota's commitment to ensuring access to health care is evidenced in the Medical Assistance program, General Assistance Medical Care, the Children's Health Plan, and the Minnesota Comprehensive Health Association (MCHA). MCHA, the risk pool for uninsurable Minnesotans, has served as the model program of its type for many other states.

• Minnesota has a strong managed care system in place. Minnesota is a leader in the development and growth of health maintenance organizations and large-group medical practices.

2. KEY COMMISSION RECOMMENDATIONS.

The Commission developed recommendations to the legislature to ensure universal access to health care for all Minnesotans, and to provide a solid foundation for managing health care costs. The following are some of the key recommendations in these areas.

A. Ensure access to needed health care for all Minnesotans.

The Commission recommends that access to basic health care be guaranteed for all Minnesotans. The following recommendations are central to this objective.

1. Ensure universal access to care. The Commission recommends that all Minnesotans have health care coverage. Under the Commission's recommendations, Minnesotans will no longer be denied needed health care, or delay getting care, because they lack health coverage. Minnesotans will have a right, and a corresponding responsibility, to obtain coverage.

2. Help lower-income people with the costs of coverage. The Commission recommends that the state establish a new program that provides subsidized health coverage to lower-income people (up to 275 percent of the poverty level). The availability of subsidized coverage through this program will ensure that all Minnesotans have access to affordable coverage through a government-supported program, an employee benefit plan, or private insurance.

3. End discrimination in health care financing. The Commission concluded that health care is a public good, and thus recommends that health care financing should be shared by all members of society, and not on the basis of individual health care needs, age or sex. To accomplish this change, we recommend reforms in the sale of health insurance for individual and small group (under 30) coverage, in which the greatest inequities occur. Recommendations include: (a) ending the practice of coverage denials and exclusions based on health status and preexisting conditions, and (b) using a "community rating" method of premium development, under which the same rates apply to all individuals and small groups.

4. Provide equitable benefits. The Commission concluded that the current wide variation in access to health care for different members of society is unacceptable. We thus recommend that before defining a universal, basic benefit set by 1995 we must commit to *drawing a line* around our entire community extending access to all. This sense of community will be critical if the new system is to be perceived as equitable and fair.

* * *

These recommendations are the cornerstone of the Commission's report. One in 10 Minnesotans under age 65 are uninsured at least part of each year. Most of the remaining 9 out of 10 are only one major life change away from losing health coverage---such as moving, changing or losing a job, retiring, getting divorced, having a 19th birthday (23rd birthday if a full-time student), or having

a signficant illness. Access to health care should not depend on age, sex, health, employment status or marital status.

B. Provide a solid foundation to manage health care costs.

The Commission recommendations lay a foundaton to address the economic pressures in the health care system. The following recommendatons are central to this objective.

1. Statewide limit on health care spending. The Commission recommends that the Health Care Expenditures Advisory Committee advise the Department of Health Care Access (DHCA) concerning establishment of an overall, statewide limit on public and private health care spending, and subsequent limits on annual increases in health care spending. All participants in the health care system in Minnesota will be required to take action necessary to ensure that total health care spending, and increases in spending, remain within the overall limits established by the DHCA.

2. Manage costs instead of shifting them. The Commission finds that, in the 1980's, much health care cost containment consisted of little more than shifting costs to consumers and diminishing access to care. With the guarantee of universal access and the insurance reforms recommended by the Commission, cutting people out of the system will no longer be an option. The insurance reforms will change underwriting and rating practices to allow all citizens, including those with less than perfect health histories, to obtain adequate and affordable health coverage. With all Minnesotans included in the health care system, insurers' future cost containment efforts will focus on managing care and limiting administrative costs, rather than on simply shifting costs or avoiding risk.

3. Control administrative costs. The Commission recommends that reforms be adopted to limit expenditures on administrative costs by health insurers, HMOs, and health care providers, including costs associated with underwriting, premium rate development, claims processing and data collection. Reforms to current underwriting and rating practices will diminish the cost and complexity associated with insurance marketing and enrollment. Development of standard forms and procedures for outpatient and clinic claims, utilization review and data collection will also diminish administrative costs.

4. Foster an expanded role for managed-care organizations. The Commission recommends that the new state program control health care costs through managed-care organizations, such as HMOs and PPOs, the types of health plans that have proven most efficient in providing and insuring health care. These types of health plans are a key strength of Minnesota's health care delivery system. Use of these plans for the new state program---with a potential enrollment of 500,000 or more---will foster their continued growth throughout Minnesota, as well as lower costs for the state.

5. Improve the state's abilities as a health care purchaser. The Commission recommends that the Department of Health Care Access include a *Health Care Analysis Unit*. This unit will promote the application of health care research and managed-care techniques with the health plans and health care providers under contract with the DHCA. The goal of the unit will be to advance the *state of the art* for managing care throughout Minnesota, and especially in state-sponsored programs. The unit will develop specifications concerning effective case-management systems, applications of standards of practice, and related measures for inclusion in the DHCA's contracts with health plans and health care providers.

6. Consolidate the state's health care programs. The Commission recommends that most of the state's health care programs be consolidated in a new Department of Health Care Access. Currently six different state agencies administer health care or health coverage programs. Consolidation will yield a variety of efficiencies, including: (a) more effective use of the state's bargaining leverage in health care purchasing, (b) wider application in health care purchasing of the state's health care research and analysis capabilities, (c) reduced overlap and duplication in administrative functions, (d) improved service to citizens through reduced program variety and complexity, and (e) improved service and lower administrative costs for health care providers through streamlining and standardization of programs.

7. Undertake research to improve health care delivery. The Commission recommends that the Department of Health Care Access undertake significant new research and data collection initiatives concerning health care delivery and outcomes of care. The centerpiece of these initiatives

will be a large-scale data project for a limited number of health conditions. The project will emphasize high total-cost conditions and health outcomes associated with medical treatment, including mortality, patient functional status and quality of life, symptoms, and patient satisfaction. Research findings will be available in the public domain to promote advances in the efficiency and effectiveness of care.

8. Ensure cost-effective management of high-cost cases. The Commission finds that a limited number of high-cost cases represent a large share of total health care expenditures. Careful and efficient management of such cases may have a significant and beneficial effect on the total costs of the new state program. To provide for such management, the Commission recommends that a Reinsurance Pool be established and administered by the Department of Health Care Access. The DHCA will contract with a case management company (or companies) to oversee, coordinate and, in a limited number of cases, assume responsibility of treatment plans for cases for which the Reinsurance Pool is liable. In addition to ensuring efficient treatment of high-cost cases, the Reinsurance Pool will provide a mechanism to ensure that all of society shares in bearing the costs for, and making priority decisions about, the most expensive conditions.

9. Enable patients to obtain preventive care and early medical interventions. Inadequate or no health coverage discourages many Minnesotans from obtaining health care for minor conditions until they become major. The Commission's universal coverage recommendations will have direct and tangible cost savings in the form of reduced emergency room visits and high-cost, crisis health care. The recommended benefit design in the new state program emphasizes coverage of primary and preventive care, rather than catastrophic care only, to enhance the effectiveness of early medical interventions and to prevent minor problems from becoming major.

10. Encourage greater patient responsibility. The Commission recommends that the new state program require participating health plans to have programs to educate consumers about appropriate use of the health care system. Such programs could include self-care education, telephone nurse access, encouragement of healthy lifestyles and conformance with prescribed courses of treatment. We also recommend that small premium discounts be permitted to encourage self-care activities. Health plans participating in the new state program will also encourage greater patient responsibility by coordinating referrals, hospitalizations and other care through specific primary care clinics.

11. Consumer choice of health plans. Consumers' ability to choose among two or more health plans in many areas of the state will foster competition among health plans based on efficiency, quality and member service. Price differences among plans will be passed along to consumers. The experience of large employers has shown that consumers are very sensitive to such price differences, and that this sensitivity can result in heightened competition.

3. MINNESOTANS' HEALTH CARE PLAN.

A. Introduction.

To ensure access to needed health care for all Minnesotans, the Commission recommends that a new state program be established to provide health coverage to the uninsured, the underinsured, small employers, and others who may be attracted to the program's features. We find that no program now in existence has the capacity to provide access to care, control costs, and lay a foundation for needed reforms in the overall health care system. Rather than correcting the shortcomings of an existing program, we recommend starting afresh with a new state program designed to guarantee access and manage health care costs.

B. Overview of recommendations concerning the new state program.

The Commission recommends that the program be named the "Minnesotans' Health Care Plan," and that responsibility for its development and implementation be located in a new Department of Health Care Access. We recommend that the new program serve as the cornerstone of a system of affordable health care available to all Minnesotans.

We recommend that the state recognize the right of all Minnesota citizens to health care, and establish a corresponding responsibility for all citizens to obtain health care coverage---based on their ability to pay. We recommend that client outreach

be a primary emphasis of the new state program, to ensure that all citizens are aware of the program's availability.

The Commission finds that a system in which all Minnesotans have health care coverage allows effective pooling of risk, regardless of the source of coverage (the new state program, an employee benefits program, or other insurance). Without universal coverage the program would attract a disproportionate share of high-cost enrollees. The resulting high premiums could make the program unattractive to the majority of people who have relatively low costs.

The Commission finds that, for many Minnesotans, cost is the primary barrier to adequate health coverage. Therefore, we recommend that individual premium subsidies be available through the new state program to enable low-income people to afford coverage. Individual premium subsidies will be structured in the form of a sliding scale based on gross family income. Subsidies will be high for people with very low incomes, and gradually diminish as incomes approach 275 percent of the federal poverty level. All enrollees in the program will contribute something toward the cost of their coverage.

We recommend that the new state program insure and deliver health care through contracts with "managed-care health plans," such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). These arrangements will bring enrollees the advantages of large-group purchasing, and promote the use and expansion of the most efficient systems for health care delivery. To participate in the new program, health plans will be required to meet the state's managed-care specifications. These specifications will include an effective system for managing all health care provided an individual patient. The specifications will include a requirement that all enrollees register with a primary clinic of their choice, that will coordinate their subsequent care. If there are areas of the state where acceptable managed-care arrangements are unavailable, the new program will make its own direct arrangements, and/or pay for care on a fee-for-service basis as is currently done in the Children's Health Plan.

We recommend that the new state program be open to any Minnesota resident who is uninsured, or who has coverage that primarily supplements, rather than duplicates, the coverage available through the new program. We also recommend that the program allow employers to enroll as a group, giving their employees access to the same choice of plans as individuals who enroll directly.

We recommend that a new Reinsurance Pool be established within the Department of Health Care Access. The Reinsurance Pool will limit health plans' liability for high-cost cases, and verify that the best managed-care arrangements are made for such cases. If necessary, the pool will be able to assume direct managed-care responsibility for individual cases. The Reinsurance Pool will provide a mechanism to ensure that all of society shares in bearing the costs for, and making priority decisions about, the most expensive conditions.

The Commission recommends that the new state program provide a benefit package covering preventive, primary, outpatient and inpatient care. The package will also include coverage for prescription drugs, mental health care and chemical dependency care. Certain limits will apply to some types of care to maintain an affordable premium. Fewer limits will apply to coverage for children under age 18. To evaluate and refine the benefit package over time, we recommend that a Technology and Benefits Advisory Committee be established. The committee will be responsible to develop recommendations about the new program's benefits, benefits in other government-supported plans, and benefit levels required in HMO and insurance policies.

4. THE DEPARTMENT OF HEALTH CARE ACCESS.

A. Introduction.

The Commission finds that federal, state and local governments provide a bewildering array of programs that provide health coverage or health care. Many people in need of assistance must seek out multiple programs, and encounter a variety of obstacles in doing so. At least six departments of state government currently administer programs that provide health care or coverage. We find that although many programs are excellent, the overall system is intimidating and confusing to Minnesotans. Many people are unaware of programs for which they qualify, or encounter a variety of obstacles in trying to find assistance.

The Commission recommends, therefore, that the state consolidate government-sponsored health care programs in a new state agency---as described in this chapter. We recognize that some programs can be consolidated more quickly than others, and that for various reasons certain programs will need to retain distinct identities. We recommend, subject to these unique requirements, that the state pursue program consolidation in the interest of:

- Diminished overlap and complexity for clients and health care providers.

- Dimunition of the welfare stigma attached to some state programs.

- Improved efficiency and purchasing leverage for the state.

- Improved application of the state's expertise in contracting and working with health plans and health care providers.

- Improved pooling of risk.

- Broader state monitoring and analysis of health care utilization.

B. Overview of recommendations concerning the new department.

The Commission recommends that a new agency, the "Minnesota Department of Health Care Access" (DHCA), be created to consolidate and coordinate the state's health care programs. The Department of Health Care Access does not establish a new state bureacracy---instead, it will consolidate existing state programs in a single agency. By consolidating existing programs the DHCA will be able to improve the efficency of the state's delivery of health care.

We recommend that the DHCA be established as a cabinet level department headed by a commissioner. After a transition period, the DHCA will be responsible for serving the clients now covered by the following state health care programs---to the extent that they provide personal health services. Some of these programs will retain distinct identities and/or remain in other departments, but will be closely coordinated with the new state program.

- The Minnesotans' Health Care Plan (new).

- Minnesota Comprehensive Health Association.

- The Children's Health Plan.

- General Assistance Medical Care.

- Medical Assistance.

- Maternal and Child Health---health care component.

- Services for Children with Handicaps---health care component.

- Consolidated Chemical Dependency Treatment Fund.

- Community Social Services Act county-based programs---health care component.

- Minnesota Crime Victims Reparations Board---health care component.

- Workers' compensation and auto insurance---health care component.

- Public employees health benefit programs.

- Corrections system health care programs.

- And other state and local health care and health coverage programs.

The Commission recommends that July 1, 1993 be the target date for consolidation of the programs that can be most readily merged with the Minnesotans' Health Care Plan, including the Children's Health Plan, General Assistance Medical Care and the Minnesota Comprehensive Health Association. At the same time, close coordination of benefits and some transfers of responsibility will occur with Maternal and Child Health, Services for Children with Handicaps, the Consolidated Chemical Dependency Treatment Fund, and Community Social Services Act county-based programs.

We recommend that July 1, 1995 be the target date for consolidation of other existing programs which will require more complex planning and preparation to accomplish the consolidation or closer coordination. These programs will include Medical Assistance, the Minnesota Crime Victims Reparations Board, public employee health benefit programs (state and local), corrections system health programs, and the health care component

of workers' compensation and automobile insurance coverage. We recommend that the Department of Health Care Access study and recommend changes to other state and local programs to improve the effectiveness of public health care purchasing and to streamline and consolidate government health care programs.

The Commission finds that the state's system of health plan regulation would also benefit from streamlining and consolidation. We recommend, therefore, that the state adopt the recommendations of the Minnesota Commission on Health Plan Regulatory Reform pertaining to the division of responsibility for health plan regulation. Specifically, we recommend that the Minnesota Departments of Commerce and Health develop a plan for the functional division of regulatory authority, to be submitted to the 1992 legislature.

5. HEALTH INSURANCE REFORM.

A. Introduction.

The Commission finds that the health insurance market for individual and small group coverage is in a state of crisis. Insurers have responded to the pressure to contain costs by using underwriting, the practice of determining who to accept or reject for coverage, to exclude Minnesotans with health care needs. Stringent underwriting is fueled by competitive pressures: tougher underwriting standards create a healthier pool of insureds and better profits. A company with less stringent standards than its competitors may need to have higher, less competitive rates to pay for its comparatively less healthy pool.

Underwriting has reached a stage where a high percentage of people are denied coverage, face exclusions for preexisting health conditions, or must pay the higher-than-market premiums in the state high-risk pool. Minnesota's high-risk pool, the program to serve people turned down for coverage by insurers, is now the largest in the nation---and the program continues to grow.

As a result of aggressive underwriting practices in the individual and small group markets, insurers compete more on the basis of attracting the healthiest mix of enrollees than on the basis of managing health care well. These practices discriminate against women, older persons and Minnesotans with health problems and disabilities. As an example, women pay the full costs of childbearing in their health care premiums. Therefore, health insurance coverage is significantly more expensive for women.

Competitive pressures have also led insurers to contain costs by excluding preexisting conditions from coverage. These exclusions mean that an individual's health insurance does not cover specified medical conditions diagnosed prior to obtaining the policy. For example, a policy may exclude services related to preexisting high blood pressure, such as drugs to control high blood pressure, or treatment of a heart attack. This practice often excludes from coverage precisely those conditions for which the individual needs to receive health care.

Insurers' methods for developing premium rates also contribute to problems in the marketplace. Historically, insurers offered community rates---the same rate for each person. Experience rating, the practice of charging groups a premium based on their actual claims experience, has become increasingly common in recent years. While experience rating may work for groups large enough to maintain fairly stable rates from year to year, it leads to erratic increases for small employers. Small group experience rating, together with aggressive underwriting, have led to an extremely unstable market for small employers.

Experience rating also affects individuals purchasing insurance, where rates are developed based on the experience of a class of persons---mainly according to age and sex. While individual experience rating may have merit in other lines of insurance, we find that it is discriminatory as applied to health care---a basic human need. We believe that the costs of sickness should be shared equitably by all of society.

B. Overview of recommendations concerning insurance reform.

To respond to the crisis in the health insurance market the Commission recommends a major set of reforms. The reforms apply to coverage purchased by individuals and families, small groups of up to 29 people, and, in some cases, to medium-sized groups of 30-99 people. The reforms apply to coverage obtained through the new state program and through the private insurance market.

The Commission recommends that the new state program and health plan companies operating in Minnesota be required to accept all individuals, small and medium-sized groups who apply for coverage. Insurers will no longer be able to deny coverage or cancel coverage on the basis of health status or exclude coverage for preexisting conditions.

The Commission believes that health care is a public good, and that health care financing should be shared equitably by all members of society---rather than on the basis of individual health care needs. Therefore, we recommend that health plan companies establish premium rates for all coverage purchased by individuals, families and small groups on a "community rated" basis. Under community rates, the same premium will apply to all individuals and small groups covered by a given insurer regardless of ages, sex, or health history. We recommend that an adjustment mechanism be established to protect companies who enroll a disproportionately large number of high-cost people (as determined by demographic factors). Finally, we also recommend that premium rate variations for medium-sized groups (30-99) be restricted to a smaller range than now occurs, to provide greater rate stability and predictability for employers.

The Commission recommends that the Minnesota Departments of Commerce and Health be allocated sufficient resources and authority to enforce these changes in underwriting and rating practices. We also recommend that the Department of Health Care Access develop recommendations to reduce administrative costs resulting from health insurance claims processing and data collection.

6. HEALTH CARE DELIVERY RESEARCH AND DATA.

A. Introduction.

As a society we spend a tremendous amount of money on health care. In Minnesota alone, total 1990 health care expenditures are estimated to be in the range of $9 to $10 billion. Yet despite this high level of expenditures, there is little consensus about what we are getting in return, about the efficiency and effectiveness of care. (By "efficiency" we mean the extent to which an appropriate service is provided for the least cost, and by "effectiveness" we mean the extent to which a service is of high quality and has the desired outcome.)

Despite evidence that some procedures are unnecessary or of marginal benefit, and a lack of evidence about the efficacy and appropriateness of many other procedures, progress in improving efficiency is proceeding very slowly. There is a growing sense of crisis about health care costs on the part of employers, labor, government and consumers. Health plans and health care providers are beginning to respond to these concerns, but many purchasers remain frustrated by the pace of change. Significant research efforts have been initiated to advance the *state of the art*, but results so far have been limited. To the extent that some results have been achieved by health plans or provider organizations, application and broad dissemination is often limited by the proprietary and competitive restrictions.

Our health care system may be the most advanced in terms of procedures and technologies, but it is far from advanced in its capacity to use limited resources wisely. The introduction and use of expensive, high-technology equipment and procedures continues at a rapid rate, in excess of the state's reasonable needs. Minnesota, with its population of 4.3 million, contains more high-technology equipment such as Magnetic Resonance Imaging (MRI) and Shock Wave Lithotripsy machines than all of Canada, with its population of 26.3 million (6 times more than Minnesota).

In addition to inadequate knowledge about the effectiveness and appropriateness of various procedures and technologies, growth in health care expenditures is fueled by: (1) the demands and expectations of patients, (2) "defensive medicine" by providers, prompted by malpractice concerns, (3) incentives associated with fee-for-service reimbursement, which remains widespread, and (4) the increasing numbers of older Minnesotans. We discuss some of these issues in chapter 10 of this report---"Vision for the Future." Regardless of the precise mix of factors driving the growth in health care costs, underlying them all is the fact that, as a society, we have yet to come to grips with the need to limit our health care appetite, to make difficult but necessary choices based on what we can afford rather than what we want.

B. Overview of recommendations concerning health care research and data.

The Commission recommends that the state invest in activities that will address these concerns, and that may lead to improvements in health care efficiency and effectiveness. Such activities will be designed to serve the needs and applications of: (1) public health programs, (2) health care providers, including providers who serve a large number of low-income people, (3) health plan companies, (4) employers and other purchasers of health care and health plans, and (5) the general public.

Specifically, the Commission recommends that the Department of Health Care Access, through a health care analysis unit, undertake statewide data initiatives to collect uniform health care data in the public domain as a foundation for health care research and analysis. We recommend that data related to health outcomes be a research priority, and that data be collected on the basis of specific health conditions rather than specific procedures or services. The health care analysis unit will also use the state's existing health care data, new data bases developed by the DHCA, and other appropriate public and private data sources.

The health care analysis unit will work closely with the private sector to promote the widest possible application of methods to improve the efficiency and effectiveness of health care. The DHCA will assist consumers and employers by providing them with information about premiums, benefit levels, managed-care procedures, health care outcomes, and other features of health plans and health care providers in a format which can be easily understood and interpreted by laypersons.

The Commission recommends that planning and preparation for these data and research initiatives take place from July 1991 through June 1992, with implementation to begin in July 1992. We recommend that the DHCA plan to make public initial findings of its research in January 1994.

7. ADDRESS THE PARTICULAR ACCESS PROBLEMS FACING RURAL MINNESOTA.

A. Introduction.

Inadequate or no health insurance constitutes a financial barrier to health care access. As indicated in the findings of the Commission's household survey, several regions in greater Minnesota have disproportionate shares of uninsured individuals. Several predominantly rural areas also have disproportionate shares of residents who purchase individual insurance---which usually costs more and covers less than group insurance.

Under the Minnesotans' Health Care Plan, health coverage will be available to people at each income level at a price they can reasonably afford through individual premium subsidies. Although cost is the primary barrier to access for many Minnesotans, we recognize that there are other obstacles to access, especially in rural Minnesota. The recommendations in this chapter acknowledge that these barriers also need to be addressed as part of ensuring access to health care.

The Commission finds that the rural health care system in Minnesota is in a state of transition. Regional health centers are assuming an increasingly prominent role, especially in the provision of specialty care. Many smaller communities face difficulties in attracting and retaining health personnel. Lower Medicare reimbursement rates for rural providers, coupled with the high percentage of Medicare recipients in rural areas, place an added strain on the health care system.

We recommend that the following priorities guide the state's policies to ensure access to health care in greater Minnesota.

- Adequate access to care. Ensure adequate access to health care services in rural Minnesota, with emphasis on primary care and emergency services.

- Adequate supply of health personnel. Ensure an adequate supply of health care personnel to provide these services.

- Planning assistance. Provide local communities with state assistance for planning and decision-making concerning access to health care.

B. Overview of recommendations concerning rural health care.

The Commission recommends that a Rural Health Advisory Committee be established to advise the Department of Health Care Access and other relevant state agencies on rural health issues, and

to facilitate a more systematic approach to rural health planning among local communities.

The Commission finds that access to health care is under pressure in some parts of rural Minnesota due to health personnel shortages, financial pressures facing small hospitals, and other related factors. To respond to these changes affecting the rural health care delivery system, we recommend that the *hub and spoke* model be considered as a basis for providing access to health services in some areas of rural Minnesota.

In this approach, a larger rural hospital (e.g., 75 beds) and clinic would serve as the *hub* of a system and provide care for a fairly broad array of services. The *spokes* would be constituted by smaller configurations of providers including solo practitioners and satellite clinics staffed by physician assistants, nurse practitioners and nurse midwives. We believe that this approach would provide a sound strategy for the effective utilization of smaller health care facilities and available health personnel in parts of rural Minnesota. Within this context, the Commission supports efforts to maintain the financial viability of the *spokes*.

The Commission recommends that the state provide assistance for rural health care in the following ways: (1) provision of planning and transition grants to rural hospitals, providers and communities, (2) technical assistance to facilitate local planning and coordination regarding the delivery of health services, (3) subsidies to isolated hospitals in danger of closing, (4) financial assistance for medical education, including support for training programs on-site in rural areas, (5) development and maintenance of a data base on rural health personnel, (6) technical assistance to rural communities for health personnel recruitment, and (7) assistance in funding a telecommunications network to facilitate rural health education and health care delivery.

The Commission supports efforts to improve Medicare reimbursement rates as they affect rural health care providers. We also support efforts to improve the overall level of Medical Assistance (MA) reimbursement rates, which should enable more rural providers to participate in the MA program and/or accept additional MA patients.

The Commission recommends that state regulations regarding the licensure and supervision of health personnel, such as physician assistants and nurse practitioners, be changed to facilitate greater utilization of their services in rural Minnesota.

8. HEALTH CARE EXPENDITURES ADVISORY COMMITTEE.

To continue the progress on reform of the health care system begun by the Commission's recommendations, the Commission recommends that a Health Care Expenditures Advisory Committee be established with support from the Department of Health Care Access. The Committee will include representatives of health insurers, other health plans, government health programs, health care providers, and consumer groups. Committee members will be appointed by the Governor. The Department of Health Care Access will make recommendations for Committee membership. We recommend that the Committee be created and commence operations on January 1, 1992.

The Commission recommends that the Health Care Expenditures Advisory Committee advise the DHCA concerning establishment of an overall, statewide limit on public and private health care spending, and subsequent limits on annual increases in health care spending. All participants in the health care system in Minnesota will be required to take action necessary to ensure that total health care spending, and increases in spending, remain within the overall limits established by the DHCA.

The Commission recommends that the Health Care Expenditures Advisory Committee also be charged to study and recommend additional reform of the health care delivery system in Minnesota, and to submit recommendations for reform to the legislature on January 1, 1993. The Committee will solicit comments, advice, and participation in its deliberations from the many communities with an interest in accessible, affordable health care.

9. COSTS, REVENUES AND SAVINGS.

A. Costs and revenues of the Commission's recommendations.

The Commission was charged with developing a plan to insure the uninsured with a net cost to the state of $150 million. In accordance with the charge, the total cost to the state to provide subsidized coverage to the uninsured through the Minnesotans' Health Care Plan will be $144 million. This estimate is based on a total state cost for the uninsured of $171 million, offset by $27 million in transfers from current expenditures from existing state programs.

The Commission recommends that the legislature also provide subsidized coverage to people who currently have individually-purchased policies, many of whom have low incomes and are underinsured, at a cost to the state of $140 million. This estimate is based on a total state cost for the individually insured of $149 million, offset by $9 million in transfers from current expenditures from existing state programs.

The state's total net costs for both groups is $284 million ($144 million + $140 million). Program enrollees will contribute $134 million, or 30 percent in aggregate, toward the cost of their own coverage. Total program expenditures including enrollee payments, state payments, and existing program transfers, are $454 million.

These cost estimates are centered on January 1, 1991. Actual state costs during the biennium of July 1, 1991 through June 30, 1993 are considerably less, and depend on the pace of implementation. Full program costs will not be incurred until the new state program is fully operational and the universal coverage requirement is in effect. The Commission recommends that the new program be in full operation beginning July 1, 1993.

These cost estimates are based on a total subsidized enrollment of 415,000, which includes all uninsured and individually-insured people within the range of the sliding scale. The estimates are based on a monthly premium of $101 for a one-person household, $202 for a two-person household, and $303 for a household of three or more, and a sliding scale of premium subsidies that caps at 6.5 percent of gross income and 275 percent of the federal poverty level.

The estimated premium is based on the Intermediate Benefit Set. The premium is also adjusted for community rating, which has the effect of pooling expected claims for all individual and small group coverage in Minnesota.

The estimated premium is adjusted to reflect the possible higher costs associated with groups that will be covered through the new program, including many current MCHA enrollees and the uninsured themselves. An adjustment of this type is made on the advice of the Commission actuary. The Commission moderated the degree of adjustment based on its judgement about the degree to which the uninsured and individually-insured populations are likely to differ from the statewide norm in health status. This judgement relies on the findings of the household survey, and the experience of other states which have established programs for the uninsured.

The estimated premium includes a 15 percent factor for administrative costs, as recommended by the Commission's actuarial firm. Actual costs vary among Minnesota HMOs from 9 to 16 percent of total premiums; higher percentages are generally required for individual and small-group coverage. We believe that this administrative costs factor is a conservative but reasonable estimate of the costs necessary to implement the new state program. The administrative costs factor will include program administration costs of the Department of Health Care Access, including costs pertaining to outreach, enrollment, premium collection, and related services. It will also include adminstrative costs incurred by health plans participating in the new state program.

B. Transfers and savings resulting from the Commission's recommendations.

The Commission's recommendations are designed to result in a more affordable, equitable and efficient health care system. Consequently, some current costs in the health care system will be relieved. A list of significant transfers and savings is outlined below, divided according to: (1) existing programs, short-term transfers to the new state program; (2) systemwide savings; and (3) existing programs, longer-term transfers to, or increased coordination with, the new state program.

1. Existing programs, short-term transfers to the new state program. This category refers to existing state health care and health coverage programs that the Commission recommends be consolidated, in whole or part, with the new state program during its initial years of operation. In this context, existing program "transfers" refers to the state appropriations currently going to these programs, which would subsequently be transferred to the new state program.

At least 75 percent (conservatively), or $27 million, of these expenditures provide services or coverage for people who are otherwise uninsured. The remaining $9 million benefit people with individually-purchased policies which do not provide adequate coverage for the services covered by these programs.

$11.6 million	Children's Health Plan.
$9.4 million	Medical Assistance---reduced state spenddown expenditures.
$9.4 million	GAMC---reduced state spenddown expenditures.
$3.4 million	Consolidated Chemical Dependency Treatment Fund---reduced state expenditures for outpatient chemical dependency services.
$1.9 million	Services for Children with Handicaps---reduced state expenditures for children's health services.
$1.0 million	Maternal and Child Health (MCH)---reduced state expenditures for prenatal care through MCH-supported clinics.
$36 million	Total (approximate, estimates subject to refinement)

The estimated transfers described in this section are based on the continuation of current eligibility standards, covered services, and state budget levels for these programs. Any significant changes in the current terms of these programs would affect the size of estimated transfers.

2. Systemwide savings. This category refers to savings in the overall health care system which we envision will result from the Commission's recommendations. The primary types of savings are: (a) diminished uncompensated or charity care costs for uninsured and underinsured patients; (b) lower health care costs through wider use of managed-care techniques, and (c) broad, public health and system reform savings.

The latter category is not quantified in the following table, but includes some of the most significant (but difficult to quantify) benefits of the Commission's recommendations, including: improved public health, increased productivity and fewer days lost to illness, diminished use of public assistance programs, lower administrative costs for health care providers, and other benefits of improved access to health care.

$3 - $5 million	Minnesota Comprehensive Health Association (based on 10 - 20 percent savings due to managed care)
$35 - $175 million	Workers' compensation insurance---health care component (based on 10 - 50 percent savings due to managed care)
$21 - $42 million	Automobile insurance---health care component (based on 10 - 20 percent savings due to managed care)
$150 million	Charity care costs---hospitals, clinics, other
$11 million	Community Social Services Act county-based programs---mental health care
$220 - $383 million	Total (approximate, estimates subject to refinement)

If the indicated systemwide savings are achieved as a result of the Commission's recommendations, as we envision they will be, total savings will equal approximately $220 - $383 million per year---an amount that may equal or exceed the new state program's total costs. These savings will not accrue directly to the state to reduce the program's expenditures, but they are an important indication of the capacity for streamlining and

improved efficiency in the overall health care system. These estimates do not include savings associated with broad public health and health care delivery reforms.

3. Existing programs, longer-term transfers to or increased coordination with the new state program. This category refers to existing state health care and health coverage programs that the Commission recommends be consolidated or more closely coordinated with the new state program after its initial years of operation. Again, existing program "transfers" refer to the state appropriations currently going to these programs, which could subsequently be transferred to the new state program.

$368 million	Medical Assistance---subject to obtaining waivers (for families and children only, excludes MA for aged, blind and disabled)
$132 million	General Assistance Medical Care (state and county share)
$1 million	Crime Victims Reparations Board
$6 million	Corrections system health care programs
$500 million	Public employees health benefits programs
$350 million	Workers' compensation insurance---health care component
$208 million	Automobile insurance---health care component
$1500 million	Medicare---and other federal programs, subject to waivers
$3 billion	Total (approximate, estimates subject to refinement)

C. Recommended sources of additional needed revenues.

The Commission's recommendations concerning sources of new funding were developed on the basis of a series of principles, including sufficient revenue-raising capacity, equitable sharing of costs across the population, stability over time, and political acceptability. Based on these principles, we recommend that the legislature consider the following sources of new funds, listed in priority order:

1. Individual income tax changes to increase progressivity at higher income levels. Minnesota has three income tax rates: 6.0 percent, 8.0 percent, and 8.5 percent. The income *break points* between the three rates are $13,000 and $42,700 for single persons; $19,000 and $75,000 for married/joint return. We recommend that the Commission's recommendations be funded through increased income tax progressivity, such as by increasing the tax rates applicable to the higher income brackets.

2. Extension of the general sales tax to health care services. Extension of all or part of the general 6 percent sales tax to health services would have several advantages. It would *recapture* monies now applied to charity care for uninsured people, estimated to be in the range of $150 million in Minnesota. In an environment of universal coverage, it would be a tax on *coverage* rather than *care*, borne equitably by all people with health insurance---and invisible to most patients. Such a tax could also be readily designed as a dedicated funding source---health care related funding for a health care program. The monies from the tax would be returned to the payers of the tax in the form of payment for covered services.

3. A tax on "intangible" property (vs. "real" estate) such as the value of stocks and other investments. This tax is not currently used by Minnesota, but some other states have such a tax. This tax could be a dedicated funding source for a new state program. It could also be considered progressive, in the sense that it would be borne primarily by households with high net worths and a greater ability to pay the tax.

4. An across-the-board employer-paid payroll tax. This tax would apply to all payroll in the state, and could also be a dedicated funding source. Because the tax base is large, the amount of tax required to raise the needed revenues for the new state program could be quite small (e.g., 0.6 percent).

5. "Sin" taxes on products such as tobacco and alcohol, and lottery revenues. These revenue sources did not rate highly in the Commission's

deliberations, mainly due to their regressiveness and limited revenue-raising capacity. However, increasing taxes on tobacco and alcohol is consistent with the public health aims of a program to ensure universal access to health care.

10. VISION FOR THE FUTURE.

In attempting to meet its goals, the Commission has learned that the current health care system in Minnesota is dysfunctional in a number of ways. We have learned of unreasonable premiums and costs to individuals and employers, lapses in coverage, frustrated employees, hassled providers, and neglected citizens. Clearly, continued systemic reform will be necessary in order to create a more effective and efficient health care system.

The Commission has reached a number of conclusions and recommendations that address systemic reform. Although these recommendations provide a foundation for system reform, continued reform is needed. At present, many parts of the health care delivery system contain incentives that work against efficiency and productivity. These incentives are driven especially by: (a) fee-for-service reimbursement, and (b) the proliferation of expensive new technologies, procedures and drugs. Continued reform of the health care system must address:

- Incentives for health care providers that reward productivity, efficiency and positive health outcomes.

- Development of a system and culture conducive to the development and continuous improvement of health care practice standards.

- Excessive capital spending for equipment and facilities.

- Better systems and incentives to match health care providers and facilities with community needs.

- Mechanisms for making informed, society-wide decisions about the appropriate and equitable allocation of resources.

- Simplification of the administrative system for patients and providers.

In the long run, to guarantee health care access for all Minnesotans we must move toward a system that makes progress in these areas. One such vision would be for the new Department of Health Care Access to function like a public service commission. It would grant franchises to managed-care organizations that meet the state's specifications, and establish a budget for total health care expenditures through those organizations. All citizens would be entitled to health care through a managed-care organization, with regular opportunities to choose a different organization in their area. We believe this to be a vision based on fairness, compassion, and a shared social responsibility. We trust that it will be modified and improved---this we expect and encourage.

Chapter 2

THE HEALTH CARE ACCESS COMMISSION

The Commission approached its charge by considering different solutions to the health care access problem. We sought and received ideas and suggestions from a broad spectrum of people and organizations, commissioned new research to develop a necessary base of knowledge, and deliberated various options in numerous meetings---all of which were open to the public.

The Health Care Access Commission was appointed September 1, 1989. The Commission organized its work along three major lines: (1) new research on health care access in Minnesota; (2) statewide public hearings and other forums for soliciting ideas; and (3) deliberations by the committees assigned to develop recommendations about various facets of the problem and our proposed solutions. As background for understanding the process we followed to develop this report and its recommendations, this chapter summarizes each of these activities.

A. RESEARCH FINDINGS.

To provide the legislature with solid cost estimates and a feasible policy, the Commission engaged independent research organizations to conduct new research in four areas.

1. THE HOUSEHOLD SURVEY: HEALTH COVERAGE AND UNINSURANCE IN MINNESOTA.

Although Minnesota is recognized as a national leader in health care, many Minnesotans are uninsured or inadequately insured. Approximately 370,000 Minnesotans, or 8.6 percent of the state's population, have no health insurance for all or part of the year. (This includes 194,000 uninsured all year, and 176,000 unininsured part of the year.) Nearly the same number, 366,000, have individually-purchased policies, many of which require high deductibles and provide less coverage than group policies. Many people with this type of policy are underinsured, meaning that they face the same types of access barriers as the uninsured.

These and other findings were developed through a statewide telephone survey of over 10,000 Minnesotans, the centerpiece of the Commission's research efforts. The survey was conducted through the Division of Health Services Research and Policy, University of Minnesota School of Public Health, and the Department of Medicine, Hennepin County Medical Center. The survey researchers were Nicole Lurie, M.D., M.S.P.H., Michael Finch, Ph.D., and Bryan Dowd, Ph.D. A detailed report of the survey findings was issued in October, 1990, entitled "Who Are the Uninsured in Minnesota?" The report is available from the Commission.

The following are some of the other significant findings from the household survey:

- Northern and west-central Minnesota have the highest uninsurance rate. The majority of all uninsured Minnesotans live in the Twin Cities area, but northern and west-central Minnesota have significantly higher uninsurance rates.

- Inadequate insurance is a clear barrier to getting needed health care. The survey found that lack of health insurance is associated with significant barriers in access to care. Of people without health insurance all year, 28 percent reported that they delayed receiving care when they thought they needed it. For those who delayed care, 70 percent said it was for a "very or somewhat serious problem," and 84 percent said the delay was

due to cost.

• Most uninsured adults are in the workforce. Excluding retirees, 86 percent of adults uninsured all year are employed.

• The uninsured are as healthy as the general population. Although inadequate insurance creates access to care barriers for the uninsured, as a whole their health status is comparable to that of the general population. This finding is important because it suggests that extending coverage to them should not be significantly more costly, on a per capita basis, than for a normal insured population.

• Individually-purchased insurance is expensive and inadequate for hundreds of thousands of Minnesotans. The Commission's recommendations address the needs of people with inadequate health insurance coverage as well as the uninsured. Taking into account out-of-pocket expenditures and premium costs, 34 percent of all Minnesotans with individually-purchased policies spend more than 10 percent of their income on health care. Consequently, nearly 1 in 5 individually insured Minnesotans have very high unpaid medical bills, averaging $1207 per person.

2. THE EMPLOYER SURVEY: EMPLOYER-PROVIDED HEALTH BENEFITS IN MINNESOTA.

Because employers play a central role in health care financing, the Commission also conducted a survey about employer-provided health benefits. The purpose of the survey was to obtain current, Minnesota-specific information about the extent of employer-based health insurance, the cost and characteristics of insurance for firms that provide it, and the types of firms that don't provide it and their reasons.

The Commission contracted with Anderson, Niebuhr & Associates, a St. Paul survey research firm, to conduct the statewide telephone survey of over 1,100 employers. Karen Lyon was the Anderson, Niebuhr project coordinator. A detailed report of the survey findings was prepared by Cynthia Orbovich, Policy Design Associate with the Commission staff. The report was issued in October, 1990, and is available from the Commission. The following are some of the key findings from the employer survey:

• Four out of ten Minnesota employers do not provide health benefits. Overall, 41 percent of Minnesota employers do not provide employee health benefits. Most of these employers have very few employees.

• Most employees have health benefits, especially at larger employers. Only in the smallest size category, 1-4 employees, do less than two-thirds of all firms provide health benefits. Among employers with 100 or more employees over 98 percent offer health benefits. The availability of benefits decreases with smaller employers, as follows: 50-99 employees = 93 percent offer benefits; 30-49 = 90 percent; 15-29 = 78 percent; 5-14 = 68 percent; 1-4 = 33 percent.

• The availability of coverage varies significantly by industry. The survey found that coverage is most limited in retail and sales, transportation, agriculture and construction.

• Two-thirds of employers who do not offer insurance would like to do so. Of those employers who do not offer health benefits, 68 percent are interested in doing so and are willing to pay some of the cost for their employees. However, the high cost of health insurance is the primary reason why employers do not currently offer health benefits. One third of these employers are willing to pay $120 per month per employee for insurance. An additional 21 percent are willing to contribute between $10 and $100 per month per employee.

• Most employers who do not offer insurance prefer coverage for routine care. When asked to choose between catastrophic insurance and coverage for routine care, 51 percent preferred coverage for routine medical care while 39 percent favored catastrophic coverage.

The employer survey also contained a series of hypothetical questions for employers who do not currently offer health benefits, concerning the conditions, if any, under which they would begin to do so. For instance, employers were asked about their interest in participating in a new state program and the types of coverage they prefer for their employees---a majority preferred coverage that includes primary care over a policy that emphasizes catastrophic care. These findings were incorporated into the Commission's policy and program design deliberations.

3. LEGAL RESEARCH ON ERISA.

The Commission initiated research on relevant state and federal laws to guide its policy making. The Commission was charged with studying the federal ERISA law (Employee Retirement Income Security Act). ERISA limits the authority of state governments to regulate employee benefits, including health benefits. ERISA has proven to be a major complicating factor for many states in their attempts to craft a solution to the health care access problem. By studying ERISA carefully, the Commission was able to develop policy recommendations which do not present an opportunity for legal challenge under ERISA.

The Commission hired the law firm of Ropes & Gray, based in Boston, Massachusetts, to provide assistance in analysis of ERISA and other legal issues affecting our deliberations. Ropes & Gray had done previous work of a similar nature in support of a health care access commission in Massachusetts. Susan Nicholson served as our primary contact at Ropes & Gray. We also received legal assistance from Sharon Lewis of the Minnesota Attorney General's Office.

4. ACTUARIAL RESEARCH ON THE COST OF THE PROGRAM.

In order to provide the legislature with the best available cost estimates, the Commission hired an actuarial firm to analyze the Commission's benefit package and recommendations. The Commission hired the actuarial consulting firm of Milliman & Robertson, with offices in the Twin Cities, and worked primarily with William Bluhm and Robert Cumming. Milliman & Robertson staff drew upon the results of the Commission's household survey in preparing their analyses.

B. PUBLIC HEARINGS.

The Commission held 19 public hearings throughout Minnesota to gather information, receive suggestions, and answer questions from people affected by the problem of health care access. In addition to Commission members and staff, the hearings were attended by legislators and other elected officials. Most hearings were well attended---in total the hearings attracted over 700 people, including several where more people wished to testify than time permitted. In some cases the Commission scheduled additional hearings to accomodate demand.

The most common testimony at public hearings came from people who had encountered problems in getting health care or health coverage. Uninsured Minnesotans testified to delaying care for themselves and their children and to high monthly out-of-pocket expenses for health care obtained during crises. Others with some insurance described similar problems, and explained that the only insurance policies they could afford have annual deductibles as high as $5000 and, in many cases, exclude coverage for preexisting conditions for which they needed care. The public hearings underscored that health care access problems affect people from all walks of life: employed and unemployed, single people and families, low income and middle income.

We also received valuable testimony at the hearings from people with unique perspectives into the health care system and its problems. Physicians, chiropractors, hospital officials, and other health care providers testified about the problems associated with uninsured and underinsured patients. Representatives of public health departments testified about the increasing drain on their budgets posed by low-income, uninsured people needing basic services such as immunizations, well-child care and prenatal care. Representatives of insurers and HMOs testified about their role in the health care system, the need for reform of insurance practices, and the role they could play in solving the access problem. We also received testimony from people who have special health care needs, and their suggestions for how those needs may be addressed through health care system reform.

The Commission began its public hearings schedule in June, and completed the last hearing in December. The December hearing gave interested parties an opportunity to comment on the Commission's draft "Final Report to the Legislature." The full schedule of Commission hearings were as follows.

Public Hearings Conducted by the Health Care Access Commission

City	Date
Fergus Falls	June 5th
Moorhead	June 6th

Crookston	June 7th
Willmar	July 11th
Marshall	July 12th
Worthington	July 13th
Duluth	August 1st
Eveleth	August 2nd
Winona	August 7th
St. Paul	August 16th
Mankato	August 29th
Minneapolis--south	September 13th
Brainerd	September 27th
Blue Earth	October 16th
Rochester	October 17th
Minneapolis--south	October 24th
Minneapolis--north	October 25th
St. Cloud	November 1st
State Capitol	December 18th

In addition to the public hearings, individual Commission members and staff also held hundreds of meetings with interested parties, speaking engagements, and other opportunities to discuss the Commission's work and to receive suggestions. Another series of 10 public hearings was held over the course of the year by the Minnesota Health Care Campaign, an organization working for health care reform. Commission members and staff also participated in many of these hearings.

C. DELIBERATIONS.

Extensive deliberation by the Commission and its committees resulted in the Commission's recommendations. For this purpose, the Commission formed three major committees.

- Delivery Mechanisms Committee. This committee was responsible for the main program design recommendations, including a health care delivery system, outreach and enrollment, benefit design, data and research initiatives, new program structure, changes to current programs, and broad issues of program design philosophy such as the goal of universal coverage and the role of employers. Charles Oberg, M.D., a pediatrician at Hennepin County Medical Center, chaired the Delivery Mechanisms Committee.

- Finance Committee. This committee was responsible for program design recommendations and analysis concerning program costs, revenues, and savings. These recommendations included issues such as eligibility terms and incentives, the structure and amount of premium subsidies, recommended revenue sources, and estimates of needed state subsidies. John McIntire, CEO of Carondelet LifeCare, chaired the Finance Committee.

- Legal Committee. This committee was responsible for program design recommendations concerning the role of employers---including the related ERISA analysis, health insurance underwriting and rating reforms, and other legal issues associated with the Commission's work. Martha Van de Ven, J.D., an attorney with Gray, Plant, Mooty, Mooty & Bennett, chaired the Legal Committee.

In addition to these standing, year-long committees, special program committees, subcommittees, and task forces were convened for shorter periods to analyze and develop recommendations on the following subjects.

- Demographics and survey design---chaired by Teresa VanderEyk, Community Services Director, Koochiching County.

- Communications---chaired by George Halvorson, CEO, Group Health, Inc.

- Benefit design---chaired by James Hart, M.D., an internist practicing in Stillwater.

- Data and research initiatives---chaired by James Ring, Vice President for Human Resources, Control Data Corporation.

- Geographic access---chaired by Roger Krantz, Medical Plan Administrator, Minnesota Power and Light.

- Administrative structure---chaired by Nina Rothchild, Commissioner of the Minnesota Department of Employee Relations.

- Pace and timing of implementation---chaired by Peter Benner, Executive Director of the Minnesota State Employees Union, AFSCME Council No. 6, AFL-CIO.

For most program and policy issues, committees prepared issue papers containing their analysis and recommendations, which were submitted to the full Commission for discussion and decision. The following are the formal issue papers adopted by the Commission over the course of 1990.

Health Care Access Commission Issue Papers

A. Universal coverage (research priorities).
B. Employer role (research priorities).
C. Open participation (research priorities).
D. Health care delivery.
E. Outreach and enrollment.
F. Underwriting, rating and reinsurance.
G. Eligibility terms and incentives.
H. Data and research initiatives.
I. Individual subsidies.
J. New program structure, current program changes.
K. Benefit design.
L. Geographic access.
M. Non-participant revenues.
N. Costs, revenues and savings.
O. Pace and timing of implementation.

The full Commission met at monthly intervals through August, and twice monthly from September through December, 1990. All Commission decisions were made on a preliminary basis, subject to review as part of the overall set of recommendations at the end of the year. The Commission held a two-day retreat in mid-November to conduct this review, and to reach consensus on key outstanding issues. The Commission held day-long meetings in late November and early December to address final issues.

Chapter 3
MINNESOTANS' HEALTH CARE PLAN

A. INTRODUCTION AND OVERVIEW.

1. INTRODUCTION.

To ensure access to needed health care for all Minnesotans, the Commission recommends that a new state program be established to provide health coverage to the uninsured, the underinsured, small employers, and others who may be attracted to the program's features. We find that no program now in existence has the capacity to provide access to care, control costs, and lay a foundation for needed reforms in the overall health care system. Rather than correcting the shortcomings of an existing program, we recommend starting afresh with a new state program designed to guarantee access and manage health care costs.

2. OVERVIEW OF RECOMMENDATIONS CONCERNING THE NEW STATE PROGRAM.

The Commission recommends that the program be named the "Minnesotans' Health Care Plan," and that responsibility for its development and implementation be located in a new Department of Health Care Access. We recommend that the new program serve as the cornerstone of a system of affordable health care available to all Minnesotans.

We recommend that the state recognize the right of all Minnesota citizens to health care, and establish a corresponding responsibility for all citizens to obtain health care coverage---based on their ability to pay. We recommend that client outreach be a primary emphasis of the new state program, to ensure that all citizens are aware of the program's availability.

The Commission finds that a system in which all Minnesotans have health care coverage allows effective pooling of risk, regardless of the source of coverage (the new state program, an employee benefits program, or other insurance). Without universal coverage the program would attract a disproportionate share of high-cost enrollees. The resulting high premiums could make the program unattractive to the majority of people who have relatively low costs.

The Commission finds that, for many Minnesotans, cost is the primary barrier to adequate health coverage. Therefore, we recommend that individual premium subsidies be available through the new state program to enable low-income people to afford coverage. Individual premium subsidies will be structured in the form of a sliding scale based on gross family income. Subsidies will be high for people with very low incomes, and gradually diminish as incomes approach 275 percent of the federal poverty level. All enrollees in the program will contribute something toward the cost of their coverage.

We recommend that the new state program insure and deliver health care through contracts with "managed-care health plans," such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). These arrangements will bring enrollees the advantages of large-group purchasing, and promote the use and expansion of the most efficient systems for health care delivery. To participate in the new program, health plans will be required to meet the state's managed-care specifications. These specifications will include an effective system for managing all health care provided an individual patient. The specifications will include a requirement that all enrollees register with a primary clinic of their choice, that will coordinate their subsequent care. If there are areas of the state where acceptable managed-care arrangements are unavailable, the

new program will make its own direct arrangements, and/or pay for care on a fee-for-service basis as is currently done in the Children's Health Plan.

We recommend that the new state program be open to any Minnesota resident who is uninsured, or who has coverage that primarily supplements, rather than duplicates, the coverage available through the new program. We also recommend that the program allow employers to enroll as a group, giving their employees access to the same choice of plans as individuals who enroll directly.

We recommend that a new Reinsurance Pool be established within the Department of Health Care Access. The Reinsurance Pool will limit health plans' liability for high-cost cases, and verify that the best managed-care arrangements are made for such cases. If necessary, the pool will be able to assume direct managed-care responsibility for individual cases. The Reinsurance Pool will provide a mechanism to ensure that all of society shares in bearing the costs for, and making priority decisions about, the most expensive conditions.

The Commission recommends that the new state program provide a benefit package covering preventive, primary, outpatient and inpatient care. The package will also include coverage for prescription drugs, mental health care and chemical dependency care. Certain limits will apply to some types of care to maintain an affordable premium. Fewer limits will apply to coverage for children under age 18. To evaluate and refine the benefit package over time, we recommend that a Technology and Benefits Advisory Committee be established. The committee will be responsible to develop recommendations about the new program's benefits, benefits in other government-supported plans, and benefit levels required in HMO and insurance policies.

B. A NEW STATE PROGRAM: MINNESOTANS' HEALTH CARE PLAN.

1. PURPOSE.

The Commission recommends that a new state program be established to provide health coverage to the uninsured, the underinsured, and other individuals and groups who may be attracted to the program's features.

2. NAME AND LOCATION.

The Commission recommends that responsibility for the design and implementation of the new program be located in a new Department of Health Care Access (or DHCA, see chapter 4), and that the new program be named the "Minnesotans' Health Care Plan."

3. TIMING OF IMPLEMENTATION.

A. Enrollment target date.

The Commission recommends that the new state program commence to enroll eligible applicants on July 1, 1992. We recognize that it may be possible to establish arrangements for program implementation more quickly in some areas of the state than others. We recommend that the new state program commence enrollment simultaneously statewide if possible.

B. New program planning and development.

The Commission recommends that planning and development for the new state program take place from July 1, 1991 to June 30, 1992. These tasks may include, but are not limited to:

- Development of outreach, enrollment, and eligibility determination procedures, and commencement of outreach activities.

- Development of premium collection and coverage enforcement procedures.

- Planning, development, and acquisition of necessary computer systems---including forms, software, and training.

- Development of health plan contractor specifications and issuance of requests for proposals (RFPs).

- Health plan contract negotiations and execution.

- Planning, development, and preparation of systems for direct health care delivery management by the state, and/or use of the Department of Human Services administrative systems, as necessary.

- Reinsurance Pool planning, RFP process, contract negotiations, and related preparations.

C. UNIVERSAL COVERAGE: OUTREACH AND ENROLLMENT.

1. UNIVERSAL COVERAGE: A RIGHT AND A RESPONSIBILITY.

The Commission finds that a system of universal health care coverage would:

- Extend access to health care more effectively than a non-universal system.

- Enhance public health through early medical intervention and preventive care.

- Allow the effective pooling of risk, and significantly lower per-capita costs through avoidance of adverse selection.

- Ensure that the costs of health care are shared broadly and equitably.

Therefore, we recommend that the state: (a) recognize the right of all Minnesota citizens to health care; and (b) establish a corresponding responsibility for all Minnesota citizens to obtain health care coverage---based on their ability to pay.

2. A STRONG EMPHASIS ON OUTREACH ACTIVITIES.

The Commission recommends that client outreach be a major emphasis in the new state program. The purpose of outreach activities will be to inform Minnesotans about public and private sources of health coverage, and to assist them to obtain coverage. Outreach activities will include health coverage information and counseling services, available throughout the state and through a toll-free telephone number. Outreach services will be targeted at individuals and small employers. Outreach activities will include publicity and advertising, funded on an ongoing basis.

3. SIMPLE AND EASY APPLICATION.

A. Availability of application forms.

The Commission recommends that application forms, instructions, and mailing materials be available at numerous locations, including but not limited to the following:

- At state offices around Minnesota.

- At hospitals, clinics, and other health care providers' offices, especially providers who serve a large number of low-income people.

- With individual income tax forms.

- With applications for a driver's license, state ID card, or motor vehicle license.

- With materials for school and college registration.

- With applications for unemployment insurance benefits.

- At food shelves.

- At the offices of insurers, HMOs, and other health plan companies.

B. Application forms and procedures.

The Commission recommends that new state program application forms be simple and streamlined, with more detailed forms required for appli-

cants potentially eligible for federally-subsidized programs or, if applicable, other state programs. Application forms will ask for all information necessary to determine eligibility for subsidies under the new state program, and to determine other sources of insurance for the purpose of coordination of benefits (if necessary, based on program benefit levels).

Applications will be submitted directly to the new agency, either by mail or in-person. The new agency will process applications promptly, and notify applicants of application acceptance, rejection, or unusual delay---and the reason and expected resolution. Processing will require information necessary to determine eligibility and receipt of a minimum premium (e.g., one month).

C. Enrollment confirmation.

The Commission recommends that the new agency operate a toll-free telephone service to confirm individual enrollment in the new state program for the benefit of health plans, providers and enrollees.

4. COVERAGE EFFECTIVE DATE.

The Commission recommends that coverage begin on the next 1st or 15th of a month, whichever comes first, following the transfer of enrollment information from the Department of Health Care Access (DHCA) to the health plan chosen by the applicant. The DHCA will transfer enrollment information to the health plan as soon as possible, and no later than two weeks after receipt of a complete application.

We recognize that it would be optimal for enrollees if coverage is effective immediately or even retroactively. We considered these alternatives, but concluded that they would add significantly to the program's expense and, in some cases, discourage people from enrolling in a timely fashion. We find that, in the long run, the effective date of coverage will not be a major barrier to health care access, based on our recommendations concerning universal coverage, vigorous outreach, and premiums based on the ability to pay.

5. ENROLLMENT EDUCATION AND ASSISTANCE.

The Commission recommends that the Department of Health Care Access provide education and assistance concerning enrollment in the new state program, which may include written materials, workshops, and individual assistance. Enrollment education and assistance topics will include:

- Basic and supplemental coverage offered by the new state program.

- Features of specific health plans offered through the new state program, including how to obtain health care within those plans, and descriptions of provider networks.

- Premium costs associated with each plan, and premium payment procedures and obligations.

- What to do if eligibility status changes during the course of coverage.

We recommend that enrollment education and assistance be designed to fulfill the needs of people who do not speak or read English well, or who have other special communication needs.

6. OPEN ENROLLMENT.

The Commission recommends that the new state program allow enrollees an annual open enrollment period, at which time they may switch health plans. Except for the open enrollment period, enrollees may not switch plans unless they move to an area not served by their current plan.

7. ENFORCEMENT PROCEDURES.

A. First year of program operation.

The Commission recommends that the new state program begin enforcement of the individual responsibility to obtain health coverage after the program has been in operation for one year---on July 1, 1993. This grace period will allow people to become familiar with the workings of the program, enrollment procedures, features of participating health plans, etc. It will also allow the

Department of Health Care Access time to correct any shortcomings in outreach and enrollment procedures.

B. Disenrollment restriction.

The Commission recommends that the new state program restrict individual disenrollment unless the enrollee provides evidence of alternative coverage that will be in effect as of the date of disenrollment.

C. Failure to obtain health coverage.

The Commission recommends that, beginning July 1, 1993, in the second year of program operation, the Department of Health Care Access implement a system to identify people who have not obtained health coverage. For example, a question added to driver's license applications, income tax filings, school registration, and similar forms could be used for this purpose. We recommend that the DHCA provide health coverage to the people identified through this system and collect the appropriate premiums. Procedures for providing coverage to and collecting premiums from uninsured people will be developed by the DHCA in consultation with the Attorney General's office.

D. ELIGIBILITY FOR THE NEW PROGRAM.

1. ELIGIBILITY TO PARTICIPATE--- INDIVIDUALS AND FAMILIES.

The Commission recommends that eligibility to participate in the new state program be extended to any person who has been a resident of Minnesota for at least 90 days, and who is uninsured, or has individual or group health coverage that primarily supplements, rather than duplicates, the benefits available through the new state program. The minimum period of residency will be waived for individuals with employment in Minnesota.

Refusal to provide health history information will not disqualify an individual from eligibility for the new state program. For children, the eligibility of the parent or guardian determines the eligibility of the child. If a child's parents are separated or divorced, the parent with physical custody determines eligibility---provided that a child can also be eligible through the non-custodial parent if that parent is legally required to provide coverage. Eligibility as a child ends on the child's 19th birthday, or the 23rd birthday if a full-time student.

Individual eligibility to participate is not the same as eligibility for subsidies. Individuals participating in the new state program will be able to choose among the health plans under contract with the program and available where they live.

2. ELIGIBILITY FOR PREMIUM SUBSIDIES--- INDIVIDUALS AND FAMILIES.

The Commission recommends that individual premium subsidies be available through the new state program for the purpose of enabling low-income people to afford coverage. Subsidy eligibility will extend to any person eligible to participate in the new state program (item 1) who also meets the following criteria:

- Gross income. The individual's gross family income falls within the range of the new state program's sliding scale for premium subsidies.

- Not eligible for employer-subsidized coverage. The individual is not eligible for subsidized health coverage through his/her employer, or through the employer of a family member (spouse or parent). For this purpose, "subsidized health coverage" means coverage: (1) equal to or greater than the level of benefits subsidized through the new state program (e.g., the Intermediate Benefit Set), and (2) with subsidies from the employer equal to or more than a certain amount---to be determined by the Department of Health Care Access.

The Commission recommends that the Department of Health Care Access include employer contributions to *cafeteria plans* (IRS Code 125 plans) in the definition of employer-subsidized coverage.

Children will be considered eligible for employer-subsidized coverage if either parent is eligible for subsidized family coverage through his/her employer, including the non-custodial parent if the child's parents are separated or divorced.

• Not eligible for federally-subsidized coverage. The individual is not eligible for subsidized health coverage through a federally-supported health program, such as Medical Assistance or Medicare. For this purpose, "subsidized health coverage" means coverage: (1) equal to or greater than the level of benefits subsidized through the new state program (e.g., the Intermediate Benefit Set), (2) with public subsidies equal to or more than a certain amount---to be determined by the Department of Health Care Access, and (3) which pays for emergency services incurred outside Minnesota at "non-program" providers. (The third criterion means that eligibility for programs such as the Indian Health Service and Veterans Administration health care would not disqualify an individual from eligibility for a subsidy under the new state program.)

• Medicare-supplement coverage. Medicare-supplement coverage will be available on a self-supporting, unsubsidized basis through the new state program for individuals eligible for Medicare.

• No asset test. Family assets will not be used in determining eligibility for individual premium subsidies.

3. ELIGIBILITY DETERMINATION.

The Commission recommends that standard eligibility determination procedures be used statewide, and administered by staff of the Department of Health Care Access. Eligibility determination will be based on the honor system, without routine verification of income or other information.

We recommend that eligibility reverification take place fairly infrequently---at one-year intervals, for example. The emphasis of reverification will be on eligibility criteria other than income. Income eligibility will be reverified through the individual income tax system. Reverification will be handled by mail, with random follow-up checks to confirm accuracy. People who fail to respond to mail eligibility reverification will be contacted by telephone to encourage or help them to respond. The new state program will also encourage enrollees to self-report changes in eligibility status that occur at times other than the periodic reverification.

E. ENROLLEES' SHARE OF PREMIUMS.

1. PREMIUM SUBSIDY TERMS AND CONDITIONS.

The Commission finds that for many Minnesotans the primary barrier to adequate health coverage is cost. The purpose of individual premium subsidies is to reduce this barrier, by ensuring that health coverage will be available to people at each income level at a price they can reasonably afford. Consistent with this purpose, we recommend that the following terms and conditions apply to individual premium subsidies:

• Sliding scale. Individual premium subsidies will be structured in the form of a sliding scale based on gross family income. The Federal Poverty Guidelines (FPG) will be the primary unit of measurement for the sliding-scale, which includes adjustments for family size.

• Indexed over time. The sliding scale will be indexed or adjusted over time to take into account changes in prevailing income levels and health coverage costs.

• Reviewed for benefit level changes. The sliding scale will be reviewed over time based on changes in the level of benefits subsidized through the new state program. If the level of benefits is fairly comprehensive, and equals or approaches the recommended Universal Basic Benefit Set (UBBS), it may be appropriate for the sliding scale to require somewhat higher enrollee payments. If the level of subsidized benefits is less comprehensive, it may be appropriate for the sliding scale to require somewhat lower enrollee payments.

• Separate from employer subsidies. Sliding-scale subsidies will be used only to purchase coverage through the new state program, and not to purchase coverage through an employer.

• Ascending percentage of gross income. As incomes increase, disposable income also increases. Enrollees' required premium payments under the sliding scale will, therefore, increase as a percentage of gross income as income increases.

• Universal enrollee participation in premium payments. All persons eligible for the new state

program pay at least some amount towards the premium costs, based on their ability to pay.

• The size of income steps in the sliding scale. We recommend that the sliding scale be based on "steps" in increments of approximately 20 percent of the poverty level. We find that larger steps would provide excessively high increases at certain income thresholds, but that smaller steps would add significantly to the program's administrative complexity.

• Maximum household income. We recommend that no subsidies be provided to families with annual incomes greater than $40,000, regardless of family size. A family of four at 300 percent of the poverty level has an annual income of $38,100. The maximum household income will also be indexed or adjusted over time, in the same manner as the sliding scale.

2. BENEFIT LEVEL AND THE SLIDING SCALE.

A. Benefit level equal to the Universal Basic Benefit Set.

The Commission sought to find a level of enrollee payments that could be reasonably afforded for higher income people, as well as a point beyond which subsidies are unnecessary. We recommend that the sliding scale end at approximately 275 percent of the poverty level, and that as income approaches that level the sliding scale require enrollees to pay 8 percent of gross family income toward the cost of premium. We recommend that, for people at the very lowest income levels (1-20 percent of the federal poverty level), the sliding scale require enrollees to pay 1.25 percent of gross family income toward the cost of premium.

We find that, for the UBBS, 8 percent of gross family income is a reasonable amount to pay for most people as incomes approach 275 percent of the poverty level. Based on the household survey results, a significant number of people in these income ranges pay this amount now for individually-purchased health coverage. Among uninsured people in these income ranges, answers to the "what could you afford" question indicate that the 8 percent figure would be reasonable. The sliding-scale program for a prepaid program operated by a Minneapolis community clinic also provides support for a scale with this range.

B. Benefit level less than the Universal Basic Benefit Set.

If the set of benefits subsidized through the new state program is less than the UBBS, the Commission recommends that the sliding scale be adjusted proportionately. The Intermediate Benefit Set (IBS) recommended by the Commission as the initial subsidized benefit level provides approximately three-quarters of the UBBS benefit level. For the IBS, therefore, we recommend that the sliding scale would end at approximately 6.5 percent of gross family income and begin at approximately 1.1 percent of income. The ratio of actual subsidized benefits to the UBBS may be determined by the respective premiums associated with the two benefit levels. The following table illustrates this sliding scale at selected income levels for the Intermediate Benefit Set. Attachment A contains a detailed exhibit of the sliding scale.

Sliding Scale for the Intermediate Benefit Set

Household size	Federal poverty level	Monthly income	Monthly premium
One	100%	$522	$12.39
One	150%	$783	$26.76
One	200%	$1043	$47.77
One	250%	$1304	$73.95
Two	100%	$702	$16.59
Two	150%	$1053	$35.83
Two	200%	$1403	$63.99
Two	250%	$1754	$99.06
Three	100%	$812	$20.80
Three	150%	$1320	$44.93
Three	200%	$1760	$80.21
Three	250%	$2200	$124.18

3. PREMIUM PAYMENTS BY INDIVIDUALS.

The premium payment procedures recommended by the Commission apply to all coverage available through the new state program, including: (a) the Intermediate Benefit Set, (b) the Universal Basic Benefit Set, and (c) Medicare supplement coverage.

A. Automatic payments.

The Commission recommends that the new state program rely on automatic payments from enrollees to the state whenever practical, especially for enrollees expected to remain on the program for a relatively long time. Subject to additional investigation concerning feasibility as determined by the Department of Health Care Access, automatic premium payments could be made through:

- The system for state income tax withholding---wage withholding for people employed by someone else, or estimated tax payments for self-employed people.

- The system for payment of unemployment insurance benefits.

- The system for payment of child support and spousal maintenance.

- Automatic bank account withholding.

B. Direct payments.

The Commission recommends that the new state program rely on direct or "manual" premium payments from enrollees for:

- The initial premium payment with the application form.

Enrollees expected to remain on the new state program a relatively short time.

- Enrollees for whom automatic payments are impractical.

We recommend that the new state program encourage, but not require, enrollees to make premium payments for relatively long periods (e.g., three months at a time) whenever practical.

4. ENFORCEMENT PROCEDURES.

The Commission recommends that non-payment of premium to the new state program will not result in coverage cancellation. The Department of Health Care Access will attempt to recover delinquent premiums through standard collection procedures. For example, the new agency could use the procedures followed for collecting unpaid child support obligations, one of which is the state individual income tax system.

F. THE ROLE OF EMPLOYERS.

1. PERMIT EMPLOYERS TO ENROLL.

The Commission recommends that the new state program permit employers to apply and enroll directly on behalf of their employees. Employers will be provided with special enrollment instructions and procedures for coordinating enrollment and disenrollment of their employees, retirees, and family members. People who enroll in the new state program through an employer will also receive enrollment education and assistance---tailored to the differences in their status from individual enrollees. The coverage effective date for group enrollees will be tied to the group's ongoing participation in the new state program, and to the continued membership of individuals in that group (e.g., continued employment with that firm).

2. ELIGIBILITY TO PARTICIPATE---EMPLOYERS.

A. General eligibility terms.

The Commission recommends that eligibility to participate in the new state program be extended to any employer doing business in Minnesota---for employees working in Minnesota, whether or not the employees are residents of Minnesota. For this purpose, an "employer" is an organization that pays Minnesota unemployment insurance premiums, and has two or more covered employees, which may include the owner. Self-employed people with no employees may participate in the new state program as individuals, but not as employers. Employers participating in the new state program will be able to offer their employees a choice of the health plans under contract with the program in that area.

B. Minimum eligibility standards.

The Commission recommends that employer

eligibility for the new state program be conditioned on meeting minimum standards concerning employer premium contribution and employee eligibility. The purpose of such conditions is to promote wide availability of health coverage through the new state program. Such conditions will be determined by the Department of Health Care Access, and may include, and need not be limited to:

- Minimum employer contribution. A minimum employer premium contribution for employee and family coverage. This minimum should be equal to or greater than the employer contribution level which, if available, would disqualify an individual for a subsidy under the new state program.

- Minimum employee eligibility standards. Minimum standards for employee eligibility, including eligibility for employees who work less than 40 hours per week, and eligibility waiting periods for new employees.

Subject to these conditions, employers will determine the features of their benefits program including which employees are eligible, whether family coverage is offered, and the size of the employer and employee contributions to premium costs.

3. PREMIUM PAYMENTS BY EMPLOYERS.

The Commission recommends that employers make all premium payments directly to the new state program on behalf of all persons covered by their employee benefit programs. Employers will be responsible to collect employees' share of premiums for remittance to the state together with the employer's share of premiums.

4. TECHNICAL ASSISTANCE AND OUTREACH.

In addition to the opportunity to participate in the new state program, the Commission recommends that the state provide the following assistance and incentives for employers to begin, improve, or maintain employee health benefit programs.

A. Technical assistance.

The Commission recommends that the new state program include technical assistance services for employers participating in the program. These services will be targeted to employers who do not currently offer employee health benefits, and/or for whom technical assistance services are not readily available. These services will be provided at cost, and may include assistance in:

- Designing and establishing a health benefits program.

- Administering state and federal (COBRA) continuation coverage requirements.

- Establishing tax sheltered premium accounts for employees.

The new state program will also provide technical assistance through the program's basic structure and operation, including services such as health plan selection and negotiations, health data research and analysis, open enrollment administration, and overall financial and legal administration.

B. Outreach activities.

The Commission recommends that outreach be a major emphasis in the new state program for employers as well as individuals. The purpose of outreach activities will be to inform Minnesota employers about the new state program and other sources of coverage, and to assist them to obtain or expand coverage. Outreach activities will be targeted to the types of employers most likely to be interested in the new state program.

5. STATE CONTRACTORS AND VENDORS.

The Commission recognizes that the state has significant potential to influence the availability of health coverage through its relationships with contractors and vendors. We recommend, therefore, that when the new state program is fully implemented the state require all of its contractors and vendors to demonstrate that they provide employee health benefits that meet the minimum standards of subsidized coverage through the new state program.

We also recommend that the Department of Health Care Access and the Department of Human Services consider the costs and feasibility of promoting or requiring the availability of health

benefits to the staff of health care facilities, including long-term care facilities, that receive significant state and federal support.

6. PART-TIME AND SEASONAL EMPLOYEES.

The Commission recognizes that many uninsured and underinsured people work part-time or seasonally, and that many employers cannot readily afford to extend full health benefits to part-time and seasonal workers on the same basis as full-time or annual workers. We also recognize that some employers would be willing to contribute part of the cost toward part-time and seasonal health benefits, perhaps on a pro-rata basis of the full-time or annual contribution.

To provide a vehicle for such contributions, we recommend that a special accounting mechanism be created within the new state program for employers of part-time and seasonal employees. The purpose of the accounting mechanism will be to allow employers to defray the cost of coverage for such employees, but without including them in the employer's standard health benefits program. This accounting mechanism will not be available to employers who have terminated health benefits for part-time or seasonal employees within three years prior to application.

Part-time and seasonal employees on whose behalf employer contributions have been submitted must obtain coverage through the new state program as individuals, and not as part of the employer's group. The employer contributions will be used to reduce the premium that the employee would otherwise have owed, and will be in addition to any individual premium subsidies to which the employee is entitled.

This mechanism is the only circumstance in which employer premium contributions may be used together with individual premium subsidies under the new state program. We do not recommend any additional comingling of employer and new state program subsidies because of the possibility of: (1) encouraging a decrease in employer-paid health benefits, and (2) creating a class of employers who benefit from ongoing state subsidies which are not available to all employers.

7. POTENTIAL CHANGES IN EMPLOYERS' ROLE.

A. Difficulties in predicting employer behavior.

The majority of Minnesotans receive health coverage through their own or a family member's employer. The Commission recognizes that, over time, the new state program may lead to a change in the overall size of employers' role in providing subsidized health coverage. Such a change may lead:

- To more people being covered by employers, due to the positive employer incentives provided through the new state program, insurance reforms, and other Commission recommendations. Or,

- To fewer people being covered by employers, due to the availability of sliding-scale premium subsidies for certain individuals.

If the new state program leads to a significant decrease in the number of people covered by employers, more people will obtain coverage directly through the new state program and will use the program's sliding-scale premium subsidies. This will lead to a shift in premium subsidy costs from employers to the new state program.

B. Monitor changes in employers' role.

The Commission recommends that the Department of Health Care Access conduct surveys and other activities to monitor changes over time, if any, in employers' role in providing subsidized health coverage. We recommend that detailed surveys of employer behavior be conducted at no less than annual intervals. After each survey is completed, the findings and an analysis of the positive or negative impact, if any, on the costs to the new state program resulting from changes in employers' role will be reported to the Finance Commissioner, the Revenue Commissioner, the chairs of the House Appropriations Committee, the Senate Finance Committee, and the House and Senate Tax Committees.

C. If employers' role decreases.

To fund the increased state costs associated with a significant decrease in employers' role, the

Commission recommends that additional revenues be raised, and that the legislature consider whether an employer-paid payroll tax should take effect if the new state program's enrollment exceeds a designated level.

The designated level will be equal to the "Subsidized Enrollment Base" (SEB) plus an additional margin. The SEB is the number of enrollees who could qualify for sliding-scale premium subsidies in the new state program, given the current (1990) number of people covered through employers. The SEB will be adjusted to reflect changes in state population. The additional margin is intended to reflect changes in enrollment that may be caused by natural employment cycle changes, or by other environmental factors unrelated to employment.

The Commission recommends that the following terms and conditions apply if a payroll tax is adopted:

• Tax base and credit. The payroll tax will apply only to the payroll of employees who reside in Minnesota. Employers who provide health benefits for their employees will receive credit for the full amount of the tax or the actual amount they spend for health benefits, whichever is less. If the tax credit provision is found to be in conflict with federal law, the credit provision will be waived. This will result in a lower overall tax rate (see below).

• Exemptions. A limited number of employers may be exempted from the payroll tax. For example, exemptions could apply to categories of employers where the tax would pose a significant barrier to business creation or growth (e.g., employers that have been in business for less than two years).

• Application of revenues. Revenues raised through the payroll tax will be applied entirely to the new state program, to supplement other revenues necessary to operate the program. The timing of revenue collections will be matched to the new state program's revenue needs.

Based on estimates by the Minnesota Department of Revenue, a payroll tax with credits for employers who currently provide health benefits would raise the following amounts:

1% tax	=	$36 million
2% tax	=	$73 million
3% tax	=	$109 million
4% tax	=	$145 million
5% tax	=	$182 million
6% tax	=	$218 million

More revenue will be raised if fewer employers provide health benefits; less revenue will be raised if certain categories of employers are exempted from the tax. A payroll tax without credits for employers who provide health benefits would raise comparable revenues at much lower tax rates.

8. EXEMPTION FROM ERISA.

The Commission recommends that the state of Minnesota apply to Congress for a time-limited exemption from ERISA preemption that would allow the state to apply underwriting reforms and community rating to all groups with 99 or fewer members without the danger that low-risk groups would self-insure. We also recommend that, under this exemption, Minnesota seek express approval to implement, if necessary, an employer-paid payroll tax, under which employers who provide health coverage would receive offsetting credits. The tax would be used to fund health coverage for employees and dependents who do not have health coverage.

G. USE THE BEST AVAILABLE METHODS FOR MANAGING CARE.

1. MANAGED-CARE HEALTH PLANS.

A. Central role of managed-care health plans.

The Commission finds that managed-care health plans, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), provide health care and health benefits more efficiently than traditional, all-provider, fee-for-service systems. We recommend, therefore, that the new state program insure and deliver health care through contracts with managed-care health plans that meet the state's specifications. These specifications will stress a plan's:

- Long-term commitment to improving the quality and efficiency of care.
- Financial integrity.
- Provider network capacity.
- Health care delivery management capabilities.
- Incorporation of clear standards of practice, where they exist, in managed care protocols.

B. Effective case management system.

The Commission recommends that the new state program's managed-care specifications require participating health plans to have an effective system for managing all health care received by an individual patient. This system must require enrollees to sign up with a specific primary care clinic, which will coordinate referrals, hospitalizations, and other care that patients receive---or propose an alternative, comparably effective, system of case management. A managed-care health plan which does not have such a system for managing patient care can still participate in new state program, provided that the plan implements such a system within three years after joining the program.

C. Changes in health plan regulation.

The Commission recommends that health care providers other than state-licensed HMOs and PPOs have the opportunity to participate in the new state program, provided they meet the state's specifications. This recommendation requires changes in current HMO and PPO requirements to establish an alternative licensing standard for such providers. We recommend that the Departments of Commerce and Health advise the legislature concerning appropriate changes in state law to accomplish this purpose.

2. AREAS WITHOUT SATISFACTORY MANAGED-CARE PROPOSALS.

If satisfactory managed-care proposals are not available in certain areas of the state, the Commission recommends that the Department of Health Care Access pursue one or a combination of the following options: (a) health plan recruitment; (b) state-administered managed-care health plans; (c) the Department of Human Service (DHS) administrative system; or (d) state-sponsored clinics. In order to minimize any delay in making coverage available through the new state program, we recommend that the DHCA consider these options simultaneously with the preferred option of contracts with managed-care health plans.

A. Health plan recruitment.

The state will continue its efforts to recruit or encourage managed-care health plan expansion or start-up in the area.

B. State-administered managed-care health plans.

The state will establish managed-care health plans through direct contracts with health care providers in the area, consistent with the specifications and objectives of the program.

C. Department of Human Services administrative system.

The state will pay providers in the area on a fee-for-service basis, using the Department of Human Services' (DHS') claims processing system, health care utilization review system, and other managed-care procedures. Payment will be based on a new fee schedule, set at a level to ensure that the program's costs in the area will be lower than they would have been under a managed-care health plan. Providers will also be required to operate under the DHS managed-care standards and procedures. Providers will be required to accept program patients as a condition of serving patients covered by any health coverage program supported by state or local government, including public employee health benefit programs, and will be prohibited from balance billing.

D. Alternative provider reimbursement system.

As an alternative to fee-for-service reimbursement under the DHS administrative system, the DHCA should investigate the forthcoming (under Medicare) resource-based relative value scale as the basis for a new fee schedule. Furthermore, the

Commission recommends that the Department of Health Care Access explore the possibility of collective bargaining with health care providers.

E. State-sponsored clinics.

To ensure adequate health care services within appropriate managed-care arrangements in areas of the state where such arrangements are otherwise unavailable, the DHCA will directly develop its own clinics and employ its own health care providers.

3. ACCESS TO PROVIDERS WHO SERVE LOW-INCOME PEOPLE.

The Commission recommends that the new state program encourage expansion or development of health plans which include providers who currently serve many low-income, uninsured Minnesotans (non-profit community clinics, public health departments, public hospitals). The program's managed-care specifications will apply to such providers.

4. ACCESS TO ALTERNATIVE PRIMARY CARE PROVIDERS.

In order to ensure adequate access to primary and preventive care and efficient health care delivery, the Commission recommends that the new state program's managed-care specifications require participating health plans to make appropriate use of non-physician providers within their overall framework of managed care.

5. CONSUMER EDUCATION AND INCENTIVES.

A. Consumer responsibility programs.

The Commission recommends that the new state program's managed-care specifications require participating health plans to have programs to educate consumers about appropriate use of the health care system. Such programs could include self-care education, telephone nurse access, and encouragement of healthy lifestyles and conformance with prescribed courses of treatment.

B. Self-care premium discounts.

The Commission recommends that small discounts be permitted in premium rates for individuals or small groups participating in the new state program to provide incentives for self-care activities. The decrease in premium revenues resulting from such discounts will require a slightly higher base rate. Such discounts will be small, consistent with the purpose of providing modest incentives to take care of one's health, rather than providing a mechanism for reintroducing actuarially-based rating factors. The factors will be optional and may vary from company to company. (See chapter 5 for a more in-depth discussion of insurance rating practices.)

6. HEALTH PLAN COMPENSATION.

The Commission recommends that compensation for health plans participating in the new state program be structured to ensure strong financial incentives to improve the effectiveness and efficiency of health care delivery. We find that this goal can be accomplished most effectively by requiring all participating health plans to provide the same set of benefits (initally, the Intermediate Benefit Set), and allow plans to compete on the basis of price to provide those benefits most efficiently.

Price differences between health plan companies will be passed along to individuals and groups enrolled in the new state program. For individuals who receive a premium subsidy based on the program's sliding-scale, the full effect of price differences will be modified to prevent excessive enrollment in the lowest-cost plan---which could tax the plan's capacity.

Participating health plans will be required to assume financial risk and responsibility for health care delivery, subject to the limits established through the Reinsurance Pool. We recognize that in the initial years of the new state program there may be a higher level of uncertainty about the mix and cost of enrollees each health plan company will enroll. To prevent this uncertainty from resulting in higher costs to the new state program, we recommend that the Department of Health Care Access be authorized to share risk above or below

a health plan company's target premium, to the degree and for the period that such risk sharing would be in the financial interests of the state.

H. CREATE A REINSURANCE POOL.

1. REINSURANCE POOL.

The Commission finds that a limited number of high-cost cases represent a large share of total health care expenditures. Careful and efficient management of such cases may have a significant and beneficial effect on the total costs of the new state program. To provide for such management, and to provide a mechanism to ensure that all of society shares in bearing the costs for, and making priority decisions about, the most expensive conditions, we recommend that a Reinsurance Pool be established as part of the new state program. The Reinsurance Pool will be administered by the Department of Health Care Access.

2. HIGH-COST CASE MANAGEMENT.

The Commission recommends that the Reinsurance Pool contract for case management services, using a contracting procedure similar to the procedure that the Department of Health Care Access will use in contracting for managed-care health plans. This procedure will allow for, but not require, the assumption of risk by the company, and the use of separate contracts and companies for different types of high-cost cases.

This case management company (or companies) will be responsible for overseeing and coordinating the treatment plans of all cases for which the Reinsurance Pool is liable. The case management company will also have authority, on behalf of the Reinsurance Pool, to assume a role in any cases where there is a high probability that the stop-loss limits will be reached---in the judgement of the case management company.

We recommend that the Reinsurance Pool establish a policy favoring continued management of high-cost cases by the primary health plan. To facilitate this policy, the case management company will approve standard treatment plans and protocols by participating health plans for common high-cost conditions and procedures.

3. POOL PARTICIPATION.

The Commission recommends that participation in the Reinsurance Pool be mandatory for: (a) all coverage through the new state program, and (b) all individual, small group (2-29), and medium-sized group (30-99) coverage provided through the private market. We recommend that the Department of Health Care Access evaluate the merits of participation in the Reinsurance Pool of: (c) self-insured groups, and (d) insured, large-group (100+) business.

4. STOP-LOSS LEVELS.

The Commission recommends that the Reinsurance Pool limit participating health plans' liability for high-cost cases based on a standard stop-loss level (e.g., $30,000 per case). We recommend that beyond the standard stop-loss level, a limited degree of risk be retained by the health plan company (e.g., 10-20 percent), with the Reinsurance Pool assuming 100 percent of the risk at a higher level (e.g., $100,000). The same risk-sharing arrangement will apply to high-cost conditions assigned to the Reinsurance Pool below the standard stop-loss level. This arrangement will maintain a financial incentive for the primary health plan company in the management of the case.

5. REINSURANCE POOL ASSIGNMENT FOR CERTAIN CONDITIONS.

For all health coverage subject to the Reinsurance Pool, the Commission recommends that a limited number of high-cost conditions result in automatic assignments made to the Reinsurance Pool, if the condition is present at the time of enrollment. These assignments will be restricted to conditions where: (a) the probability of high costs is very high (e.g., AIDS, various transplants), and (b) where there are significant advantages in establishing consistent treatment standards statewide. The Reinsurance Pool will assume risk for these cases even if the stop-loss level has not been reached. The costs of these assignments will be

incorporated in the overall Reinsurance Pool premium.

6. REINSURANCE PREMIUMS.

The Commission recommends: (a) that premiums for Reinsurance Pool coverage be developed on a community-rated basis for all primary coverage extended to individuals, small groups, and medium-sized groups, and (b) that premiums be adjusted to reflect differences in the managed-care structures and procedures in use in different types of health plans.

I. THE GOAL OF EQUITABLE BENEFITS.

1. THE PRINCIPLE OF HEALTH CARE EQUITY.

A. A principle of including everyone.

The Commission believes that wide variations in access to health care for different members of society are unacceptable. We recommend, therefore, that health care equity serve as the central principle for development of a benefit design for the new state program, and for refinements over time in benefit standards applicable to existing government-supported and private health insurance programs. We find that any benefit design will cross through legitimate and compelling human needs and wants. The Commission finds that we can properly design benefits only after we commit to "drawing a line" around our entire community, extending health care access to all.

B. The principle applied to those on the outside.

The Commission finds that many Minnesotans are uninsured or underinsured, and have inadequate access to health care. We recommend that adequate and affordable health coverage, defined as the Universal Basic Benefit Set (UBBS), be available to all Minnesotans. To the extent that the state cannot carry out this recommendation directly for reasons of cost, we recommend that the state progress toward universal access to health care beginning with the Intermediate Benefit Set (IBS) defined later in this chapter.

C. The principle applied to those on the inside.

The Commission recommends that the state give a higher priority to ensuring adequate and affordable health coverage for Minnesotans currently without it, than to expanding coverage for people who are already adequately insured. Specifically, we recommend that the state assign sufficient resources to provide the UBBS to the currently uninsured and underinsured before the state: (1) adds to the level of insurance or HMO coverage mandates, or (2) adds to the conditions covered through public health coverage programs already at or above the UBBS level.

2. UNIVERSAL BASIC BENEFIT SET (UBBS).

The Commission spent considerable time discussing alternative benefit designs, both for the UBBS and for an alternative, less comprehensive set of benefits that the legislature might adopt as an initial step. We recognized that an intermediate step is likely to be necessary before implementing the UBBS. For this reason, we developed greater detail for the design of the "Intermediate Benefit Set" (IBS).

For the purpose of the UBBS, we recommend that the goal of the Department of Health Care Access should be to progress toward a benefit set which:

- Incorporates the current state mandated benefits as applicable to HMOs, insurers and health service plan corporations (e.g., Blue Cross/Blue Shield).

- Has new, uniform provisions that will apply to all health plans, to the extent that the mandates differ for different types of health plan companies.

- Provides full coverage for preventive care, prenatal care and immunizations, as currently mandated for HMOs.

We recommend that the new state program provide the Universal Basic Benefit Set on a subsidized basis by July 1, 1995.

3. TECHNOLOGY AND BENEFITS ADVISORY COMMITTEE.

A. Committee formation.

The Commission recommends that a Technology and Benefits Advisory Committee be established in the new agency. The committee will consist of laypersons, health care providers, and experts in medical ethics. Committee members will be appointed by the Governor. The Department of Health Care Access will make recommendations for committee membership. We recommend that the committee be created and commence operations on January 1, 1992. The committee will advise and receive support services from the Department of Health Care Access.

B. Committee responsibilities.

The Commission recognizes that it is necessary and appropriate to refine state-created benefit standards over time, both before and after the goals of a Uniform Basic Benefit Set have been achieved. The Technology and Benefits Advisory Committtee will be the primary vehicle for developing these refinements, and will serve as a forum for developing a social consensus about the allocation of limited health care resources. Interested persons will have opportunities to comment on the issues under consideration by the committee.

The Technology and Benefits Advisory Committee will be responsible for reviewing, analyzing, and making recommendations about health care technology and benefits issues, including but not limited to:

- The Universal Basic Benefit Set.
- The Intermediate Benefit Set.
- State mandated benefits applicable to insurers and HMOs.
- Benefit levels in other state health coverage programs.
- Coverage for expensive new procedures and technologies.
- Coverage and health care standards for cases subject to the Reinsurance Pool. The committee's recommendations will be binding on the Reinsurance Pool.

The committee's recommendations will be based on social and financial principles established by the legislature. These principles will be interpreted in light of available funding, new medical procedures and technologies, and the experience of public and private health coverage programs.

J. PROGRESS TOWARD EQUITABLE BENEFITS.

1. THE FIRST STEP TOWARD EQUITABLE BENEFITS.

If the legislature deems that insufficient funds are available to finance the full UBBS in the initial phase of the new state program, the Commission recommends that the state progress toward the UBBS by first providing an intermediate level of benefits through the new state program. We developed the following principles in designing the features of such an intermediate benefit set (IBS).

A. Emphasize primary and preventive care.

The Commission recommends that "breadth" of coverage take precedence over "depth" of coverage. This recommendation proceeds from a belief that all people should have basic access to the health care system for primary and preventive care, and that people who have such access are more likely to seek treatment for minor conditions before they become major ones.

B. Balance expenditures for high-cost and low-cost cases.

Treatment for catastrophic, high-cost cases is clearly important and necessary. However, the Commission finds that with increases in the cost, capabilities, and technological sophistication of health care, high-cost cases are claiming an increasing share of all health care expenditures. We recommend, therefore, that expenditures for high-cost cases under the IBS and the UBBS be capped at a fixed percentage of the total. The determination and refinement of such an expenditure cap should be part of the responsibilities of

the Technology and Benefits Advisory Committee.

C. Limit the use of copayments.

The Commission recommends that copayments play a minimal role in the benefits provided through the new state program. Copayments will be used for a limited number of services where they have the effect of encouraging appropriate use of the health care system---such as emergency room copayments. Copayments will not be used where they have the effect of shifting costs to enrollees, and reducing significant amounts of appropriate as well as inappropriate utilization. We recommend that inappropriate use of the health care system be addressed primarily through managed-care initiatives and patient education, rather than copayments.

2. THE INTERMEDIATE BENEFIT SET.

Attachment B contains a detailed description of the Intermediate Benefit Set as recommended by the Commission. The IBS provides coverage for a wide range of health conditions and services subject to various limits and exclusions. The IBS includes some, but not all, of the current insurance and HMO mandates. The main features of the IBS are described in the following table (in the table "children" means through age 17).

We recommend that, until the UBBS is offered on a subsidized basis, coverages subject to specified dollar maximums be adjusted annually using an appropriate price index. We also recommend that if the legislature cannot fully fund the Chemical Dependency Consolidated Fund, the IBS include an inpatient chemical dependency benefit at the level designated under current law.

The Intermediate Benefit Set

Preventive Care

ALL: Pre-natal and post-natal care (including certified nurse-midwife services); well baby exams; immunizations; selected preventive tests and screening.

CHILDREN: Physical exams; vision exams; hearing exams; speech exams.

Office Visits, Drugs, Supplies

ALL: Up to 8 total visits per year to primary care physicians (for example, general practitioners, family practitioners, internists, pediatricians, and obstetricians/gynecologists), nurse practitioners, and physician assistants; additional visits covered when an alternative to inpatient care. Prescription drugs and therapeutic injections---$5 copay and limited formulary.

CHILDREN: Unlimited primary care visits; no drug copayment; durable medical equipment; prosthetic and orthotic devices; glasses; hearing aids.

Outpatient and Office Surgery, Tests, Therapies

ALL: Up to 8 total visits per year to chiropractors, podiatrists, physical therapists, occupational therapists, speech therapists, audiologists, and physician specialists (non-primary care); additional visits covered when an alternative to inpatient care. Full coverage for all other outpatient services including surgery; x-rays; lab tests; dialysis; cardiovascular tests and therapies; and other miscellaneous tests and therapies.

CHILDREN: Unlimited visits to chiropractors, podiatrists, physical therapists, occupational therapists, speech therapists, audiologist, and physician specialists (non-primary care). Allergy testing and immunotherapy.

Mental Health and Chemical Dependency Care

ALL: 80% coverage for inpatient mental health care, 100% coverage after $2500 in out-of-pocket expenses per household per year, up to a maximum benefit of $70,000 per person per year ($72,500 in total expenses, including out-of-pocket); the maximum out-of-pocket expense for inpatient mental health care is a combined maximum with general inpatient care. No coverage for inpatient chemical dependency care. Up to 10 hours per year of outpatient mental health care; up to 10 hours per year of outpatient chemical dependency care.

Maternity, Deliveries and Non-Deliveries

ALL: Physician, certified nurse midwife, and other health professional care; 80% coverage for inpatient care, 100% coverage after $500 in out-of-pocket expenses per pregnancy.

Emergency Services

ALL: Physician and other health professional care at an emergency room; hospital emergency room---$50 copay, waived if admitted to the hospital; ambulance---20% copay.

Hospital Inpatient and Home Health Care

ALL: 80% coverage for general inpatient care, 100% coverage after $2500 in out-of-pocket expenses per household per year, up to a maximum benefit of $70,000 per person per year ($72,500 in total expenses, including out-of-pocket); the maximum out-of-pocket expense for general inpatient care is a combined maximum with inpatient mental health care. General inpatient care includes room, board and hospital ancillaries; surgery; x-rays; lab tests; visits and consultations. Home health care and extended care facilities covered when alternatives to inpatient care.

Dental Care

CHILDREN: 100% coverage for preventive dental services; 80% coverage for simple and surgical extractions, oral surgery, anesthesia, restorations, emergency treatments, space maintainers, periodontics and endodontics; 50% coverage for inlays and crowns, dentures and other removable prosthetics, bridges and other fixed prosthetics, denture and bridge repair, and other prosthetics; no coverage for orthodontia.

3. A FLOOR FOR GOVERNMENT-SUPPORTED HEALTH INSURANCE.

The Commission recommends that the benefits provided through the new state program on a subsidized basis (e.g., the IBS) constitute a "floor" for all health coverage programs in Minnesota supported by state or local government. The requirement will apply to programs such as Medical Assistance amd General Assistance Medical Care. Public health coverage programs must provide benefits equal to or greater than the benefits provided through the new state program. The principle of a "floor" extends to both services that must be covered and the use of cost-sharing features such as copayments, coinsurance, and deductibles.

4. A FLOOR FOR PRIVATE HEALTH INSURANCE.

A. While the IBS is in effect.

After the IBS becomes available through the new state program but before the UBBS is available on a subsidized basis, the Commission recommends that no insurance policy may be sold to a Minnesota resident that does not, at a minimum, meet the requirements of a #2 qualified plan with a $500 deductible, as described in state insurance law and regulations.

B. Once the UBBS is in effect.

Once the UBBS level of benefits is subsidized through the new state program, we recommend that the benefits provided through the new state program constitute a floor for all private health coverage in Minnesota. All private insurance and HMO policies will provide benefits equal to or greater than the benefits provided through the new state program. The principle of a floor extends to both what services must be covered and to the use of cost-shifting features such as copayments, coinsurance, and deductibles.

5. AVAILABILITY OF THE INTERMEDIATE BENEFIT SET.

The Commission recommends that, during the period that the new state program provides the Intermediate Benefit Set rather than the UBBS on a subsidized basis, that the IBS, in addition to purchase through the new state agency, be available for purchase only through health plan companies participating in the new state program by:

- Small groups of five or fewer people.

- Individuals and families with incomes above the level entitling them to a subsidy through the new state program.

6. COVERAGE TO SUPPLEMENT THE INTERMEDIATE BENEFIT SET.

The Commission recommends that health plans participating in the new state program be required

to make supplemental coverage available to individuals and groups that have purchased the IBS. The supplemental coverage must have the effect of bringing the total coverage (IBS plus the supplement) up to the UBBS level.

Chapter 4

THE DEPARTMENT OF HEALTH CARE ACCESS

A. INTRODUCTION AND OVERVIEW.

1. INTRODUCTION.

The Commission finds that federal, state and local governments provide a bewildering array of programs that provide health coverage or health care. Many people in need of assistance must seek out multiple programs, and encounter a variety of obstacles in doing so. At least six departments of state government currently administer programs that provide health care or coverage. We find that although many programs are excellent, the overall system is intimidating and confusing to Minnesotans. Many people are unaware of programs for which they qualify, or encounter a variety of obstacles in trying to find assistance.

The Commission recommends, therefore, that the state consolidate government-sponsored health care programs in a new state agency---as described in this chapter. We recognize that some programs can be consolidated more quickly than others, and that for various reasons certain programs will need to retain distinct identities. We recommend, subject to these unique requirements, that the state pursue program consolidation in the interest of:

- Diminished overlap and complexity for clients and health care providers.

- Dimunition of the welfare stigma attached to some state programs.

- Improved efficiency and purchasing leverage for the state.

- Improved application of the state's expertise in contracting and working with health plans and health care providers.

- Improved pooling of risk.

- Broader state monitoring and analysis of health care utilization.

2. OVERVIEW OF RECOMMENDATIONS CONCERNING THE NEW DEPARTMENT.

The Commission recommends that a new agency, the "Minnesota Department of Health Care Access" (DHCA), be created to consolidate and coordinate the state's health care programs. The Department of Health Care Access does not establish a new state bureacracy---instead, it will consolidate existing state programs in a single agency. By consolidating existing programs the DHCA will be able to improve the efficency of the state's delivery of health care.

We recommend that the DHCA be established as a cabinet level department headed by a commissioner. After a transition period, the DHCA will be responsible for serving the clients now covered by the following state health care programs---to the extent that they provide personal health services. Some of these programs will retain distinct identities and/or remain in other departments, but will be closely coordinated with the new state program.

- The Minnesotans' Health Care Plan (new).

- Minnesota Comprehensive Health Association.

- The Children's Health Plan.

- General Assistance Medical Care.
- Medical Assistance.
- Maternal and Child Health---health care component.
- Services for Children with Handicaps---health care component.
- Consolidated Chemical Dependency Treatment Fund---health care component.
- Community Social Services Act county-based programs---health care component.
- Minnesota Crime Victims Reparations Board---health care component.
- Workers' compensation and auto insurance---health care component.
- Public employees health benefit programs.
- Corrections system health care programs.
- And other state and local health care and health coverage programs.

The Commission recommends that July 1, 1993 be the target date for consolidation of the programs that can be most readily merged with Minnesotans' Health Care Plan, including Children's Health Plan, General Assistance Medical Care and Minnesota Comprehensive Health Association. At the same time, close coordination of benefits and some transfers of responsibility will occur with Maternal and Child Health, Services for Children with Handicaps, the Consolidated Chemical Dependency Treatment Fund, and Community Social Services Act county-based programs.

We recommend that July 1, 1995 be the target date for consolidation of other existing programs which will require more complex planning and preparation to accomplish the consolidation or closer coordination. These programs will include Medical Assistance, the Minnesota Crime Victims Reparations Board, public employee health benefit programs (state and local), corrections system health programs, and the health care component of workers' compensation and automobile insurance coverage. We recommend that the Department of Health Care Access study and recommend changes to other state and local programs to improve the effectiveness of public health care purchasing and to streamline and consolidate government health care programs.

The Commission finds that the state's system of health plan regulation would also benefit from streamlining and consolidation. We recommend, therefore, that the state adopt the recommendations of the Minnesota Commission on Health Plan Regulatory Reform pertaining to the division of responsibility for health plan regulation. Specifically, we recommend that the Minnesota Departments of Commerce and Health develop a plan for the functional division of regulatory authority, to be submitted to the 1992 legislature.

B. A NEW AGENCY: THE DEPARTMENT OF HEALTH CARE ACCESS.

1. PURPOSE, NAME AND STRUCTURE.

The Commission recommends that a new agency be created to consolidate and coordinate the state's health plan activities. The agency will ultimately have responsibility for most of the state's health coverage programs.

We recommend that the new agency be named the Minnesota Department of Health Care Access (DHCA). We believe that this name best captures the primary mission and responsibility of the new agency.

We recommend that the DHCA be structured as a cabinet level department headed by a commissioner. We find that the department/commissioner structure will provide appropriate status and authority within the executive branch for an agency responsible for the state's health coverage programs.

2. START-UP PHASE: A BUREAU WITHIN DHS.

The Commission recommends that the Department of Health Care Access, be structured initially as a bureau of the Department of Human Services (DHS). The bureau will be headed by its own deputy commissioner appointed directly by the

Governor. We recommend that on July 1, 1993, the bureau be separated from DHS and established as an independent department. We find that such a transition phase will speed the implementation and start-up of the new department, while drawing on the expertise of DHS. We find that separation from DHS is essential, however, to minimize the welfare associations that might otherwise attach to the new program.

We recommend that DHS provide administrative and program support services to facilitate a rapid start-up of the new bureau, and that DHS be assigned sufficient resources and staff to provide the new bureau with these services. We recommend that recruitment for key personnel of the new bureau commence as soon as possible after final enactment of legislation.

3. THE NEED FOR ADMINISTRATIVE FLEXIBILITY.

A. Administrative rules.

The Commission recommends that the DHCA be granted emergency rulemaking authority for rules concerning eligibility determination, enrollment and disenrollment, premium collection, and universal coverage enforcement. We find that such authority is necessary to ensure that the new state program will be able to begin operations and extend health care coverage in a timely fashion.

B. Contracting flexibility.

The Commission recommends that the DHCA be granted substantial flexibility in contracting with health plans and health care providers. This flexibility will include the development of contract specifications and contract negotiations, subject to standards and goals established by the legislature. It will also include the ability to make judgements as to the appropriateness and timeliness of pursuing alternatives to the preferred choice of contracting with private health plan companies and organizations. This flexibility will require that the DHCA have the ability to adjust its staffing, equipment, and other resources as may be necessary to pursue the best option in a given area of the state for implementation of the new state program.

C. THE FIRST STAGE OF CONSOLIDATION.

1. PACE OF IMPLEMENTATION.

The Commission recommends that July 1, 1993 be the target date for consolidation of programs that can most readily be merged with the new program for the uninsured and the underinsured. These programs will include, but need not be limited to, the Children's Health Plan, General Assistance Medical Care, and the Minnesota Comprehensive Health Association. At the same time, the Department of Health Care Access will coordinate coverage with services covered through the Maternal and Child Health Services program, the Services for Children with Handicaps program, the Consolidated Chemical Dependency Treatment Fund, and county-based mental health care programs established under the Community Social Services Act. In some cases, funds will be transferred to the new state program as it takes responsibility for providing specific services to program clients.

2. MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION.

The Commission recommends that the Minnesota Comprehensive Health Association (MCHA) be phased out after the new state program is in full operation. The Commission finds that the new state program, together with our recommendations for underwriting and rating reform, will meet the health coverage needs of current MCHA enrollees who have been unable to obtain coverage elsewhere. We recommend that, when the phase-out occurs, current MCHA enrollees be advised about the availability of comparable coverage through the new state program (both the IBS and optional benefits) and the private market.

Under the new state program, all MCHA enrollees will have access to community rated individual premiums. In addition, those MCHA enrollees with incomes less than 275 percent of the federal poverty level, currently 48 percent of all enrollees, will receive some subsidy under the new state program sliding scale. Families that currently purchase an MCHA policy for one member of the family and another for the rest of family, approximately 23 percent of all enrollees, will move to a

single policy that includes the entire family. MCHA enrollees who are members of small employee groups may also find themselves eligible for employer subsidized coverage.

3. CHILDRENS' HEALTH PLAN.

The Commission recommends that the Children's Health Plan be merged with the new state program after it is in full operation. This recommendation is made with the understanding that the Children's Health Plan benefits will be fully incorporated in the new state program's subsidized benefit set for children ages 0 - 17. We recommend that, when the merger occurs, current Children's Health Plan enrollees will be advised about the characteristics of coverage available through the new state program, including coverage for adult family members.

4. GENERAL ASSISTANCE MEDICAL CARE.

The Commission recommends that the General Assistance Medical Care (GAMC) program be merged with the new state program after the new program is in full operation, and provided that the new state program provides comparable coverage for current GAMC enrollees. Additional coverage beyond the Intermediate Benefit Set may be necessary to maintain current benefit levels for GAMC enrollees. We recommend that no changes be made to the GAMC program or coverage for GAMC enrollees, including the GAMC spenddown provision, which will result in diminished coverage or increased financial obligations for public hospitals and other providers who currently serve GAMC enrollees.

5. MATERNAL AND CHILD HEALTH SERVICES.

The Commission finds that the new state program's coverage of prenatal and well-child care will overlap with services provided through local public health and non-profit clinics to low- and moderate-income uninsured women and children. Such services are subsidized with federal and state Maternal and Child Health (MCH) Services grants as well as local sources. We recommend that, to the extent these services overlap, the new state program assume responsibility for these services through its managed care contracts (in which some public health clinics may participate). Funding from the MCH Services program associated with prenatal and well-child care will be transferred to the new program. We also recommend close coordination between the new program, the MCH program and local public health departments in the areas of outreach, patient education, case management, and related services.

6. SERVICES FOR CHILDREN WITH HANDICAPS.

The Commission recommends that the Services for Children with Handicaps (SCH) program be merged with the new state program at the same time that the Children's Health Plan is merged. The SCH program and the Children's Health Plan are closely coordinated. SCH is a state-funded program administered through the Minnesota Department of Health that pays for services related to children's handicapping conditions on a sliding scale.

Benefits covered under the new state program at the Intermediate Benefit Set level will substitute for approximately 80 percent of the services covered by the SCH program. The remaining 20 percent provides supplemental products and services needed by handicapped children and their families but not normally covered by health insurance. The Commission recommends that when the SCH program is merged, the new state program maintain these supplemental benefits for the SCH target population.

7. CONSOLIDATED CHEMICAL DEPENDENCY TREATMENT FUND.

The Consolidated Chemical Dependency Treatment Fund (CD Fund) provides low-income, chemically dependent people with a range of health services on a sliding-scale basis, including outpatient care, inpatient care, halfway house services, and extended care. To qualify for services through the CD fund, clients are assessed and referred by an authorized counselor. To ensure objectivity in referrals, counselors cannot generally have a financial relationship with a referral provider. The CD fund is supported with state,

county and federal funds.

The Commission recommends that the CD Fund, currently administered by the Department of Human Services, be partially merged with the new state program. The extent and pace of the consolidation will depend on the degree to which the new state program covers chemical dependency services that overlap with services covered by the CD fund---and would initially include certain outpatient services. The target populations of the CD fund and the new state program overlap approximately 95 percent.

8. COMMUNITY SOCIAL SERVICES ACT COUNTY-BASED PROGRAMS.

The state makes grants under the Community Social Services Act (CSSA) to counties. Counties use these grants, along with other funds, to provide a range of social and mental health services. The Intermediate Benefit Set includes some outpatient mental health services that would overlap with services provided by counties supported through CSSA arrangements. As with the CD fund, the target populations of CSSA county-based programs and the new state program overlap approximately 95 percent.

The Commission recommends that the new state program closely coordinate its mental health benefits with CSSA county-based mental health services to ensure non-duplication of services, appropriate referrals, and efficient transfers of patients to county-based services where IBS coverage limits have been exceeded. The Commission does not recommend merger of the programs because of high level of complexity of CSSA arrangements and diverse county-based programs. However, we do recommend that, over time, refinements be made to the new state program benefit set and services supported through the CSSA to: (a) improve the new program's mental health benefits, and (b) minimize duplication with county-based programs.

9. CATASTROPHIC HEALTH EXPENSE PROTECTION PROGRAM.

The Catastrophic Health Expense Protection Program (CHEPP) was established in 1976 to provide a source of reimbursement for catastrophic health care expenses for qualifying Minnesotans. Because of budget constraints, the program has not received any state appropriations for many years. The program remains in state law (M.S. 62E.51 - 62E.55) under the jurisdiction of the Department of Human Services, but is essentially dormant. We find that the goals and scope of CHEPP are superseded by our health care access recommendations, and we therefore recommend that CHEPP be repealed.

10. HEALTH INSURANCE AND HMO REGULATION.

The Commission finds that the state's system of health plan regulation, like the state's health coverage programs, would benefit from streamlining and consolidation. We recommend, therefore, that the state adopt the recommendations of the Minnesota Commission of Health Plan Regulatory Reform that pertain to the division of responsibility for health plan regulation.

Specifically, we recommend that the Department of Commerce and the Department of Health should develop a plan for the functional division of regulatory authority. This proposal should be submitted to the 1992 legislature as part of the biennial budget process, and should be premised on the following principles:

- The primary jurisdiction of the Department of Commerce will be regulations pertaining to financial integrity and corporate structure.

- The primary jurisdiction of the Department of Health will be regulations pertaining to health care delivery and health care quality.

- Each agency should exercise its authority independently of the other to the extent possible, and avoid jurisdictional overlaps.

We recommend that the Departments of Commerce and Health be assigned sufficient resources to implement this recommendation.

D. THE SECOND STAGE OF CONSOLIDATION.

1. PACE OF IMPLEMENTATION.

The Commission recommends that July 1, 1995 be the target date for consolidation of other existing programs, for which more complex planning and preparation is required to accomplish the consolidation or much closer coordination. These programs will include, but need not be limited to, Medical Assistance---contingent on receipt of necessary congressional waivers, the health care component of the Minnesota Crime Victims Reparations Board, the health care component of workers' compensation and automobile insurance coverages, public employees health benefits programs, and corrections system health programs.

2. MEDICAL ASSISTANCE.

The Commission recommends that the Medical Assistance (MA) program be coordinated with the new state program to the greatest practical extent, consistent with the overall goals and recommendations of this report. We recommend that the state pursue congressional waivers which will allow greater flexibility of the MA program, including possible merger of coverage for certain MA populations (e.g., AFDC) and the new state program.

We recommend that, if permitted by federal requirements, the MA program eventually be administered by the Department of Health Care Access. We have no recommendation about whether all or part of the MA program should be transferred to the DHCA. Distinct issues arise with MA coverages for acute care, long-term care, and care for certain unique conditions and populations.

3. MINNESOTA CRIME VICTIMS REPARATIONS BOARD--- HEALTH CARE COMPONENT.

The Crime Victims Reparations Board, located within the Department of Public Safety, maintains a fund through which it assists victims of crime who have suffered injury or death for some of their losses/expenses. The Commission recommends that health care provided through the Crime Victims Reparations Board be coordinated with the new state program, and the managed-care health plans participating in that program.

4. WORKERS' COMPENSATION AND AUTO INSURANCE--- HEALTH CARE COMPONENT.

The Commission finds that the medical component of workers' compensation and automobile insurance contains few features of managed care, which leads to significantly higher costs than for comparable conditions when covered by a managed care health plan. We recognize the advantages of introducing managed-care features into these liability insurance systems, and of further streamlining the fragmented system of health care reimbursement. We also recognize, however, that reform and consolidation of these systems will require resolution of many complex issues.

For this reason, the Commission recommends that the Department of Labor and Industry, in consultation with the Department of Commerce, study and develop recommendations concerning the merger of workers' compensation and auto insurance medical coverages with primary health coverages, including coverages available through the new state program. For example, the study may consider the merits of requiring workers' compensation medical coverage to be separated from indemnity coverage, and sold only by HMOs, health insurers, and the new state program. Under this option, employers would still be required to purchase workers' compensation medical coverage, but could do so as a supplement or rider to the employer's primary health coverage.

5. PUBLIC EMPLOYEE HEALTH BENEFITS PROGRAMS.

The Commission recommends that the Department of Health Care Access coordinate its programs with state and local public employee health benefits programs to make the most effective use of: (a) the state's expertise in contracting and working with health plans and health care providers, and (b) the state's market leverage; as represented by the number of employees and depend-

ents covered by public employee health benefits programs.

Since public employee health benefits are subject to collective bargaining, we do not recommend that benefit levels established in these programs be subject to the jurisdiction of the DHCA, or that these programs be administered by the DHCA except by agreement of the parties.

6. CORRECTIONS SYSTEM HEALTH CARE PROGRAMS.

The Commission recommends that the Department of Health Care Access coordinate its programs with the health care programs under the jurisdiction of state and local corrections system to make the most effective use of: (a) the state's expertise in contracting and working with health plans and health care providers, and (b) the state's market leverage, as represented by the volume of health care provided through the corrections system.

We do not recommend that health care programs under the jurisdiction of the corrections system be subject to the jurisdiction of the DHCA, or that these programs be administered by the DHCA except by agreement of the parties.

7. OTHER STATE AND LOCAL HEALTH CARE PROGRAMS.

The Commission recognizes that the list of state and local health care and health coverage programs described in this chapter is incomplete. We recommend that the Department of Health Care Access identify, analyze, and recommend changes to other state and local health care and health coverage programs to improve the effectiveness of public health care purchasing, and to streamline and consolidate government health care programs.

8. FEDERAL HEALTH COVERAGE PROGRAMS.

The Commission recommends that the Department of Health Care Access pursue partnerships and waivers with federal health coverage programs that will further the state's health care access goals. We recognize that it is difficult to amend a federal program to meet the objectives of any one state, but also recognize that federal programs, especially Medicare, play a major role in Minnesota's health care system. As the state makes progress in the consolidation and improvement of its health coverage programs, it may be appropriate to extend those reforms to federal programs that have a significant Minnesota presence.

Chapter 5
HEALTH INSURANCE REFORM

A. INTRODUCTION AND OVERVIEW.

1. INTRODUCTION.

The Commission finds that the health insurance market for individual and small group coverage is in a state of crisis. Insurers have responded to the pressure to contain costs by using underwriting, the practice of determining who to accept or reject for coverage, to exclude Minnesotans with health care needs. Stringent underwriting is fueled by competitive pressures: tougher underwriting standards create a healthier pool of insureds and better profits. A company with less stringent standards than its competitors may need to have higher, less competitive rates to pay for its comparatively less healthy pool.

Underwriting has reached a stage where a high percentage of people are denied coverage, face exclusions for preexisting health conditions, or must pay the higher-than-market premiums in the state high-risk pool. Minnesota's high-risk pool, the program to serve people turned down for coverage by insurers, is now the largest in the nation---and the program continues to grow.

As a result of aggressive underwriting practices in the individual and small group markets, insurers compete more on the basis of attracting the healthiest mix of enrollees than on the basis of managing health care well. These practices discriminate against women, older persons and Minnesotans with health problems and disabilities. As an example, women pay the full costs of childbearing in their health care premiums. Therefore, health insurance coverage is significantly more expensive for women.

Competitive pressures have also led insurers to contain costs by excluding preexisting conditions from coverage. These exclusions mean that an individual's health insurance does not cover specified medical conditions diagnosed prior to obtaining the policy. For example, a policy may exclude services related to preexisting high blood pressure, such as drugs to control high blood pressure, or treatment of a heart attack. This practice often excludes from coverage precisely those conditions for which the individual needs to receive health care.

Insurers' methods for developing premium rates also contribute to problems in the marketplace. Historically, insurers offered community rates---the same rate for each person. Experience rating, the practice of charging groups a premium based on their actual claims experience, has become increasingly common in recent years. While experience rating may work for groups large enough to maintain fairly stable rates from year to year, it leads to erratic increases for small employers. Small group experience rating, together with aggressive underwriting, have led to an extremely unstable market for small employers.

Experience rating also affects individuals purchasing insurance, where rates are developed based on the experience of a class of persons---mainly according to age and sex. While individual experience rating may have merit in other lines of insurance, we find that it is discriminatory as applied to health care---a basic human need. We believe that the costs of sickness should be shared equitably by all of society.

2. OVERVIEW OF RECOMMENDATIONS CONCERNING INSURANCE REFORM.

To respond to the crisis in the health insurance market the Commission recommends a major set of reforms. The reforms apply to coverage pur-

chased by individuals and families, small groups of up to 29 people, and, in some cases, to medium-sized groups of 30-99 people. The reforms apply to coverage obtained through the new state program and through the private insurance market.

The Commission recommends that the new state program and health plan companies operating in Minnesota be required to accept all individuals, small and medium-sized groups who apply for coverage. Insurers will no longer be able to deny coverage or cancel coverage on the basis of health status or exclude coverage for preexisting conditions.

The Commission believes that health care is a public good, and that health care financing should be shared equitably by all members of society---rather than on the basis of individual health care needs. Therefore, we recommend that health plan companies establish premium rates for all coverage purchased by individuals, families and small groups on a "community rated" basis. Under community rates, the same premium will apply to all individuals and small groups covered by a given insurer regardless of age, sex, or health history. We recommend that an adjustment mechanism be established to protect companies who enroll a disproportionately large number of high-cost people (as determined by demographic factors). Finally, we also recommend that premium rate variations for medium-sized groups (30-99) be restricted to a smaller range than now occurs, to provide greater rate stability and predictability for employers.

The Commission recommends that the Minnesota Departments of Commerce and Health be allocated sufficient resources and authority to enforce these changes in underwriting and rating practices. We also recommend that the Department of Health Care Access develop recommendations to reduce administrative costs resulting from health insurance claims processing and data collection.

3. PACE OF IMPLEMENTATION.

The Commission recommends that reforms of health insurance rating, underwriting, and reinsurance practices take effect beginning on July 1, 1992 for new policies issued, and upon renewals occurring thereafter for existing policies (except policies issued on a guaranteed renewable basis).

We acknowledge that certain arrangements may be necessary to diminish the possibility of undesirable consequences that may arise from the transition to the new practices. Such arrangements may include:

- A mechanism whereby the state and health plan companies participating in the new program will share responsibility for inaccurate community rates in the initial year of the program.

- A phase-in of the community rating requirement over a period of time.

B. THE SCOPE OF INSURANCE REFORM RECOMMENDATIONS.

1. THE NEW STATE PROGRAM AND THE PRIVATE MARKET.

The Commission finds that the new state program and the private market will provide alternative and potentially competitive sources of coverage for many individuals and groups. In order for the new state program and the private market to coexist without either taking undue advantage of the other, we recommend that the same basic underwriting, rating, and reinsurance standards apply to both. Accordingly, in this chapter our recommendations apply to both the new state program and the private market except where explicitly stated otherwise. This chapter will use the following definitions in making these distinctions:

- "Private market" refers to health coverage provided directly by a health plan company to an individual or group, without going through the new state program.

- "Health plan company" refers to a licensed insurer, health maintenance organization, nonprofit health service plan corporation (e.g., Blue Cross and Blue Shield of Minnesota), or similar company that is subject to state regulations. It does not refer to self-insured plans that are not subject to state regulations.

2. INDIVIDUAL AND SMALL-GROUP COVERAGE.

The Commission finds that significantly different conditions prevail in the markets for: (a) individuals and small groups, and (b) medium-sized and larger groups. We also find that the problem of access to affordable and adequate health coverage is greatest for individuals and small-groups. Accordingly, the recommendations in this chapter apply only to individual and small group coverage, whether obtained through the new state program or the private market, except where explicitly stated otherwise. This chapter will use the following definitions in making these distinctions:

- "Individual" refers to people who apply for coverage as individuals or family units, rather than as part of a group, and includes individuals who apply for Medicare-supplement coverage.

- "Small group" refers to employment-based groups of no less than two employees, including the owner, and no more than 29 employees---the level below which self-insurance becomes rare.

- "Medium-sized group" refers to employment-based groups of no less than 30 employees and no more than 99 employees. The upper limit of the medium-sized group definition is set at the level above which the market reforms proposed for this category will be inadequate to prevent a significant trend toward self-insurance.

- "Large group" refers to employment-based groups of 100 employees or more.

The recommendations in this chapter apply only to health plan companies that participate in the relevant segment of the market. Specifically, recommendations concerning the individual market affect only companies participating in the individual market, and likewise for the small-group market, the medium-sized group market, and the large-group market.

3. SMALL-GROUP COVERAGE IN THE NEW STATE PROGRAM.

The Commission recognizes that many people change employment fairly frequently. The committee recommends, therefore, that coverage in the new state program be issued on an individual basis to members of small groups. This will enhance the portability of coverage for people who leave a group, and diminish administrative costs for the new state program associated with frequent reissuing of policies.

4. MEDIUM-SIZED GROUPS.

The Commission believes that many employers would benefit from extension of the community rating and related reforms to medium-sized and large groups. But because such reforms may lead some employers to remove their groups from the community rate through self-insurance, the resulting community rate may suffer from adverse selection and instability. For this reason, we recommend more modest reforms for medium-sized groups. We also recommend, however, that the Department of Health Care Access explore various options for including medium-sized and, potentially, large employers in a community rate and related reforms, including: (a) options under the current structure of the federal ERISA law, and (b) options which would be possible if the federal ERISA law were changed.

5. LARGE GROUPS.

The Commission recommends no change in the premium rate development standards now applicable to large groups. Current rate development standards will apply to coverage provided through the new state program or through the private market.

C. UNDERWRITING REFORM.

1. GUARANTEED ACCEPTANCE AND NON-CANCELLATION.

The Commission recommends that all individuals, small groups, and medium-sized groups have guaranteed access to health care coverage. The new state program and health plan companies in the private market must accept and extend coverage to all individuals, small groups, and medium-sized groups that apply. Coverage cannot be cancelled if an enrollee incurs a high level of health care expenditures, but may be cancelled (in

the private market) for non-payment of premium or copayments, fraud or misrepresentation, noncompliance with plan provisions, or failure to maintain participation requirements.

2. NO PREEXISTING CONDITION RESTRICTIONS.

The Commission recommends that coverage for individuals, small groups, and medium-sized groups be available on the same basis for all applicants. Coverage provided through the new state program and the private market will not be subject to restrictions, waiting periods, or exclusions based on the health status or health care utilization of any individual.

3. UNDERWRITING RESTRICTIONS FOR OPTIONAL COVERAGE.

The Commission recognizes that the underwriting reform recommendations will work best for coverage that is universal. To the extent that coverage is optional, we recognize that coverage costs may rise and availability decrease if people are allowed to purchase coverage only during periods of illness. To guard against this, we recommend that preexisting condition waiting periods of up to 12 months be permitted for optional coverage. Preexisting condition restrictions will not be permitted, however, at the time people initially enroll for Intermediate Benefit Set (IBS) coverage or for people who maintain certain optional coverage continuously in force and merely change from one insurer to another.

4. AGENT COMMISSIONS SPREAD EVENLY OVER TIME.

To promote greater stability in the private health coverage market and diminish incentives for agents to change clients' health plan companies every few years, the Commission recommends that the state: (a) prohibit agent commissions for all private market coverage from being weighted in the initial years of a policy, and (b) require that commissions be spread evenly over a minimum of the first five years. We also recommend that health coverage within the new state program not be obtained on a commission basis.

5. AGENT REWARDS AND PENALTIES NOT BASED ON UNDERWRITING RESULTS.

The Commission recommends that health insurers and HMOs that serve the individual, small group, and medium-sized group markets be prohibited from either rewarding or punishing agents and brokers for the underwriting results of the business they bring to the plans.

D. PREMIUM RATING REFORM.

1. COMMUNITY RATING.

The Commission believes that health care is a public good, and that health care financing should be shared by all members of society---rather than on the basis of individual health care needs. Therefore, we recommend that health plan companies establish premium rates for individuals and small groups on a "community rated" basis.

A. Mechanics of community rating.

Under community rating, the same premium rate will apply to all individuals and small groups covered by a given health plan company regardless of age, sex, prior health care utilization or other factors now commonly applied in premium rate development. The community rate will not vary geographically within Minnesota, but will take into account differences in benefit levels under different contracts. The only rate cells permitted under community rating will be: (1) one person, (2) two-person family, and (3) family of three or more persons.

The Commission recommends that each health plan company use all health care cost experience for individual and small group coverage in developing its community rate, including experience from policies with different benefit levels. A separate community rate will apply to Medicare-supplement coverage.

B. Differences in administrative costs.

The Commission recommends that differences be permitted in the community rate applicable to individuals and small groups to reflect reasonable

differences in acquisition costs and ongoing administrative costs associated with the two classes of business.

C. Self-care premium discounts.

As stated earlier, the Commission recommends that small discounts be permitted in premium rates for individuals or small groups to provide incentives for self-care activities. The decrease in premium revenues resulting from such discounts will require a slightly higher base rate. Such discounts will be small, consistent with the purpose of providing modest incentives to take care of one's health, rather than providing a mechanism for reintroducing actuarially-based rating factors. The factors will be optional and may vary from company to company.

2. BIASED SELECTION ADJUSTMENT MECHANISM.

The Commission finds that, under community rating, some health plan companies may attract a mix of enrollees that is more or less likely than the average to incur high health care costs ("biased selection"). This may lead to some health plan companies being rewarded or penalized on the basis of biased selection, rather than on the basis of their relative efficiency.

A. Adjustment mechanism.

To reduce the effects of biased selection, we recommend that a biased selection adjustment mechanism be established for all individual and small group coverage. The adjustment mechanism will apply to both the new state program and the private market. Under the mechanism, each health plan company will receive a payment or an assessment based on the age and sex of its enrollees in comparison to the statewide norm. A company with a higher-than-average proportion of probable high-cost enrollees, based on demographic factors, will receive a payment. A company with a lower-than-average proportion of probable high-cost enrollees will receive an assessment.

B. Refinements to the mechanism.

We recommend that, to the extent possible, the biased selection adjustment mechanism take into account the effect of:

- Differences in coverage levels.
- Community-rated Reinsurance Pool premiums.
- Managed-care activities which affect costs, including the relative efficiency of different health plan companies.

The adjustment formulas will be refined over time if additional enrollee information with significant predictive power can be efficiently collected and applied. We also recommend that, to the extent possible, the adjustment mechanism be structured to avoid rewarding a health plan company that experiences adverse selection if the selection results from the company's lesser skills in managing care---which may attract enrollees who prefer plans that allow higher utilization.

3. LIMITED RANGE OF RATES FOR MEDIUM-SIZED GROUPS.

The Commission recommends that each health plan company establish a single base or average premium rate for all medium-sized groups. Health plan companies will be permitted to vary the base rate for specific groups based on group characteristics, including experience and demographic factors. Base rates will also vary for differences in benefit levels and other product differences.

No group will be permitted to have a rate that is more than 30 percent above or below the base rate. Year-to-year changes in the rate for any one group will be limited to changes in the base rate (i.e., trend) plus 15 percent. These rate development standards will apply to coverage provided through the new state program or through the private market. All health plan companies will be required to maintain detailed descriptions of their rating methodology, including actuarial justifications.

4. MINIMUM LOSS RATIOS.

The Commission recommends that minimum loss ratio standards be established for all health coverage sold in Minnesota. These standards will be developed by the Department of Commerce and the Department of Health, and may differ for distinct classes of business (individual, small group, etc.).

5. PREMIUM RATES FOR THE NEW STATE PROGRAM.

A. Community rates.

The Commission recommends that health plan companies that participate in the new state program apply the same community rate to individual and small group enrollees for coverage extended: (1) through the new state program, and (2) through the private market.

B. Administrative costs.

The Commission recommends that the new state program assign its acquisition and overhead costs to premium in a way that will put it on parallel footing with the private market. Acquisition and overhead costs closely associated with the broad mission of the new state program, and different from costs commonly incurred by health plan companies, will not be assigned to premium costs. All costs will be reported in the overall budgeting of the Department of Health Care Access.

E. ENFORCEMENT ISSUES.

1. INCREASED ENFORCEMENT CAPABILITY.

The Commission recognizes that the underwriting and rating reform recommendations may, if implemented, lead to efforts to circumvent them. We recommend, therefore, that the state agencies responsible for insurance and HMO regulation be allocated sufficient staff, budget, and rulemaking authority to permit adequate enforcement of the new requirements.

2. ANTI-DISCRIMINATION PROVISIONS.

The Commission recommends that the state human rights laws regarding disability discrimination be amended and enforced as necessary to provide an effective deterrent to employers shifting the costs for higher-risk individuals from an employee benefits program to the new state program.

3. DEFINITIONS OF GROUPS BY SIZE.

To avoid employers altering, re-forming, or redefining their employee groups for the express purpose of taking advantage of or avoiding community rating, the Commission recommends that large, medium-sized and small groups be defined by Internal Revenue Code (IRC) sections 414(b), 414(c) and 414(m). These provisions of the IRC are designed to prevent employers from artificially changing group size for the purpose of avoiding the impact of certain pension fund requirements. In addition, the Commission recommends that the Departments of Health Care Access, Commerce and Health be granted sufficient regulatory authority to prevent groups from qualifying as large, medium-sized or small through the use of: (a) separate organizations, (b) multiple organizations, (c) employee leasing, or (d) other arrangements.

F. ADMINISTRATIVE COSTS REFORM.

The Commission finds that health plan companies and health care providers incur significant costs in recording health care information and submitting it to government, insurers, and other third-parties. We recommend that the Department of Health Care Access investigate these costs and requirements, and recommend reforms that may reduce these costs without compromising the purposes for which information is collected.

We recommend that the DHCA develop recommendations concerning: (1) establishment of standard claim forms for ambulatory care by July 1, 1993, and (2) establishment of standards for certain types of utilization review procedures (e.g., preadmission certification) by July 1, 1994. The design of such standards should not limit innovation and improvement in health care delivery management.

Finally, we also recommend that the DHCA implement methods to streamline public sector data collection to minimize additional administrative burdens on health plans, health care providers, public programs, and the health care delivery system as a whole.

Chapter 6

HEALTH CARE DELIVERY RESEARCH AND DATA INITIATIVES

A. INTRODUCTION AND OVERVIEW.

1. INTRODUCTION.

As a society we spend a tremendous amount of money on health care. In Minnesota alone, total 1990 health care expenditures are estimated to be in the range of $9 to $10 billion. Yet despite this high level of expenditures, there is little consensus about what we are getting in return, about the efficiency and effectiveness of care. (By "efficiency" we mean the extent to which an appropriate service is provided for the least cost, and by "effectiveness" we mean the extent to which a service is of high quality and has the desired outcome.)

Despite evidence that some procedures are unnecessary or of marginal benefit, and a lack of evidence about the efficacy and appropriateness of many other procedures, progress in improving efficiency is proceeding very slowly. There is a growing sense of crisis about health care costs on the part of employers, labor, government and consumers. Health plans and health care providers are beginning to respond to these concerns, but many purchasers remain frustrated by the pace of change. Significant research efforts have been initiated to advance the *state of the art*, but results so far have been limited. To the extent that some results have been achieved by health plans or provider organizations, application and broad dissemination is often limited by the proprietary and competitive restrictions.

Our health care system may be the most advanced in terms of procedures and technologies, but it is far from advanced in its capacity to use limited resources wisely. The introduction and use of expensive, high-technology equipment and procedures continues at a rapid rate, in excess of the state's reasonable needs. Minnesota, with its population of 4.3 million, contains more high-technology equipment such as Magnetic Resonance Imaging (MRI) and Shock Wave Lithotripsy machines than all of Canada, with its population of 26.3 million (6 times more than Minnesota).

In addition to inadequate knowledge about the effectiveness and appropriateness of various procedures and technologies, growth in health care expenditures is fueled by: (1) the demands and expectations of patients, (2) "defensive medicine" by providers, prompted by malpractice concerns, (3) incentives associated with fee-for-service reimbursement, which remains widespread, and (4) the increasing numbers of older Minnesotans. We discuss some of these issues in chapter 10 of this report---"Vision for the Future." Regardless of the precise mix of factors driving the growth in health care costs, underlying them all is the fact that, as a society, we have yet to come to grips with the need to limit our health care appetite, to make difficult but necessary choices based on what we can afford rather than what we want.

2. OVERVIEW OF RECOMMENDATIONS CONCERNING HEALTH CARE RESEARCH AND DATA.

The Commission recommends that the state invest in activities that will address these concerns, and that may lead to improvements in health care efficiency and effectiveness. Such activities will be designed to serve the needs and applications of: (1) public health programs, (2) health care providers, including providers who serve a large number of low-income people, (3) health plan companies, (4) employers and other

purchasers of health care and health plans, and (5) the general public.

Specifically, the Commission recommends that the Department of Health Care Access, through a health care analysis unit, undertake statewide data initiatives to collect uniform health care data in the public domain as a foundation for health care research and analysis. We recommend that data related to health outcomes be a research priority, and that data be collected on the basis of specific health conditions rather than specific procedures or services. The health care analysis unit will also use the state's existing health care data, new data bases developed by the DHCA, and other appropriate public and private data sources.

The health care analysis unit will work closely with the private sector to promote the widest possible application of methods to improve the efficiency and effectiveness of health care. The DHCA will assist consumers and employers by providing them with information about premiums, benefit levels, managed-care procedures, health care outcomes, and other features of health plans and health care providers in a format which can be easily understood and interpreted by laypersons.

The Commission recommends that planning and preparation for these data and research initiatives take place from July 1991 through June 1992, with implementation to begin in July 1992. We recommend that the DHCA plan to make public initial findings of its research in January 1994.

3. PACE OF IMPLEMENTATION.

The Commission recommends that planning and preparations for the Department of Health Care Access' data and research initiatives take place from July 1, 1991 to June 30, 1992, with implementation to begin on July 1, 1992. We recommend that the DHCA plan to make public initial findings of the data and research initiatives on January 1, 1994.

B. RESEARCH AND DATA PRINCIPLES AND APPLICATIONS.

1. PRINCIPLES OF RESEARCH AND DATA INITIATIVES.

The Commission recommends that the health care research and data initiatives recommended in this chapter be pursued in accordance with the following principles:

- Accelerated pace of research. The initiatives are intended to promote a significantly accelerated pace of publicly disseminated applied research concerning health care delivery, outcomes, costs, quality and management. The initiatives will promote new applied research and improvements in health care delivery based on existing research.

- Scientific soundness. The initiatives are intended to conduct and promote health care research applications based on scientifically sound methods.

- Continuous improvement in health care delivery. The initiatives will promote improvement in the efficiency and effectiveness of health care delivery systems rather than adopting a punitive focus directed at the providers of health care.

- Statewide in scope. The initiatives will be statewide in scope to ensure that data will benefit health care purchasers and providers in all parts of Minnesota, and to ensure a broad and representative data base for research, comparisons and applications.

- Public domain. Data produced through the initiatives will be in the public domain, with appropriate safeguards for patient and health care provider confidentiality. Where appropriate, health care providers and health plan companies will have an opportunity to respond to findings prior to public dissemination. The initiatives may supplement private activities, but may also be duplicative if necessary to ensure that data will be in the public domain.

- Non-redundant. Consistent with the overall goals, the initiatives will: (a) emphasize data that is useful, relevant, and not redundant of data already available from other sources, and (b) be structured to minimize additional administrative

burden on health plans, health care providers, and the health care delivery system.

2. APPLICATIONS OF RESEARCH AND DATA INITIATIVES.

A. General applications.

The Commission recommends that initiatives in health care data collection, analysis, and dissemination be designed to serve the needs and applications of: (a) public health care programs, (b) health care providers, including providers who serve a large number of low-income people, (c) health plan companies, (d) employers and other purchasers of health care and health plans, and (e) the general public. The initiatives will be executed to promote the interest of all of these parties in improving the efficiency and effectiveness of health care.

B. Public health care programs.

Concerning public health care programs specifically, the Commission recommends that data and research initiatives be designed to serve the following purposes:

- Health care delivery and purchase. The initiatives will assist the state's current health care financing and delivery programs, and the new state program to deliver and purchase health care in a way that promotes improvements in health care efficiency and effectiveness. For example, data elements may include: (1) information concerning diagnosis and procedure utilization by beneficiary and provider, and (2) data on which to judge quality and effectiveness of care, such as complication rates, drug interactions, and health care outcomes. These types of data will permit the state to refine its judgements about coverage, and to provide a more rational basis by which to purchase care---by quality and cost.

- Public health. The initiatives will assist the state in its public health activities, including analysis of disease prevalence and trends, and development of public health responses. Data on disease prevalence, for example, will permit effective monitoring of the remainder of the system to ensure that trends are monitored, that public health responses are timely, appropriate and effective, and that the remainder of the delivery system deals effectively with the public health needs of the state.

- Health policy development. The initiatives will assist the state to develop and refine its overall health policy, including policy affecting health care costs, quality and access. They will also assist the state in monitoring the quality of care and the utilization/cost experience across the range of delivery mechanisms/managed care providers under contract with the state.

- State program evaluation. The initiatives will provide a vehicle and a solid data source to support the evaluation of state health care financing and delivery programs.

C. A NEW RESEARCH INITIATIVE BASED ON OUTCOMES OF HEALTH CARE.

The Commission finds that while some large-scale data bases exist within state health care systems, they are limited by: (a) different programs collection of different data; (b) the incompatibility of different programs' data systems; (c) the existence of data for some clients but not others (e.g., data may be unavailable for Medical Assistance clients after they enroll in HMOs); and (d) the lack of necessary data, including data on case mix/severity of illness, outcomes, access and satisfaction.

For these reasons, we find that a new initiative to establish a large-scale data base is necessary to achieve the state's data and research goals. However, we also find that large-scale data bases limited to claims and other "administrative" data yield modest benefits in relation to the high volume and expense of data collected. Therefore, the Commission recommends that the state establish a large-scale data base for a limited number of health conditions, subject to the following terms and principles:

- Outcomes information. Collection of data related to health outcomes is a research priority. Outcomes data collected through the initiative will include information about the effects of medical treatment on: (a) mortality, (b) patient functional status and quality of life, (c) symptoms, and (d) patient satisfaction. Some outcomes information (e.g., health and functional status, patient satisfac-

tion) will be collected directly from patients, and over a period of time following medical treatment. The initiative will emphasize comparisons based on outcomes, rather than comparisons based primarily on an existing practice standard or protocol.

• Condition based. The data collected will be based on specific health conditions, rather than specific procedures or services. The intent of this emphasis is to direct analysis to appropriate and effective treatment of given conditions.

• Case-mix information. The data collected will include information necessary to measure and make adjustments for differences in the severity of cases treated by different health care providers. This may involve collection of data derived directly from the patient, or the medical record.

• High total-cost conditions. The initiative will emphasize conditions which account for significant total costs, considering both the frequency of the condition and the unit costs of treatment. The Commission recommends that the initial emphasis of data collection be on conditions commonly treated in hospitals, either on an inpatient or an outpatient basis. The Commission recommends that, as better data collection and evaluation techniques are developed, the emphasis be expanded to entire episodes of care for given conditions, whether or not treatment includes use of a hospital.

• Data aggregation and comparison. Data will be collected in a manner which will permit aggregation by provider, health plan company, public program, patient characteristics, and other significant bases of comparison.

• Duration of data collection. Data collection for any one condition will continue for sufficient time to permit adequate analysis, feedback to providers, and monitoring for practice pattern changes. Over time, conditions for which data is collected will be added and dropped, based on changes in condition prevalence, medical practice, costs of procedures, and other relevant factors.

• Data collection procedures. The agency responsible for data collection will determine the appropriateness of collecting information: (a) through health care providers or health plan companies, or (b) directly by the agency or its contractors. The Commission recommends that the agency receive any necessary authority to conduct data collection in the most cost-effective manner (e.g., patient identification, mailing lists, cooperation in data compilation).

D. OTHER RECOMMENDED DATA AND RESEARCH INITIATIVES.

1. HEALTH CARE ANALYSIS UNIT.

The Commission recommends that the Department of Health Care Access include a health care analysis unit to undertake data and research initiatives. The health care analysis unit will use the state's existing health care data, new data bases recommended in this chapter, and other appropriate public and private data sources to conduct new applied research, and to promote applications based on existing research that will improve the efficiency and effectiveness of health care. The unit will work closely with the health plans and health care providers under contract with the new agency to promote the widest possible applications of successful methods and approaches.

The unit will evaluate the state's new and existing health care financing and delivery programs, both internally and through external contracts, where appropriate. Evaluation will include the following criteria: access to care, effectiveness of care (including health outcomes), and cost. For some measures, client and provider satisfaction will be an additional criterion.

2. PROMOTION OF DATA INITIATIVES THROUGH STATE CONTRACTS.

The Commission recommends that, in addition to other data initiatives recommended in this paper, the Department of Health Care Access require health plan companies participating in the new state program to collect and submit data that will lead to health care delivery improvements in the program. The DHCA's health care analysis unit will use the data to work closely with the health plans and health care providers under contract with the agency to promote the widest possible application of methods to improve the efficiency and effectiveness of health care.

3. USE OF EXISTING PUBLIC-SECTOR DATA BASES.

The Commission recommends that, in addition to the condition-specific data base, maximum use be made of existing public-sector data bases, including data collected for the Medicare and Medical Assistance programs. We recommend that all public-sector data bases, both current and future, be used to accomplish the state's health care data and research goals. We recommend that the Department of Health Care Access establish explicit linkages and integration among public-sector data bases.

4. PERIODIC SURVEYS.

The Commission recommends that the Department of Health Care Access conduct periodic surveys to further the state's health care data and research goals, including but not limited to the following types of surveys:

- Health plan enrollees. The DHCA may conduct surveys of health plan enrollee satisfaction, including perceptions about a plan's handling of: enrollee questions and complaints, specialist referrals, complex or high-cost cases, out-of-area services, emergency and urgent care, and specific types of conditions such as chemical dependency, back pain, and mental illness.

- Health care patients. The DHCA may conduct surveys of patient satisfaction with health care providers, such as: adequacy of attention from nursing and medical staff, clarity and completeness of instructions and explanations, waiting times, staff courtesy, and perceptions of overall health care quality.

- Health insurance and access to care. The DHCA may conduct surveys to monitor changes over time in access to care (both financial and geographic) and sources of health coverage among Minnesota residents.

- Health service prices. The DHCA may conduct surveys of health service prices, especially for services less commonly covered by health insurance, and/or for which patients commonly face significant out-of-pocket expenses.

- Health plan prices. The DHCA may conduct surveys of health plan prices, especially for health plans commonly sold on a community-rated or table-rated basis. Even under community rates, health plan prices will vary for different insurers and different benefit levels.

- New procedures. The DHCA may conduct surveys of health care providers to determine what new procedures and treatments are being provided, as a basis for considering changes in the benefits provided by state health coverage programs. The findings of such surveys will be used in the deliberations of the Technology and Benefits Advisory Committee.

We recommend that the DHCA receive any necessary authority to conduct surveys in the most cost-effective manner (e.g., patient identification, mailing lists, cooperation in data compilation).

5. TECHNICAL ASSISTANCE FOR PURCHASERS.

A. Health plans.

The Commission finds that many individuals and employers find shopping for health plans a confusing and even intimidating chore. Health plans have many complex features, and premium comparisons are further complicated by experience or table rating. These complications will be diminished by reforms in underwriting and rating practices (chapter 5), but may still be confusing to many. Most health plan purchasers are also unable to interpret technical information that may be available about different companies' procedures and experience in health care management, quality assurance, and outcomes.

We recommend that the Department of Health Care Access provide technical assistance interpreting the data, including claims experience, for employers, consumers, and other health plan purchasers. The DHCA will assist individuals and employers by regularly:

- Collecting information about premiums, benefit levels, managed-care procedures, health care outcomes, and other features of popular health plans and health plan companies. And,

- Publicizing the information in a format which can be readily understood and interpreted by

laypersons.
Previous surveys by the Minnesota Department of Health have indicated a high level of interest in such assistance.

B. Health services.

The Commission recommends that, for services less commonly covered by health insurance and/or for which patients commonly face significant out-of-pocket expenses (e.g., dental care, chemical dependency services), the state:

- Collect information about health service prices, outcomes, level of provider experience or frequency of providing the service, and other significant features, with an emphasis on services covered to different degrees by health plan companies. And,

- Publicize the information in a format which can be readily understood and interpreted by laypersons.

6. ESTIMATES OF STATEWIDE HEALTH SERVICES EXPENDITURES.

The Commission finds that up-to-date, Minnesota-specific estimates of total health service expenditures and sources of payment are unavailable. Such estimates were prepared by the University of Minnesota Division of Health Services Research and Policy from 1981 through 1985 with the sponsorship of a Bush Foundation grant, but have not been updated since that time. We believe that such estimates serve an important purpose in monitoring trends in Minnesota's health care system, including the effects of changes recommended by the Commission. We recommend, therefore, that such estimates be prepared regularly by the Department of Health Care Access. If possible, estimates of statewide expenditures should be made available by population and service characteristics.

7. STATE/PRIVATE PARTNERSHIPS.

The Commission finds that many worthwhile data initiatives are underway in Minnesota's private sector. These include initiatives sponsored by health plan companies, health care providers, and statewide and national associations and task forces. We recommend that the state seek to participate as a partner or sponsor in such initiatives if: (a) the private organizations are interested in and would benefit from the state's participation, and (b) such participation would promote publicly disseminated applied research concerning health care delivery, outcomes, costs, quality and management.

Chapter 7

HEALTH CARE ACCESS IN RURAL MINNESOTA

A. INTRODUCTION AND OVERVIEW.

1. INTRODUCTION.

Inadequate or no health insurance constitutes a financial barrier to health care access. As indicated in the findings of the Commission's household survey, several regions in greater Minnesota have disproportionate shares of uninsured individuals. Several predominantly rural areas also have disproportionate shares of residents who purchase individual insurance---which usually costs more and covers less than group insurance.

Under the Minnesotans' Health Care Plan, health coverage will be available to people at each income level at a price they can reasonably afford through individual premium subsidies. Although cost is the primary barrier to access for many Minnesotans, we recognize that there are other obstacles to access, especially in rural Minnesota. The recommendations in this chapter acknowledge that these barriers also need to be addressed as part of ensuring access to health care.

The Commission finds that the rural health care system in Minnesota is in a state of transition. Regional health centers are assuming an increasingly prominent role, especially in the provision of specialty care. Many smaller communities face difficulties in attracting and retaining health personnel. Lower Medicare reimbursement rates for rural providers, coupled with the high percentage of Medicare recipients in rural areas, place an added strain on the health care system.

We recommend that the following priorities guide the state's policies to ensure access to health care in greater Minnesota.

- Adequate access to care. Ensure adequate access to health care services in rural Minnesota, with emphasis on primary care and emergency services.

- Adequate supply of health personnel. Ensure an adequate supply of health care personnel to provide these services.

- Planning assistance. Provide local communities with state assistance for planning and decision-making concerning access to health care.

2. OVERVIEW OF RECOMMENDATIONS CONCERNING RURAL HEALTH CARE.

The Commission recommends that a Rural Health Advisory Committee be established to advise the Department of Health Care Access and other relevant state agencies on rural health issues, and to facilitate a more systematic approach to rural health planning among local communities.

The Commission finds that access to health care is under pressure in some parts of rural Minnesota due to health personnel shortages, financial pressures facing small hospitals, and other related factors. To respond to these changes affecting the rural health care delivery system, we recommend that the *hub and spoke* model be considered as a basis for providing access to health services in some areas of rural Minnesota.

In this approach, a larger rural hospital (e.g., 75 beds) and clinic would serve as the *hub* of a system and provide care for a fairly broad array of services. The *spokes* would be constituted by smaller configurations of providers including solo practitioners and satellite clinics staffed by physician assistants, nurse practitioners and nurse

midwives. We believe that this approach would provide a sound strategy for the effective utilization of smaller health care facilities and available health personnel in parts of rural Minnesota. Within this context, the Commission supports efforts to maintain the financial viability of the *spokes*.

The Commission recommends that the state provide assistance for rural health care in the following ways: (1) provision of planning and transition grants to rural hospitals, providers and communities, (2) technical assistance to facilitate local planning and coordination regarding the delivery of health services, (3) subsidies to isolated hospitals in danger of closing, (4) financial assistance for medical education, including support for training programs on-site in rural areas, (5) development and maintenance of a data base on rural health personnel, (6) technical assistance to rural communities for health personnel recruitment, and (7) assistance in funding a telecommunications network to facilitate rural health education and health care delivery.

The Commission supports efforts to improve Medicare reimbursement rates as they affect rural health care providers. We also support efforts to improve the overall level of Medical Assistance (MA) reimbursement rates, which should enable more rural providers to participate in the MA program and/or accept additional MA patients.

The Commission recommends that state regulations regarding the licensure and supervision of health personnel, such as physician assistants and nurse practitioners, be changed to facilitate greater utilization of their services in rural Minnesota.

B. ISSUES FACING RURAL HEALTH CARE.

1. POPULATION AND ECONOMIC INFLUENCES.

The Commission finds that in recent years changing demographic trends and less favorable economic conditions have contributed to concerns about the accessibility of health services in parts of rural Minnesota. These trends have a substantial impact on the rural health care system and access to care.

Population declines have occurred in certain counties and elderly residents constitute a higher percentage of the population in the non-metropolitan areas of the state. These trends have resulted in lower occupancy rates and revenues for rural hospitals, with higher costs per admission.

Economic conditions in many areas of rural Minnesota also influence the rural health care system. Low commodity prices, high interest rates and falling land values affect incomes in farm communities. The mining and manufacturing industries in rural Minnesota have also experienced difficulties. These factors diminish the ability of some rural communities to finance health care facilities and recruit needed personnel.

2. KEY OBSTACLES TO ACCESS IN RURAL MINNESOTA.

The Commission finds that the following conditions represent serious issues for the rural health care system in parts of Minnesota.

A. Health personnel shortages.

Many rural communities in Minnesota face a severe health personnel shortage. A majority of all hospitals and clinics in rural Minnesota are actively recruiting physicians, particularly family practitioners. There is also a shortage of nurses, nurse practitioners, nurse midwives and other nursing personnel, physician assistants and other allied health personnel for existing employment opportunities. The health personnel shortage also affects hospitals---without an adequate supply of physicians and other primary care providers many rural hospitals may be forced to close.

B. Financial condition of rural hospitals.

Many rural hospitals throughout the state are financially troubled due to declining hospital utilization and decreased revenues. A number of rural hospitals are financially vulnerable and may be forced to close in the near future. While some closures may be inevitable and do not pose a threat to adequate health care access, the loss of other hospitals may pose a serious danger to access.

C. The effect of Medicare reimbursement levels.

Medicare, the largest source of reimbursement to rural providers, pays rural hospitals and physicians significantly less than their urban counterparts, although their costs are often comparable. These reimbursement rates increase the financial vulnerability of rural hospitals and contribute to the already difficult task of recruiting physicians, nurses and other health personnel.

C. BUILDING THE FUTURE RURAL HEALTH CARE SYSTEM.

1. PRIORITIES FOR A SYSTEM IN TRANSITION.

The Commission finds that the rural health care system in Minnesota is in a state of transition. We recommend that the following priorities guide the state as it develops and implements policies to ensure access to health care.

- Adequate access to care. Ensure adequate access to health care services in rural Minnesota, paying particular attention to access to certain basic services such as primary care and emergency services.

- Adequate supply of health personnel. Ensure an adequate supply of health care personnel to provide these services.

- Planning assistance. Provide local communities with state assistance for planning and decision-making related to geographic access.

2. "HUB AND SPOKE" MODEL.

The Commission finds that access to health care is under pressure in some parts of rural Minnesota due to health personnel shortages, financial pressures facing small hospitals, and other related factors. To respond to these changes affecting the rural health care delivery system, we recommend that the *hub and spoke* model be considered as a basis for providing access to health services in some areas of rural Minnesota. Variations of this approach should also be investigated in terms of their appropriateness for other areas of the state.

In the hub and spoke model, a larger rural hospital (e.g., 75 beds) and clinic would serve as the *hub* of a system and provide care for a fairly broad array of services. The *spokes* would be constituted by smaller configurations of providers including solo practitioners, satellite clinics staffed by physician assistants, nurse practitioners, and nurse midwives, and small hospitals and medical facilities which would provide primary and emergency care for a limited number of days. Such facilities would be staffed by a smaller number of physicians and have fewer beds.

3. RURAL HEALTH ADVISORY COMMITTEE.

The Commission recommends that a Rural Health Advisory Committee be established to advise relevant state agencies on rural health issues and to facilitate a more systematic approach to rural health planning among local communities, including the following activities.

- Build cooperation. The committee will develop and evaluate mechanisms to facilitate greater cooperation among rural communities and among providers.

- Sensitivity to local needs. The committee will recommend and evaluate approaches to rural health issues that are sensitive to local community needs.

- Adequate access. The committee will explore ways of identifying "underserved" Minnesotans in the context of the rural health care system. The perspectives of consumers and providers will be included in assessments of what constitutes adequate access to health care services.

- Future impact. The committee will evaluate and recommend changes related to the MFHP in light of its future impact on the rural health care system.

The committee will consist of laypersons, rural health care providers, experts on rural health, and community leaders from rural Minnesota. Committee members will be appointed by the Governor. The Department of Health Care Access will make recommendations for committee membership. We recommend that the committee be

created and commence operations on January 1, 1992. The committee will advise and receive support services from the DHCA.

4. STATE ASSISTANCE FOR RURAL HEALTH CARE.

A. Planning and transition grants.

The Commission recognizes the need for rural hospitals, providers and communities to engage in planning to evaluate their various roles in the rural health care system. To support these activities, we recommend that the state provide planning and transition grants to rural hospitals, providers and communities. Such grants may be used for planning regarding the use of facilities, the recruitment of health personnel, and the coordination of health services.

B. Technical assistance.

The Commission recommends increased technical assistance to facilitate local planning and coordination regarding the delivery of health care services. Assistance could be provided by public and private sources, and could include, but would not be limited to: (1) assistance with needs assessment, (2) studies of utilization of hospitals, (3) evaluation of primary care, emergency services and outcomes, and (4) information on how to secure resources for projects.

C. Subsidies to hospitals.

As a transitional strategy, the Commission recommends that the state provide financial subsidies to a limited number of isolated rural hospitals in danger of closing without financial assistance, and only after all local sources of support have been exhausted. The purpose of the subsidies would be to preserve access in certain areas of Minnesota.

D. Financial assistance for medical education.

The Commission recommends that the state continue to provide financial assistance to students pursuing health careers through such programs as the Rural Physicians' Associates program, the Next Step Program for Pediatric Residency Training, and grant programs for registered nurses and licensed practical nurses.

E. Technical assistance for health personnel recruitment.

The Commission recommends that the state provide technical assistance to rural communities in their efforts to hire physicians and other health personnel through the development of a statewide, coordinated recruitment strategy.

F. Data base on health personnel.

The Commission recommends that the state develop and maintain a data base on health services personnel. This information will be used by local communities and the state to develop plans for recruitment and retention of health personnel.

G. Education programs in rural communities.

The Commission recommends that the state provide health education and training programs on-site in rural areas as a way of attracting and retaining health personnel in those locations.

H. Changes in reimbursement systems.

The Commission supports efforts to improve the differential urban-rural Medicare reimbursement rates as they impact on rural health care providers, particularly hospitals and physicians.

We recognize that Medical Assistance reimbursement policies for physicians' services do not distinguish between urban and rural areas of the state. However, we are concerned about the overall levels of Medical Assistance reimbursement rates throughout the state and how they may contribute to the difficulty of ensuring adequate access to health care in areas facing shortages of physicians and other health personnel. We support efforts to improve the overall level of Medical Assistance reimbursement rates. We also support efforts to modify Medical Assistance reimbursement rates that distinguish between classes of providers in order to increase the availability of health personnel such as physician assistants, nurse practitioners, and nurse midwives.

I. Regulatory and licensing changes.

The Commission recommends that state regulations regarding the licensure and supervision of health personnel like physician assistants and nurse practitioners be changed to facilitate greater utilization of their services in rural Minnesota. Changes related to their scope of practice, the amount of on-site physician supervision, and dispensing of medications could contribute to the provision of health care in rural areas.

J. Use of telecommunications.

The Commission recommends that the state provide assistance in funding telecommunications systems to facilitate rural health education and health care delivery. A telecommunications network could support alternative approaches to providing health care by creating opportunities for regular consultations between providers in different communities. It would enhance the diagnostic process and contribute to the delivery of effective emergency medical services.

Chapter 8

HEALTH CARE COST CONTAINMENT

A. INTRODUCTION.

This chapter summarizes features of the Commission's recommendations that address health care cost containment, features distributed throughout the body of the report. It also contains one new recommendation concerning a Health Care Expenditures Advisory Committee to assist the Department of Health Care Access in limiting total statewide health care costs.

Together, these recommendations provide a solid foundation to reform the health care system which addresses both cost containment and health care access. Too often in the past, cost containment efforts have simply resulted in thousands of Minnesotans being deined access to basic, necessary health care. The Commission recommends significant steps to contain health care and administrative costs, while ensuring that all Minnesotans have basic health care access.

The Commission recognizes that all parties in the health care system share responsibility for increases in health care expenditures, and must share in the solution. This summary chapter is organized accordingly, with cost containment recommendations that primarily affect: (1) government health programs, (2) health insurers and HMOs, (3) health care providers, and (4) consumers and patients. The initial section of the chapter describes the role of the Health Care Expenditures Advisory Committee.

B. HEALTH CARE EXPENDITURES ADVISORY COMMITTEE.

1. COMMITTEE ESTABLISHMENT.

To continue the progress on reform of the health care system begun by the Commission's recommendations, the Commission recommends that a Health Care Expenditures Advisory Committee be established with support from the Department of Health Care Access. The Committee will include representatives of health insurers, other health plans, government health programs, health care providers, and consumer groups. Committee members will be appointed by the Governor. The Department of Health Care Access will make recommendations for Committee membership. We recommend that the Committee be created and commence operations on January 1, 1992.

2. STATEWIDE LIMIT ON HEALTH CARE SPENDING.

The Commission recommends that the Health Care Expenditures Advisory Committee advise the DHCA concerning establishment of an overall, statewide limit on public and private health care spending, and subsequent limits on annual increases in health care spending. All participants in the health care system in Minnesota will be required to take action necessary to ensure that total health care spending, and increases in spending, remain within the overall limits established by the DHCA.

3. ADDITIONAL REFORM OF THE HEALTH CARE SYSTEM.

The Commission recommends that the Health Care Expenditures Advisory Committee also be charged to study and recommend additional reform of the health care delivery system in Minnesota, and to submit recommendations for reform to the legislature on January 1, 1993. The Committee will solicit comments, advice, and participation in its deliberations from the many communities with an interest in accessible, affordable health care.

C. GOVERNMENT HEALTH PROGRAMS.

1. FOSTER AN EXPANDED ROLE FOR MANAGED-CARE ORGANIZATIONS.

The Commission recommends the new state program control health care costs through managed-care organizations, such as HMOs and PPOs, the types of health plans that have proven most efficient in providing and insuring health care. These types of health plans are a key strength of Minnesota's health care delivery system. Use of these plans for the new state program---with a potential enrollment of 500,000 or more---will foster their continued growth throughout Minnesota, as well as lower costs for the state.

The opportunities presented by the new state program may lead to the creation or expansion of managed-care organizations in areas of the state not currently served by them. In areas of the state where managed-care organizations are unavailable, or where satisfactory proposals to the new state program are not forthcoming, the Department of Health Care Access will pursue the direct establishment of managed-care arrangements with health care providers.

2. IMPROVE THE STATE'S ABILITIES AS A HEALTH CARE PURCHASER.

The Commission recommends that the Department of Health Care Access include a *Health Care Analysis Unit.* This unit will promote the application of health care research and managed-care techniques with the health plans and health care providers under contract with the DHCA. The goal of the unit will be to advance the *state of the art* for managing care throughout Minnesota, and especially in state-sponsored programs. The unit will develop specifications concerning effective case-management systems, applications of standards of practice, and related measures for inclusion in the DHCA's contracts with health plans and health care providers.

3. CONSOLIDATE THE STATE'S HEALTH CARE PROGRAMS.

The Commission recommends that most of the state's health care programs be consolidated in a new Department of Health Care Access. Currently six different state agencies administer health care or health coverage programs. Consolidation will yield a variety of efficiencies, including: (a) more effective use of the state's bargaining leverage in health care purchasing, (b) wider application in health care purchasing of the state's health care research and analysis capabilities, (c) reduced overlap and duplication in administrative functions, (d) improved service to citizens through reduced program variety and complexity, and (e) improved service and lower administrative costs for health care providers through streamlining and standardization of programs.

D. HEALTH INSURERS AND HMOS.

1. MANAGE COSTS INSTEAD OF SHIFTING THEM.

The Commission finds that, in the 1980's, much health care cost containment consisted of little more than shifting costs to consumers and diminishing access to care. With the guarantee of universal access and the insurance reforms recommended by the Commission, cutting people out of the system will no longer be an option. The insurance reforms will change underwriting and rating practices to allow all citizens, including those with less than perfect health histories, to obtain adequate and affordable health coverage. With all Minnesotans included in the health care system, insurers' future cost containment efforts

will focus on managing care and limiting administrative costs, rather than on simply shifting costs or avoiding coverage of people considered to be bad risks.

2. CONTROL ADMINISTRATIVE COSTS.

The Commission recommends that reforms be adopted to limit expenditures on administrative costs by health insurers and HMOs, including costs associated with underwriting, premium rate development, claims processing and data collection. Reforms to current underwriting and rating practices will diminish the cost and complexity associated with insurance marketing and enrollment. Development of standard forms and procedures for outpatient and clinic claims, utilization review and data collection will also diminish administrative costs for insurers and HMOs.

E. HEALTH CARE PROVIDERS.

1. UNDERTAKE RESEARCH TO IMPROVE HEALTH CARE DELIVERY.

The Commission recommends that the Department of Health Care Access undertake significant new research and data collection initiatives concerning health care delivery and outcomes of care. The centerpiece of these initiatives will be a large-scale data project for a limited number of health conditions. The project will emphasize high total-cost conditions and health outcomes associated with medical treatment, including mortality, patient functional status and quality of life, symptoms, and patient satisfaction. Research findings will be available in the public domain to promote advances in the efficiency and effectiveness of care.

2. ENSURE COST-EFFECTIVE MANAGEMENT OF HIGH-COST CASES.

The Commission finds that a limited number of high-cost cases represent a large share of total health care expenditures. Careful and efficient management of such cases may have a significant and beneficial effect on the total costs of the new state program. To provide for such management, the Commission recommends that a Reinsurance Pool be established and administered by the Department of Health Care Access.

The DHCA will contract with a case management company (or companies) to oversee, coordinate and, in a limited number of cases, assume responsibility of treatment plans for cases for which the Reinsurance Pool is liable. In addition to ensuring efficient treatment of high-cost cases, the Reinsurance Pool will provide a mechanism to ensure that all of society shares in bearing the costs for, and making priority decisions about, the most expensive conditions.

3. ENSURE A BALANCE BETWEEN PRIMARY CARE AND CATASTROPHIC CARE.

The Commission finds that with increases in the cost, capabilities and technological sophistication of health care, high-cost cases are claiming an increasing share of all health care expenditures. We recommend, therefore, that expenditures for high-cost cases be capped at a fixed percentage of total health care benefits. A Technology and Benefits Advisory Committee will determine the level of this cap and refinements to it over time. The Committee will also evaluate and recommend changes in other benefits, especially for expensive new procedures and technologies.

4. REDUCE ADMINISTRATIVE COSTS.

Minnesota health care providers face burdensome administrative requirements connected with multiple billing and regulatory systems. The Commission recommends that reforms be adopted to reduce the administrative burden on health care providers, including costs associated with claims processing, utilization review procedures and data collection. Development of these reforms, including standard forms and procedures for outpatient and clinic claims, utilization review and data collection, will be a responsibility of the Department of Health Care Access.

5. ENCOURAGE EFFICIENT USE OF RURAL HEALTH CARE RESOURCES.

The Commission finds that demographic trends and less favorable economic conditions have contributed to concerns about the accessibility of health services in parts of rural Minnesota. To ensure that rural health care resources are used as efficiently as possible, the Commission recommends that the *hub and spoke* model be considered as a basis for providing access to health services in some areas of rural Minnesota. Under this model, a larger rural hospital and clinic would serve as the *hub* of the system, and the *spokes* would be constituted by smaller hospitals, solo practitioners, and emergency care providers. The efficiency of such a model may be enhanced by other, related Commission recommendations, including improvements in the rural telecommunications network and regulatory changes permitting a broader scope of practice for physician assistants and nurse practitioners.

F. CONSUMERS AND PATIENTS.

1. ENABLE PATIENTS TO OBTAIN PREVENTIVE CARE AND EARLY MEDICAL INTERVENTIONS.

Inadequate or no health coverage discourages many Minnesotans from obtaining health care for minor conditions until they become major. The Commission's universal coverage recommendations will have direct and tangible cost savings in the form of reduced emergency room visits and high-cost, crisis health care. The recommended benefit design in the new state program emphasizes coverage of primary and preventive care, rather than catastrophic care only, to enhance the effectiveness of early medical interventions and to prevent minor problems from becoming major.

2. ENCOURAGE GREATER PATIENT RESPONSIBILITY.

The Commission recommends that the new state program require participating health plans to have programs to educate consumers about appropriate use of the health care system. Such programs could include self-care education, telephone nurse access, and encouragement of healthy lifestyles and conformance with prescribed courses of treatment. We also recommend that small premium discounts be permitted to encourage self-care activities. Health plans participating in the new state program will also encourage greater patient responsibility by coordinating referrals, hospitalizations and other care patients receive through a specific primary care clinic.

3. CONSUMER CHOICE OF HEALTH PLANS.

Consumers' ability to choose among two or more health plans in many areas of the state will foster competition among health plans based on efficiency, quality and member service. Price differences among plans will be passed along to consumers. The experience of large employers has shown that consumers are very sensitive to such price differences, and that this sensitivity can result in heightened competition.

Chapter 9
COSTS, REVENUES AND SAVINGS

A. COSTS AND REVENUES OF THE MINNESOTANS' HEALTH CARE PLAN.

1. NEW PROGRAM COST ESTIMATES.

The Commission was charged with developing a plan to insure the uninsured with a net cost to the state of $150 million. In accordance with the charge, the total cost to the state to provide subsidized coverage to the uninsured through the Minnesotans' Health Care Plan will be $144 million. This estimate is based on a total state cost for the uninsured of $171 million, offset by $27 million in transfers from current expenditures from existing state programs.

The Commission recommends that the legislature also provide subsidized coverage to people who currently have individually-purchased policies, many of whom have low incomes and are underinsured, at a cost to the state of $140 million. This estimate is based on a total state cost for the individually insured of $149 million, offset by $9 million in transfers from current expenditures from existing state programs.

The state's total net costs for both groups is $284 million ($144 million + $140 million). Program enrollees will contribute $134 million, or 30 percent in aggregate, toward the cost of their own coverage. Total program expenditures including enrollee payments, state payments, and existing program transfers, are $454 million.

These cost estimates are centered on January 1, 1991. Actual state costs during the biennium of July 1, 1991 through June 30, 1993 are considerably less, and depend on the pace of implementation. Full program costs will not be incurred until the new state program is fully operational and the universal coverage requirement is in effect. The Commission recommends that the new program be in full operation beginning July 1, 1993.

These cost estimates are based on a total subsidized enrollment of 415,000, which includes all uninsured (209,000) and individually-insured (206,000) people within the range of the sliding scale, adjusted to reflect enrollment in Medical Assistance by eligible families. The estimates are based on a monthly premium of $101 for a one-person household, $202 for a two-person household, and $303 for a household of three or more, and a sliding scale of premium subsidies that caps at 6.5 percent of gross income and 275 percent of the federal poverty level.

The estimated premium is based on the Intermediate Benefit Set. The premium is also adjusted for community rating, which has the effect of pooling expected claims for all individual and small group coverage in Minnesota.

The estimated premium is adjusted to reflect the possible higher costs associated with groups that will be covered through the new program, including many current MCHA enrollees and the uninsured themselves. An adjustment of this type is made on the advice of the Commission actuary. The Commission moderated the degree of adjustment based on its judgement about the degree to which the uninsured and individually-insured populations are likely to differ from the statewide norm in health status. This judgement relies on the findings of the household survey, and the experience of other states which have established programs for the uninsured.

2. COMPARING ADMINISTRATIVE COSTS.

The estimated premium includes a 15 percent factor for administrative costs, as recommended by the Commission's actuarial firm. Actual costs vary among Minnesota HMOs from 9 to 16 percent of total premiums; higher percentages are generally required for individual and small-group coverage. We believe that this administrative costs factor is a conservative but reasonable estimate of the costs necessary to implement the new state program. The administrative costs factor will include program administration costs of the Department of Health Care Access, including costs pertaining to outreach, enrollment, premium collection, and related services. It will also include adminstrative costs incurred by health plans participating in the new state program.

In studying private and public health programs and delivery systems, the Commission found a wide variation in administrative costs---from a low of 4-5 percent for Minnesota's Medical Assistance program, to highs of over 20 percent in some private insurance plans. Much of the difference in administrative costs is caused by differences in the functions performed by the various programs. Public programs are often able to forego certain administrative costs such as outreach, marketing, premium collections, and certain data collection and analysis functions.

Taking the MA program as an example, much of the program's *customer* base is self-made. Approximately three-quarters of MA participants become enrolled by virtue of first enrolling in one of the cash assistance programs. Others are referred by social service and health care providers seeking assistance for their clients. The MA program collects no premium from enrollees, and does not perform other member service, provider relations, and health care research and analysis functions that are performed by many private plans. The MA program is administered very efficiently, but is not comparable to private plans in many important respects.

3. COSTS OF OTHER COMMISSION RECOMMENDATIONS.

Funding for the Commission's recommended data and research initiatives and support for geographic access activities will be separate from the costs directly associated with adminstration of the new state program. We estimate that the combined cost of these recommendations, once in full operation, will be in the range of $1-3 million per year.

B. CHANGES TO EXISTING PROGRAMS AND SYSTEM-WIDE SAVINGS.

The Commission's recommendations are designed to result in a more affordable, equitable and efficient health care system. Consequently, some current costs in the health care system will be relieved. A list of significant transfers and savings is outlined below, dividing according to: (1) existing programs, short-term transfers to the new state program; (2) systemwide savings; and (3) existing programs, longer-term transfers to, or increased coordination with, the new state program.

1. EXISTING PROGRAMS, SHORT-TERM TRANSFERS TO THE NEW STATE PROGRAM.

This category refers to existing state health care and health coverage programs that the Commission recommends be consolidated, in whole or part, with the new state program during its initial years of operation. In this context, existing program "transfers" refer to the state appropriations currently going to these programs, which would subsequently be transferred to the new state program.

At least 75 percent (conservatively), or $27 million, of these expenditures provide services or coverage for people who are otherwise uninsured. The remaining $9 million benefit people with individually-purchased policies which do not provide adequate coverage for the services covered by these programs.

The estimated transfers described in this section are based on the continuation of current eligibility standards, covered services, and state budget levels for these programs. Any significant changes in the current terms of these programs would affect the size of estimated transfers.

$11.6 million	Children's Health Plan.
$9.4 million	Medical Assistance---reduced state spenddown expenditures.
$9.4 million	GAMC---reduced state spenddown expenditures.
$3.4 million	Consolidated Chemical Dependency Treatment Fund---reduced state expenditures for outpatient chemical dependency services.
$1.9 million	Services for Children with Handicaps---reduced state expenditures for children's health services.
$1.0 million	Maternal and Child Health (MCH)---reduced state expenditures for prenatal care through MCH-supported clinics.
$36 million	Total (approximate, estimates subject to refinement)

A. Children's Health Plan.

The Intermediate Benefit Set includes all Children's Health Plan (CHP) benefits for children under age 18. The merger of CHP and the new state program will result in a reduction in the funding necessary for CHP in the merger year---recommended to begin July 1, 1993. CHP's projected 1991 enrollment and budget are approximately 15,500 children and $4.9 million. In 1993, the year the Commission recommends that the CHP and the new state program merge, the projected enrollment and budget for the CHP are 31,900 and $11.6 million. The large increase is due to scheduled CHP eligibility and benefit expansions.

B. Medical Assistance.

Medical Assistance (MA) and the General Assistance Medical Care (GAMC) program have what is called a "spenddown" provision. This provision allows an individual to qualify for MA (or GAMC) on a temporary basis by offsetting the amount of medical bills against the person's income. The "spenddown amount" is the amount of incurred health care debts for which the individual is responsible, and is equal to the difference between the enrollee's income and the income level the family would have to meet to qualify for the regular MA program.

To some degree, IBS coverage under the new state program will substitute for care now covered through the MA spenddown provision. We estimate that this transfer of responsibility will result in a reduction of state MA expenditures of approximately $9.4 million, based on 1991 figures. This reduction may be tempered over time to the extent that people exhaust their benefits under the new state program and then spend down to take advantage of MA's more comprehensive benefits.

The MA program may also see some reduction in expenditures for the "qualified working disabled" category as a result of the Commission's recommendations. Employers who have employees with disabilities are now often unable to obtain affordable health coverage. The recommended underwriting and community rating reforms may enable such employers to begin or expand employee health benefits. Employment-based coverage could, therefore, replace MA coverage for some people in this category.

The Commission's survey of Minnesotans' insurance status found approximately 26,000 uninsured people living in families with children, the key requirement for AFDC eligibility, with incomes at or below the basic MA income standard---approximately 60-80 percent of poverty, depending on family size. An additional 6,000 uninsured children fell within the slightly higher income eligibility standards applicable to children---185 percent of poverty for children 0 to 1; 133 percent of poverty for children 1 to 5; and 100 percent of poverty for children 6 to 7. These people would be expected to enroll in MA following the introduction of the universal coverage requirement. The increased costs associated with this enrollment are within the range of enrollment increases currently projected and budgeted by the Department of Human Services for the next several years, or approximately 10,000 per year.

C. General Assistance Medical Care.

Uninsured and underinsured working poor adults who currently "spend down" to GAMC during periods of high health care costs will no longer need to do so after the new state program is in

operation. Approximately $12.5 million of GAMC's projected 1991 budget will go toward providing health care for people in this category. If the GAMC spenddown provision is retained after the new state program is introduced, GAMC spenddown expenditures would be reduced by approximately 75 percent, or $9.4 million.

D. Consolidated Chemical Dependency Treatment Fund.

The Consolidated Chemical Dependency Treatment Fund (CD Fund) is composed of: (1) state appropriations, (2) part of the federal Alcohol, Drug Abuse and Mental Health block grant, (3) county funds, and (4) collections from clients, insurers and MA. Each county can draw upon the fund up to an annual limit set by formula. The CD Fund pays providers who serve clients approved by the counties under the CD Fund's rules. In turn, the CD Fund bills the referring counties 15 percent toward the amount of each payment. Counties are required to expend a minimum amount on the CD Fund each year, also set by formula.

During fiscal year 1990, 35 percent of people served through the CD Fund were placed in outpatient settings. Payments to providers equaled $13.8 million. The Commission recommends that one-fourth of the CD Fund's budget for payments to outpatient treatment providers, or $3.4 million, be transferred to the new state program. This recommendation is conditioned on continuation of 1990 budget levels for the CD fund.

E. Services for Children with Handicaps.

The Intermediate Benefit Set includes many of the health services currently provided by the state-funded Services for Children with Handicaps (SCH) program. The Commission recommends that $1.9 million, or approximately 80 percent of the SCH health services budget, be transferred to the new state program. The remaining 20 percent would continue to be used to provide supplementary care to the program's target population.

F. Maternal and Child Health.

The Commission recommends that approximately $1 million of the state and federal Maternal and Child Health (MCH) and Community Health Services (CHS) funds used to provide prenatal care for low-income women be transferred to the new state program. The remaining funds would continue to be used for other MCH and CHS services that are not part of traditional insurance benefits.

2. SYSTEMWIDE SAVINGS.

This category refers to savings in the overall health care system which we envision will result from the Commission's recommendations. The primary types of savings are: (a) diminished uncompensated or charity care costs for uninsured and underinsured patients; (b) lower health care costs through wider use of managed-care techniques, and (c) broad, public health and system reform savings.

The latter category is not quantified in the following table, but includes some of the most significant (but difficult to quantify) benefits of the Commission's recommendations, including: improved public health, increased productivity and fewer days lost to illness, diminished use of public assistance programs, lower administrative costs for health care providers, and other benefits of improved access to health care.

$3 - $5 million	Minnesota Comprehensive Health Association (based on 10 - 20 percent savings due to managed care)
$35 - $175 million	Workers' compensation insurance---health care component (based on 10 - 50 percent savings due to managed care)
$21 - $42 million	Automobile insurance---health care component (based on 10 - 20 percent savings due to managed care)
$150 million	Charity care costs---hospitals, clinics, other
$11 million	Community Social Services Act county-based programs---mental health care
$220 - $383 million	Total (approximate, estimates subject to refinement)

If the indicated systemwide savings are achieved as a result of the Commission's recommendations, as we envision they will be, total savings will equal approximately $220 - $383 million per year---an amount that may equal or exceed the new state program's total costs. These savings will not accrue directly to the state to reduce the program's expenditures, but they are an important indication of the capacity for streamlining and improved efficiency in the overall health care system. These estimates do not include savings associated with broad public health and health care delivery reforms.

A. Minnesota Comprehensive Health Association.

The Minnesota Comprehensive Health Association (MCHA) is funded by: (a) enrollee premiums, which are set at 125 percent of the prevailing market rate, and (b) deficit assessments against insurance companies and HMOs doing business in Minnesota. Deficit assessments have been as high as $27 million in recent years.

After the new state program is introduced, the cost of providing care for high-cost MCHA enrollees will be spread across all community rated individual and small group policies. The absence of an explicit assessment for high-cost enrollees will benefit employers with insured groups of 30 or more, who will no longer be subject to MCHA assessments on their policies.

MCHA is administered as a fee-for-service program with no network of health care providers and relatively few managed-care features. We estimate that broader application of managed-care systems and procedures to the current MCHA population will result in systemwide savings of, conservatively, 10 - 20 percent.

B. Workers' compensation insurance---health care component.

The health care component of workers' compensation insurance in Minnesota accounts for $350 million in costs. A recent study by the Minnesota Department of Labor and Industry ("Health Care Costs and Cost Containment in Minnesota Workers' Compensation," March 1990) found that:

- Minnesota's workers' compensation health care costs are growing significantly faster than general health care costs.

- For similar injuries, health care charges in Minnesota are higher for injuries covered by workers' compensation than for injuries covered only by health insurance (based on Blue Cross and Blue Shield of Minnesota).

- Workers' compensation charges for back disorders, the most common workplace injury, are more than *twice* as high as charges for the same injury when covered only by health insurance (Blue Cross).

Based on this study, we estimate that broader application of managed-care systems and procedures to work-related injuries will result in significant systemwide savings, equal to at least 10 percent and potentially as much as 50 percent of current expenditures. If a managed care system reduces costs 10 percent below the level of the current fee-for-service system, total savings would be approximately $35 million; at 50 percent savings would be $175 million.

State government has a direct share in these costs, and in potential savings. State and local governments' workers' compensation medical expenses total $43 million, with state employees responsible for 25 percent of this total and local governments' employees 75 percent. The state shares in local governments' costs through its aid to schools, cities and counties. Using this same 10 - 50 percent estimate of the potential savings of moving to managed care, workers' compensation medical reform would result in direct savings to the state of $2 - $11 million per year. Local governments would save an additional, comparable amount.

C. Automobile insurance---health care component.

The health care component of automobile insurance in Minnesota accounts for $208 million in costs. If a managed care system were able to reduce costs 10 - 20 percent below the level of the current fee-for-service system, total savings would be approximately $21 - $42 million.

State government's direct share in these savings would be relatively small. Most of the medical claims of state and local employees are covered by workers' compensation insurance since accidents in government-owned vehicles are most

likely to occur while people are on the job. The savings to the state would be a fraction of the state's workers' compensation savings cited in the previous section.

D. Charity care---general.

Hospitals, clinics and independent practitioners provide uncompensated care to some clients. Based on Minnesota Health Department data, we estimate that private hospitals in Minnesota are providing approximately $100 million in uncompensated or *charity* care to uninsured and underinsured patients during 1990. Hospitals should experience a savings close to this amount, since the IBS includes coverage for most inpatient costs, including maternity care which absorbs a high proportion of hospital-based charity care.

We estimate that private clinics and practitioners, including physicians and other health care providers, provide their low-income uninsured and underinsured patients another $30-50 million in free care, most of which will now be covered by the new state program. The vast majority of uncompensated care will no longer exist under the Commission's universal coverage recommendations.

E. Charity care---local governments.

Currently, local units of government throughout the state use their tax dollars to provide personal health services through public health departments and contracts with local private non-profit providers. Care provided through the new state program will substitute for much of this care.

The city of St. Paul, Ramsey County and Hennepin County had a combined 1989 expenditure of $22 million for uncompensated care (included in part in the overall charity care figure). For the most part recipients were uninsured and underinsured, low and moderate income people seeking preventive or acute care at one of the two county hospitals, a public health department clinic or a community clinic. The majority of funds went for care provided by Hennepin County Medical Center and St. Paul Ramsey Medical Center.

F. Community Social Services Act county-based programs.

The legislature provides an annual block grant to counties under CSSA that they use, along with their own tax dollars and federal CSSA block grants, to fund social services not covered by categorical grants. The Department of Human Services, which administers the state's block grants, estimates that during 1989 counties used approximately $19.7 million of their combined discretionary funds to provide outpatient mental health services, most of which would be covered under a typical health insurance policy. The $19.7 million includes $3.1 in state block grants, $13.8 in county tax funds, and $2.7 in federal block grants.

Counties may experience an overall savings of approximately $11 million as the IBS outpatient mental health benefit of 10 hours substitutes for care provided through CSSA funds to people who are low income and currently under and uninsured.

G. Cash assistance programs.

The STRIDE program assists caretakers in AFDC recipient families who are at risk for long-term dependence on AFDC to assemble the education, job skills, family stability, child care and other resources needed to make the transition to employment and economic dependence. The guaranteed availability of health coverage through the new state program may give participants in the STRIDE program an additional incentive in their transition to employment. A modest decrease in state cash assistance costs for the STRIDE program may result from the creation of the new state program.

The new state program is likely to have only a small impact on the tenure of other AFDC recipients. Families currently receiving assistance through AFDC cite issues such as inadequate education, job skills, and child care services as more significant barriers to leaving AFDC than lack of health coverage. The availability of affordable health insurance is only likely to give parents an incentive to leave AFDC when it is combined with solutions to the other, more pressing, problems they face.

The decision to apply for cash assistance involves the same complex and interrelated issues that govern the decision to leave it. Since the need for

health coverage appears to be of only moderate importance, we estimate that the presence of the new state program will have only a modest effect on applications for family cash assistance.

3. EXISTING PROGRAMS, LONGER-TERM TRANSFERS TO OR INCREASED COORDINATION WITH THE NEW STATE PROGRAM.

This category refers to existing state health care and health coverage programs that the Commission recommends be consolidated or more closely coordinated with with the new state program after its initial years of operation. Again, existing program "transfers" refer to the state appropriations currently going to these programs, which could subsequently be transferred to the new state program.

$368 million	Medical Assistance---subject to obtaining waivers (for families and children only, excludes MA for aged, blind and disabled)
$132 million	General Assistance Medical Care (state and county share)
$1 million	Crime Victims Reparations Board
$6 million	Corrections system health care programs
$500 million	Public employees health benefits programs
$350 million	Workers' compensation insurance---health care component
$208 million	Automobile insurance---health care component
$1500 million	Medicare---and other federal programs, subject to waivers
$3 billion	Total (approximate, estimates subject to refinement)

C. RECOMMENDED SOURCES OF ADDITIONAL NEEDED REVENUES.

1. ISSUES IN EVALUATING REVENUE SOURCES.

The Commission used the following objectives to develop its recommendations regarding the sources of additional needed revenues.

- Has sufficient revenue raising capacity in total, together with other revenue sources.
- Is consistent with health care efficiency goals.
- Is politically acceptable.
- Maintains the competitive position of Minnesota's business community, considering the costs and benefits of the program.
- Is a stable revenue source, in the sense that it is likely to grow with the program.
- Is (or could be) a dedicated revenue source.
- Is as progressive a revenue source as possible.
- All segments of the population share equitably in the financing burden.
- Is consistent with supporting employers' current role in providing health insurance for employees and their dependents.

Based on these objectives, the Commission recommends that the legislature consider the following sources of revenue, singly or in combination, for funding our recommendations. The options are listed in rank order of priority, beginning with the source of revenue that we consider has the greatest merit.

2. INCOME TAX— INCREASED PROGRESSIVITY.

The Commission believes that, as a broad public good, health care should be funded from a broad-based and equitable tax. The individual income tax meets these criteria best. It has the advantages of a broad base, equitable distribution of

costs, and progressivity. On the other hand, it could not be used as a dedicated funding source, and may face significant political obstacles, especially if the income tax figures prominently in the legislature's 1991 plans for other state programs. On balance, however, we believe that the individual income tax be the legislature's first priority for funding the new state program.

Rather than an across-the-board increase, we recommend that additional revenues be raised by increasing the progressivity of the income tax. Minnesota's individual income tax underwent a major structural reform in 1987, including:

- Adopting changes made by the federal Tax Reform Act of 1986, making Minnesota's individual income tax consistent with federal income tax in most respects.

- Changing the starting point for computation of the tax from federal adjusted gross income to federal taxable income, thereby adopting the federal standard deduction, itemized deductions, and personal exemptions.

- Simplifying the tax brackets to two beginning in 1988---6 and 8 percent, plus an additional amount for higher-income people. This additional tax was restructured in 1988 in the form of an 0.5 surtax up to a certain income level, and a flat tax on very high incomes.

The tax brackets are as follows for single persons and married persons filing joint returns:

Tax Rate/ Amount	Single Persons	Married/ Joint Return
6.0%	$1 - 13,000	$1 - 19,000
8.0%	$13,001 - 42,700	$19,001 - 75,000
8.5%	$42,701 - 93,000	$75,501 - 165,000
8.0%	$93,001 +	$165,001 +

The income tax could be made more progressive by increasing the tax for higher-income persons but not for people with lower incomes. The following examples show how much revenue could be raised from higher tax brackets for higher-income persons, based on fiscal year 1991 figures.

New tax rates (current are 6.0 / 8.0 / 8.5)	New revenues	Overall pctg. increase in income tax revenues
6.0 / 8.5 / 9.0	$105 million	3.4
6.0 / 8.5 / 9.5	$116 million	3.7
6.0 / 9.0 / 10.0	$222 million	7.2

3. SALES TAX---HEALTH SERVICES.

A sales tax on health care services is the Commission's second priority for meeting the new state program's funding needs. The following are some of the reasons for giving a high priority to a health services sales tax.

- Avoids "windfall" to providers. A health services sales tax would recapture monies now applied to charity care for uninsured people---estimated to be in the range of $150 million in Minnesota. In the absence of such a tax, and with establishment of a universal coverage program, these monies would return to hospitals, clinics, and other health care providers who serve patients who cannot pay their bills in full.

- Health care related. Because it is directly related to health care, such a tax would be an easily understandable source of revenue for health care coverage and health care reform. The additional cost of health care resulting from such a tax will be negligible compared with the standard rates of increase in recent years, and because the tax would be offset to a large extent by the fact that it "restructures" money already in the health care system.

- Equitable. A health services sales tax would be equitable in several ways. (1) It would include in the tax base self-insured employers who do not currently share in funding Minnesota's high-risk pool. (2) In an environment of universal coverage, it would, in effect, be a tax on *coverage* rather than *care*, borne equitably by all people with health insurance. The tax would be largely invisible to most patients. (3) The tax could be structured to exempt people covered by federally-supported programs, such as Medicare and Medical Assistance. (4) Such a tax would be more fair to health care providers. Some providers now bear a disproportionate share of the costs of

serving uninsured and underinsured patients---a health services tax would ensure that all providers pay a fair share.

• Feasible and practical. A health services tax would also be a feasible and practical option in a variety of ways. (1) The tax could be a dedicated funding source, and would likely be a stable funding source over time---including periods of economic downturns. (2) It would be fairly easy to collect, since a high percentage of health care services are provided through hospitals and clinics---few in number compared to the collection points for the general sales tax. (3) With adequate lead time it could be planned for by health plans and health care providers. (4) It would include in the tax base people who come from outside Minnesota to obtain health care here.

The following estimate of the revenues that could be raised through extension of the general sales tax to health services, drugs and medical equipment is based on information from: (1) the 1987 Census of Services Industries, (2) the Minnesota Department of Revenue, and (3) the University of Minnesota Division of Health Services Research and Policy. The estimate excludes services covered by Medicare and Medical Assistance, all dental care, and all care for nursing and personal care facilities (long-term care). The estimates are for 1991.

Health service category	3% sales tax	6% sales tax	Percent of total
Hospital services	$109 million	$210 million	50%
Physician services	$72 million	$145 million	33%
Drugs	$11 million	$22 million	5%
Other health services	$26 million	$53 million	12%
Total	$219 million	$439 million	100%

If health care expenditures by persons age 65 and over are excluded from the tax base (in addition to Medicare-covered expenditures---already excluded), revenues would decrease by approximately 20 percent. This would yield $175 million at the 3 percent tax rate, and $351 million at the 6 percent tax rate.

4. INTANGIBLE PROPERTY TAX.

A tax on "intangible" property (vs. real property or real estate) has several advantages. This tax is not currently used in Minnesota, which would make it easier to "dedicate" to a new program. Seven states now have an intangibles tax of some kind. The base for an intangibles tax is very large, requiring only a small tax rate to raise significant revenues. The tax could be considered progressive, in the sense that it would be borne primarily by households with high net worths and a greater ability to pay the tax. On the other hand, many segments of society would not pay this tax at all.

It is difficult to make more than a very rough estimate of the revenues likely to be collected under an intangibles tax. The most recent comprehensive study of household net worth and assets was conducted in 1984 by the U.S. Bureau of the Census, as reported in Household Wealth and Asset Ownership: 1984. This report covers the country as a whole. Although state-specific data is not available, the State Demographer's Office advises us that national data is an adequate proxy in this area.

Based on this report and certain assumptions, we estimate that the following amount of revenue would be raised from an intangibles tax at the following rates (a 1 mill tax equals $1 on a $1000 stock or bond).

Intangibles Tax Rate	New Revenues
0.1 percent (1 mill)	$55.3 million
0.2 percent (2 mills)	$110.6 million
0.3 percent (3 mills)	$165.9 million

5. FLAT EMPLOYER PAYROLL TAX (NO CREDITS).

The option of an employer-paid payroll tax also has a large base, and could be a dedicated fund-

ing source. On the other hand, it would distribute costs less equitably than other options, and could be considered disadvantageous to the business community--- especially employers who are already providing health benefits for their own employees.

The state's estimated total payroll in 1991 is $47.3 billion. A small general payroll tax applied to this entire base would raise considerable revenues. The tax could be structured in a variety of ways, e.g., starting or stopping at certain wage levels, or different rates applying to different wage levels. This illustration does not take any such exclusions or refinements into account.

General employer payroll tax	New revenues
0.1 percent	$47 million
0.2 percent	$95 million
0.3 percent	$142 million
0.4 percent	$189 million
0.5 percent	$236 million
0.6 percent	$284 million

6. TOBACCO TAX, ALCOHOL TAX AND LOTTERY REVENUES.

These revenue sources did not rate highly in the Commission's deliberations, mainly due to their regressiveness and limited revenue-raising capacity. However, increasing taxes on tabacco and alcohol is consistent with the public health aims of the new state program.

Minnesota taxes beer, wine, distilled spirits, cigarettes, and other tobacco products. In fiscal year 1988, the combined collections from these taxes was approximately $212 million. Almost three-quarters of these revenues, or $150 million, were from the cigarette tax.

In 1987 the cigarette tax was raised to 38 cents per pack, higher than all neighboring states. Based on fiscal year 1988 collections, each cent of cigarette tax raised slightly less than $4 million. This was down from $4.7 million per cent under the prior rate of 23 cents per pack. As cigarette use continues to gradually diminish, the revenues raised per cent will also decline. For example, if the average revenue raised per cent is $2.5 million over the course of the entire 1990s, a 10 cent per pack increase would raise an average of $25 million per year over that period---more in the early 1990s, less toward the end of the decade.

In fiscal year 1988, state taxes on alcoholic beverages raised approximately $56 million. An across-the-board increase of 20 percent in alcholic beverage taxes would raise approximately $11 million per year.

Lottery revenues have been raised as a possible revenue source, but would require reallocation from current commitments. Reallocation from the environmental trust fund is now constitutionally prohibited.

7. SUMMARY.

Income tax---more progressive

Lower rate	Revenues	Higher Rate	Revenues
6.0/8.5/9.0	$105 mill.	6.0/9.0/10.0	$222 mill.

Health services sales tax

Lower rate	Revenues	Higher Rate	Revenues
3%	$219 mill.	6%	$439 mill.

Intangible property tax

Lower rate	Revenues	Higher Rate	Revenues
1 mill	$55 mill.	2 mills	$111 mill.

Flat employer payroll tax

Lower rate	Revenues	Higher Rate	Revenues
0.5%	$236 mill.	1.0%	$473 mill.

"Sin" taxes

Lower rate	Revenues	Higher Rate	Revenues
Up 10%	$25 mill.	Up 20%	$50 mill.

Chapter 10
VISION FOR THE FUTURE

It has been said that a good playwright never sits down to write a play without knowing what is to happen in the final act. This chapter brings us to our final act, our vision for the future. And although we cannot be sure how the health care system will evolve, we have formed a vision of how to pursue continued system reform---building on this Commission's recommendations to ensure accessible and equitable health care for all Minnesotans in the long run.

A. THE COMMISSION'S CONTRIBUTION TO SYSTEM REFORM.

The Minnesota Health Care Access Commission was established by the legislature "...to ensure basic and affordable health care to all Minnesotans while addressing the economic pressures of the health care system as a whole in Minnesota." Early on, the Commission set as one of its goals that its recommendations should facilitate needed reforms of Minnesota's health care system.

Throughout its work, the Commission has learned that the current health care system in Minnesota is dysfunctional in a number of ways. We have learned of unreasonable premiums and costs to individuals and employers, lapses in coverage, frustrated employees, hassled providers, and neglected citizens. These system failures are manifestations of capricious allocation of resources, illogical rationing of services, the administrative waste of an excessively fragmented and highly bureaucratic system, and continued erosion of access. Clearly, continued systemic reform will be necessary in order to create a more effective and efficient health care system.

Most of the Commission's efforts have been dedicated to outlining the foundation of this reform, including guaranteeing that Minnesotans have affordable access to needed health care. These recommendations are meant to ensure that insurance coverage is extended to all Minnesotans with a more equitable sharing of the cost of that coverage. The Commission has reached a number of conclusions and recommendations that address systemic reform. These include:

- Health care is a public good. The Commission concluded that health care is a public good, and thus recommends that health care financing should be shared by all members of society based on their ability to pay---rather than on the basis of individual health care needs.

- Equitable access to care. The Commission concluded that the current wide variation in access to health care for different members of society is unacceptable. We have thus recommended that before defining a universal, basic benefit set by 1995 we must commit to *drawing a line* around our entire community extending access to all. This sense of community will be critical if the new system is to be perceived as equitable and fair.

- Insurance reform. The Commission recommends a set of insurance underwriting and rating reforms that will allow sick people to obtain health coverage. This will bring affordable coverage to many Minnesotans who are currently disenfranchised from the system.

- Change in the role of insurers. The Commission has concluded that private health insurance (purchased either by employers or individuals) is currently an expensive and incomplete response to the health care needs of Minnesotans. If this remains the case even after our recommendations are adopted, we recommend a transition from our current private insurance system to a more equitably funded system that guarantees health care

access to each Minnesotan as a right of citizenship.

• Change in the role of employers. The Commission has concluded that the current employer-based health insurance system is an expensive and incomplete response to the health care needs of Minnesotans. We thus recommend a transition from our current employer-based health insurance system to a publicly funded system, and to provide employers an alternative opportunity to participate in the fund of a system that would guarantee health care access to each Minnesotan as a right of citizenship.

• Change in the role of patients. The Commission recommends that the state's health coverage programs educate patients about the appropriate use of the health care system, and give patients incentives and tools to be good consumers of health care.

• Expansion of managed-care organizations. The Commission recommends the expansion and creation of managed-care organizations throughout Minnesota, through the establishment of a new state program. We recommend that this be accomplished through the private sector whenever possible, but recognize that public involvement may be required in certain areas. This will encourage more efficient and effective management of health care delivery.

• Streamlining state health care programs. The Commission recommends the streamlining and consolidation of state health care programs, including the merger of existing programs at appropriate times.

• Equitable tax status. The Commission recommends that the state work to establish provisions in the state and federal tax codes that treat expenditures for health coverage equitably, whether the purchase is made by an employer in lieu of compensation or by an individual.

B. NEXT STEPS TOWARD REFORM.

Although these recommendations will provide a foundation for system reform, continued reform is needed. Noted economists have observed that significant increases in delivery system productivity are needed to reconcile the goals of universal access, improvement of quality, and stabilization or shrinkage of expenditures to a more competitive global level. At present, many parts of the health care delivery system contain incentives that work against efficiency and productivity. These incentives are driven especially by: (a) fee-for-service reimbursement, and (b) the proliferation of expensive new technologies, procedures and drugs.

Under fee-for-service reimbursement, providers are paid for volumes of care, not volumes of cures. The delivery system is characterized by the proliferation of high technology and high-cost care with unproven, and largely unstudied efficacy. Many hospitals face small bottom lines due in part to the costs of high technology, which they purchase to attract and retain physicians---even if it duplicates equipment already available in a community. The purveyors of new technology, procedures and drugs market their products in the public eye, creating demand directly from patients and placing pressure on physicians to provide those products.

Advances in technology and treatment are among the current system's greatest achievements. No one would rather suffer from cancer in the system of even five years ago and forego the advances available today. But the results of new procedures are not uniformly positive or cost-effective, as evidenced by the proliferation of highly specialized, risky, and expensive cardiac procedures. The upward pressure on costs manifests itself both in highly visible, dramatic technologies available for catastrophic cases, and in the less dramatic but, ultimately, more pervasive and expensive changes that occur in care for common conditions.

The Commission's recommendations provide a foundation for cost control and productivity improvements upon which continued reform of the health care system can be built. To accomplish this, Minnesota must address the following issues.

• Provider incentives. We must create a comprehensive system of incentives for health care providers that reward productivity, efficiency and positive health outcomes.

• Continuous improvement. We must create a health care delivery system and culture conducive to the development and continuous improvement of care protocols, and which do not freeze in place the current state-of-the-art.

• Capital spending. We must deal with excessive capital spending for equipment and facilities in parts of the delivery system, and inadequate access to capital in other parts of the system.

• Primary and rural care. We must develop better systems and incentives to match health care providers and facilities with community needs, especially to encourage greater access to primary care and rural-based care.

• Basic vs. heroic. We must develop mechanisms for making informed, society-wide decisions about the appropriate and equitable allocations of resources between universally available basic health care, and continued experimentation and heroic care of benefit to a small subset of the population.

• Preventive care. We must stress cost-effective preventive care as one means of avoiding more expensive care in the future.

• Administrative waste. We must continue to simplify the administrative system for patients and providers. This will allow us to begin to recover some of the wasted resources that go to support our currently fragmented system.

C. ONE VISION OF AN EQUITABLE AND AFFORDABLE HEALTH CARE SYSTEM.

In the long run, to guarantee health care access for all Minnesotans we must move toward a system that controls overall costs rather than only the prices of individual services. For in the end, it is the uncontrolled escalation of health care costs that contributes most directly to the erosion of health care access.

The Commission has considered one such system. It would combine the features of unified financing, competing managed-care organizations, reduction of administrative waste, consumer choice, and a means of budgeting total health care expenditures. The new Department of Health Care Access would function like a public service commission. It would grant franchises to managed-care organizations that meet the state's specifications, and establish a budget for total health care expenditures through those organizations. All citizens would be entitled to health care through a managed-care organization, with regular opportunities to choose a different organization in their area. Consumers and employers would be free to purchase additional services beyond those of the Universal Basic Benefit Set.

We hold this up as our vision---a relative simple one at that. We believe this to be a vision based on fairness, compassion, and a shared social responsibility. It is our best vision at this time. We trust that it will be modified and improved---this we expect and encourage.

Attachment A
PREMIUM SLIDING SCALE

The Commission recommends that the new state program use a sliding scale similar to the one shown on the following pages.

Federal Poverty Guidelines.

The sliding scale uses the 1990 Federal Poverty Guidelines (FPG). The FPG and the sliding scale are based on *gross* family income. Because the FPG are adjusted for inflation each year, usually in February, the scale automatically incorporates an inflation factor.

Family or Household Size

The FPG take into account both family size and income. For example, under the FPG the poverty level is $12,708 for a family of four, but only $8,424 for a family of two. This attachment shows the premium costs for families (households) of one, two, three, four, five and six.

Income Steps.

For ease of administration, the Commission recommends that the sliding scale be based on income ranges or *steps*, rather than on a continuous scale or formula.

This attachment uses steps in increments of 25 percent of the FPG, which results in 11 distinct steps between 0 and 275 percent of the FPG. The Commission recommends that, when the new state program is implemented, steps be in increments of 20 percent of the FPG. Data in 20 percent increments was not readily available for preparation of this report.

Rounding.

For ease of reading, columns two through four in the following tables round gross income to the nearest dollar.

Columns 2 and 3.

In columns 2 and 3, gross annual and monthly income, a family with income at the break point between steps would fall in the next higher income step. For example, the 0 - 25 percent of poverty step for a one-person household is actually $0 to $130.99, rather than $0 to $131.00.

Column 6.

Column 6, enrollee share of premium, is calculated by multiplying the income midpoint for the step (column 4) by enrollee premium as a percent of gross income (column 7).

Column 7.

Column 7, enrollee premium as a percent of gross income, is based on the Commission's recommended structure for the sliding scale. The Commission recommends that the scale begin at approximately 1.1 percent of gross income at the lowest income level, and progress to 6.5 percent of gross income at the high end of the scale.

ONE-PERSON HOUSEHOLDS

	Col. 1 Federal poverty level	Col. 2 Gross annual income	Col. 3 Gross monthly income	Col. 4 Income midpoint for step	Col. 5 Total monthly premium	Col. 6 Enrollee share of premium	Col. 7 Enrollee premium as pct. of gross income
Step One	0 - 25%	$0 - 1,572	$0 - 131	$65	$101.00	$0.71	1.08%
Step Two	26 - 50%	$1,572 - 3,144	$131 - 262	$197	$101.00	$3.19	1.62%
Step Three	51 - 75%	$3,144 - 4,716	$262 - 393	$328	$101.00	$7.08	2.16%
Step Four	76 - 100%	$4,716 - $6,288	$393 - 524	$459	$101.00	$12.39	2.70%
Step Five	101 - 125%	$6288 - 7,860	$524 - 655	$590	$101.00	$19.12	3.24%
Step Six	126 - 150%	$7,860 - 9,432	$655 - 786	$721	$101.00	$27.25	3.78%
Step Seven	151 - 175%	$9,432 - 11,004	$786 - 917	$852	$101.00	$36.80	4.32%
Step Eight	176 - 200%	$11,004 - 12,576	$917 - 1,048	$983	$101.00	$47.77	4.86%
Step Nine	201 - 225%	$12,576 - 14,148	$1,048 - 1,179	$1,114	$101.00	$60.16	5.4%
Step Ten	226 - 250%	$14,148 - 15,720	$1,179 - 1,310	$1,245	$101.00	$73.95	5.94%
Step Eleven	256 - 275%	$15,720 - 17,292	$1,310 - 1,440	$1,376	$101.00	$89.44	6.5%

TWO-PERSON HOUSEHOLDS

	Col. 1 Federal poverty level	Col. 2 Gross annual income	Col. 3 Gross monthly income	Col. 4 Income midpoint for step	Col. 5 Total monthly premium	Col. 6 Enrollee share of premium	Col. 7 Enrollee premium as pct. of gross income
Step One	0 - 25%	$0 - 2,100	$0 - 175	$87	$202.00	$0.95	1.08%
Step Two	26 - 50%	$2,100 - 4,212	$175 - 351	$263	$202.00	$4.27	1.62%
Step Three	51 - 75%	$4,212 - 6,312	$351 - 526	$439	$202.00	$9.48	2.16%
Step Four	76 - 100%	$6,312 - 8,424	$526 - 702	$614	$202.00	$16.59	2.70%
Step Five	101 - 125%	$8,424 - 10,530	$702 - 877	$790	$202.00	$25.6	3.24%
Step Six	126 - 150%	$10,530 - 12,636	$877 - 1,053	$966	$202.00	$36.51	3.78%
Step Seven	151 - 175%	$12,636 - 14,742	$1,053 - 1,228	$1,141	$202.00	$49.30	4.32%
Step Eight	176 - 200%	$14,742 - 16,848	$1,228 - 1,404	$1,317	$202.00	$63.99	4.86%
Step Nine	201 - 225%	$16,848 - 18,954	$1,404 - 1,579	$1,492	$202.00	$80.58	5.4%
Step Ten	226 - 250%	$18,954 - 21,060	$1,579 - 1,755	$1,668	$202.00	$99.06	5.94%
Step Eleven	256 - 275%	$21,060 - 23,166	$1,755 - 1,930	$1,843	$202.00	$119.81	6.5%

THREE-PERSON HOUSEHOLDS

	Col. 1 Federal poverty level	Col. 2 Gross annual income	Col. 3 Gross monthly income	Col. 4 Income midpoint for step	Col. 5 Total monthly premium	Col. 6 Enrollee share of premium	Col. 7 Enrollee premium as pct. of gross income
Step One	0 - 25%	$0 - 2,640	$0 - 220	$110	$303.00	$1.19	1.08%
Step Two	26 - 50%	$2640 - 5,280	$220 - 440	$330	$303.00	$5.35	1.62%
Step Three	51 - 75%	$5,280 - 7,920	$440 - 660	$550	$303.00	$11.89	2.16%
Step Four	76 - 100%	$7920 - 10,560	$660 - 880	$770	$303.00	$20.80	2.70%
Step Five	101 - 125%	$10,560 - 13,200	$880 - 1,100	$990	$303.00	$32.09	3.24%
Step Six	126 - 150%	$13,200 - 15,840	$1,100 - 1,320	$1,210	$303.00	$45.76	3.78%
Step Seven	151 - 175%	$15,840 - 18,480	$1,320 - 1,540	$1,430	$303.00	$61.80	4.32%
Step Eight	176 - 200%	$18,480 - 21,120	$1,540 - 1,760	$1,650	$303.00	$80.21	4.86%
Step Nine	201 - 225%	$21,120 - 23,760	$1,760 - 1,980	$1,870	$303.00	$101.01	5.4%
Step Ten	226 - 250%	$23,760 - 26,400	$1,980 - 2,200	$2,090	$303.00	$124.18	5.94%
Step Eleven	256 - 275%	$26,400 - 29,040	$2,200 - 2,420	$2,310	$303.00	$150.18	6.5%

FOUR-PERSON HOUSEHOLDS

	Col. 1 Federal poverty level	Col. 2 Gross annual income	Col. 3 Gross monthly income	Col. 4 Income midpoint for step	Col. 5 Total monthly premium	Col. 6 Enrollee share of premium	Col. 7 Enrollee premium as pct. of gross income
Step One	0 - 25%	$0 - 3,180	$0 - 265	$132	$303.00	$1.43	1.08%
Step Two	26 - 50%	$3,180 - 6,348	$265 - 529	$397	$303.00	$6.44	1.62%
Step Three	51 - 75%	$6,348 - 9,528	$529 - 794	$662	303.00	$14.30	2.16%
Step Four	76 - 100%	$9,528 - 12,708	$794 - 1,059	$927	$303.00	$25.03	2.70%
Step Five	101 - 125%	$12,708 - 15,885	$1,059 - 1,324	$1,192	$303.00	$38.62	3.24%
Step Six	126 - 150%	$15,885 - 19,062	$1,324 - 1,588	$1,457	$303.00	$55.06	3.78%
Step Seven	151 - 175%	$19,062 - 22,239	$1,588 - 1,853	$1,721	$303.00	$74.36	4.32%
Step Eight	176 - 200%	$22,239 - 25,416	$1,853 - 2,118	$1,986	$303.00	$96.53	4.86%
Step Nine	201 - 225%	$25,416 - 28,593	$2,118 - 2,383	$2,251	$303.00	$121.55	5.4%
Step Ten	226 - 250%	$28,593 - 31,758	$2,383 - 2,647	$2,516	$303.00	$149.43	5.94%
Step Eleven	256 - 275%	$31,578 - 34,947	$2,647 - 2,912	$2,780	$303.00	$180.72	6.5%

FIVE-PERSON HOUSEHOLDS

	Col. 1 Federal poverty level	Col. 2 Gross annual income	Col. 3 Gross monthly income	Col. 4 Income midpoint for step	Col. 5 Total monthly premium	Col. 6 Enrollee share of premium	Col. 7 Enrollee premium as pct. of gross income
Step One	0 - 25%	$0 - 3,708	$0 - 309	$154	$303.00	$1.67	1.08%
Step Two	26 - 50%	$3,708 - 7,416	$309 - 618	$464	$303.00	$7.52	1.62%
Step Three	51 - 75%	$7,416 - 11,136	$618 - 928	$773	$303.00	$16.71	2.16%
Step Four	76 - 100%	$11,136 - 14,844	$928 - 1,236	$1,083	$303.00	$29.24	2.70%
Step Five	101 - 125%	$14,844 - 18,555	$1,236 - 1,546	$1,392	$303.00	$45.09	3.24%
Step Six	126 - 150%	$18,555 - 22,266	$1,546 - 1,855	$1,701	$303.00	$64.31	3.78%
Step Seven	151 - 175%	$22,266 - 25,977	$1,855 - 2,165	$2,011	$303.00	$86.86	4.32%
Step Eight	176 - 200%	$25,977 - 29,688	$2,165 - 2,474	$2,320	$303.00	$112.75	4.86%
Step Nine	201 - 225%	$29,688 - 33,399	$2,474 - 2,783	$2,629	$303.00	$141.97	5.4%
Step Ten	226 - 250%	$33,399 - 37,110	$2,783 - 3,092	$2,938	$303.00	$174.54	5.94%
Step Eleven	256 - 275%	$37,110 - 40,000	$3,092 - 3,332	$3,247	$303.00	$211.10	6.5%

SIX-PERSON HOUSEHOLDS

	Col. 1 Federal poverty level	Col. 2 Gross annual income	Col. 3 Gross monthly income	Col. 4 Income midpoint for step	Col. 5 Total monthly premium	Col. 6 Enrollee share of premium	Col. 7 Enrollee premium as pct. of gross income
Step One	0 - 25%	$0 - 4,248	$0 - 354	$177	$303.00	$1.91	1.08%
Step Two	26 - 50%	$4,248 - 8,484	$354 - 707	$531	$303.00	$8.60	1.62%
Step Three	51 - 75%	$8,484 - 12,732	$707 - 1,061	$884	$303.00	$19.11	2.16%
Step Four	76 - 100%	$12,732 - 16,980	$1,061 - 1,414	$1,238	$303.00	$33.44	2.70%
Step Five	101 - 125%	$16,980 - 21,225	$1,414 - 1,769	$1,592	$303.00	$51.58	3.24%
Step Six	126 - 150%	$21,225 - 25,470	$1,769 - 2,122	$1,946	$303.00	$73.56	3.78%
Step Seven	151 - 175%	$25,470 - 29,715	$2,122 - 2,476	$2,300	$303.00	$99.35	4.32%
Step Eight	176 - 200%	$29,715 - 33,960	$2,476 - 2,830	$2.654	$303.00	$128.97	4.86%
Step Nine	201 - 225%	$33,960 - 38,205	$2,830 - 3,184	$3,007	$303.00	$162.40	5.4%
Step Ten	226 - 250%	Not applicable---income midpoint for this range greater than $40,000 annual income sliding scale cap.					
Step Eleven	256 - 275%	Not applicable---income midpoint for this range greater than $40,000 annual income sliding scale cap.					

Attachment B
INTERMEDIATE BENEFIT SET

Attachment B describes the services covered and terms of coverage under the Intermediate Benefit Set (IBS) offered through the Minnesotans' Health Care Plan. The first column describes the benefit, and the second column describes the terms under which it is covered. Some benefits are covered for children only, or are covered differently for children and adults. These differences are noted under the second column.

In this attachment, references to services performed by "physicians" may also include services performed by other qualified health professionals within their licensed scope of practice, including but not limited to nurse practitioners, physician assistants, chiropractors, podiatrists, physical therapists, occupational therapists, speech therapists, and audiologists. All benefits are subject to the managed-care procedures and requirements of the health plan company or comparable administering entity.

Benefit Description	Coverage Terms
I. PREVENTIVE CARE.	
A. Prenatal and Post-Natal Care. This benefit provides for prenatal and post-natal visits.	Covered in full.
B. Well Baby Exams. This benefit provides for normal periodic examinations of well children under one year of age.	Covered in full.
C. Immunizations. This benefit provides for the professional services and materials associated with administering immunizations.	Covered in full.

Benefit Description	Coverage Terms
D. Selected Preventive Tests/Screening. This benefit provides for the following: 1. Pap tests for women age 20 and over at intervals recommended by the American Cancer Society. 2. Mammograms for women age 50 and over at intervals recommended by the American Cancer Society.	Covered in full.
E. Physical Exams. This benefit provides for routine examinations, including well child exams, and includes the cost of lab and x-rays associated with the exam.	*Children 0-17:* Only as part of an EPSDT regimen (Early and Periodic Screening, Diagnosis and Treatment). *Adults:* No coverage.
F. Vision Exams. This benefit provides for eye exams conducted by a licensed opthamologist or optometrist.	*Children 0-17:* Only as part of an EPSDT regimen. *Adults:* No coverage.
G. Hearing Exams. This benefit provides for hearing exams.	*Children 0-17:* Only as part of an EPSDT regimen. *Adults:* No coverage.
H. Speech Exams. This benefit provides for speech exams.	*Children 0-17:* Only as part of an EPSDT regimen. *Adults:* No coverage.

Benefit Description	Coverage Terms

2. OFFICE/HOME VISITS AND DRUGS/SUPPLIES.

A. Primary Care Visits.
This benefit provides for office and home visits by primary care physicians (for example, general and family practitioners, internists, pediatricians and obstetrician/gynecologists), nurse practitioners and physician assistants. This benefit includes:

1. Office visits.

2. Visits to the enrollee in his/her home or in a custodial facility.

This benefit does not include prenatal and postnatal care, well baby exams, and physical exams---covered under items 1A, 1B & 1E, other health professional visits---covered under item 3A, or inpatient and outpatient pre-surgical or post-surgical visits---which are covered under items 3C and 7B.

Adults: 8 visit limit per year for all primary care visits. Additional visits covered when an alternative to inpatient care.

Children 0-17: Covered in full, no copayments.

B. Prescription Drugs.
This benefit provides for outpatient prescriptions ordered by an attending physician, including the dispensing fee.

Adults: Very limited formulary, including exclusion of certain types of drugs. $5 copayment.

Children 0-17: Broader formulary and no copayments.

C. Therapeutic Injections.
This benefit provides for professional services and materials associated with therapeutic injections when administered by the staff of the attending physician. Immunizations are not included.

Adults: Very limited formulary, including exclusion of certain types of drugs. $5 copayment.

Children 0-17: Broader formulary, no copays.

D. Durable Medical Equipment, Prosthetic and Orthotic Devices.
This benefit provides for the following types of appliances and equipment, including but not limited to: braces (orthotics), canes, crutches, glucosan, glucometer, intermittent positive pressure machines, rib belt for treatment of an accident or illness, walker, wheel chairs, etc.

This benefit also provides for prosthetics, and includes artificial parts that replace missing body parts or improve body function (e.g., artificial limbs, heart valves, medically necessary reconstruction).

Adults: No coverage.

Children 0-17: Covered in full.

Benefit Description	Coverage Terms
E. Glasses. This benefit provides for 1 pair of eyeglasses every two years. Contact lenses are excluded.	*Adults:* No coverage. *Children 0-17:* Covered in full.
F. Hearing Aids. This benefit provides for hearing aids.	*Adults:* No coverage. *Children 0-17:* Covered in full.

3. OUTPATIENT/OFFICE -- SURGERY, TESTING AND SPECIAL THERAPIES.

A. Other Health Professional Visits.
This benefit provides for visits to licensed health professionals not covered under other categories---such as item 2A, primary care visits.

Adults: Covered in full up to a total of 8 visits per year for all providers combined. No copayments. Additional visits covered when an alternative to inpatient care.

Children 0-17: Covered in full. No visit limit or copayments.

1. **Physician Specialists.**
   This benefit provides for specialist consultations, and presumes the primary care physician has due cause to seek consultation. A consultation includes services rendered by a physician or other appropriate professional for the further evaluation and/or management of the patient. When the consulting physician assumes responsibility for the continuing care of the patient, any subsequent visits to the physician will be considered primary care.

2. **Chiropractors.**
   This benefit provides for visits to licensed chiropractors, including those visits involving manipulations.

3. **Podiatrists.**
   This benefit provides for visits to licensed podiatrists.

4. **Physical Therapy and Rehabilitation Services.**
   This benefit provides for physical therapy and occupational therapy.

5. **Speech Therapy.**
   This benefit provides for speech therapy services, including treatment to correct effects of illness, injury or medical condition, and educational therapy for the purpose of correcting speech impediments or assisting the initial development of verbal facility.

6. **Audiology.**
   This benefit provides for audiology services.

Benefit Description	Coverage Terms
B. Hospital - Surgery. This benefit provides for hospital outpatient surgery services performed in a hospital outpatient facility or a freestanding surgical facility.	Covered in full.
C. Hospital - Radiology and Pathology. This benefit provides for the technical component of radiology services and pathology services performed in a hospital outpatient department or a free-standing facility.	Covered in full.
D. Physician - Surgery. This benefit provides for surgery by a physician in a hospital outpatient department, freestanding surgical facility or physician's office. This benefit includes services by an anesthesiologist or anesthetist for outpatient surgeries, and normal pre-surgical and post-surgical encounters with the surgeon.	Covered in full.
F. Physician - Radiology, Pathology. This benefit provides for professional services by the physician when x-rays and lab procedures are performed in the office, hospital outpatient department or freestanding facility.	Covered in full.
G. Cardiovascular Tests and Procedures. This benefit provides for therapeutic services (e.g. CPR), cardiography (EKGs), cardiac catheterization and other cardiovascular services performed or ordered by a physician.	Covered in full.
H. Allergy Testing and Immunotherapy. This benefit provides for professional services and materials associated with allergy testing and immunotherapy (serum, syringes. etc.) when administered by a physician or a physician's staff.	*Adults:* No coverage. *Children 0-17:* Covered in full.
I. Dialysis Procedures. This benefit provides for services by a physician and staff for dialysis treatment including hemodialysis, peritoneal dialysis and miscellaneous dialysis procedures.	Covered in full.
J. Other Miscellaneous Tests and Procedures. This benefit provides for the following professional services: Biofeedback services Chemotherapy services Dermatology services Gastroenterology services Neurology services Non-invasive peripheral vascular diagnostic studies Otorhinolayrngology services Pulmonary services Vestibular functions tests	Covered in full.

Benefit Description	Coverage Terms

4. MENTAL HEALTH AND ALCOHOL/DRUG DEPENDENCY CARE.

INPATIENT CARE -- TERMS OF COVERAGE: 80% coverage is provided for both inpatient mental health care and general inpatient care. 100% coverage is provided after $2,500 in out-of-pocket expenses per household per year, up to a maximum benefit of $70,000 per person per year ($72,500 in total expenses, including out-of-pocket). The maximum out-of-pocket expense for inpatient mental health care is a combined maximum with general inpatient care.

A. Inpatient - Mental Health. This benefit provides for inpatient hospitalization for the treatment of mental disorders.	See above.
B. Inpatient - Alcohol & Drug Dependency. Inpatient hospitalization for the treatment of alcohol and drug dependency is excluded.	No coverage.
C. Outpatient -- Mental Health. This benefit provides for mental health treatment by a qualified professional qualified professional performed on an outpatient basis.	10 hour limit per person per year. No copayment. For the purpose of the 10 hour limit, 2 hours of group therapy are counted as 1 hour.
D. Outpatient -- Alcohol & Drug Dependency. This benefit provides for outpatient assessment and treatment of alcohol and/or drug dependency by a qualified professional or outpatient treatment program.	10 hour limit per person per year. No copayment. For the purpose of the 10 hour limit, 2 hours of group therapy are counted as 1 hour.

Benefit Description	Coverage Terms

5. MATERNITY, DELIVERIES, & NON-DELIVERIES.

A. Hospital Inpatient -- Deliveries, Non-Deliveries. This benefit provides for hospital inpatient room and board and ancillary services in short-term community hospitals for the following: I. Normal and caesarean deliveries. This includes coverage for services associated with the mother and baby in cases where there is a normal delivery. This does not include services associated with premature births or other neonatal care (covered under item 7). 2. Complications of pregnancy and pregnancies that do not result in a delivery due to miscarriage or therapeutic abortion.	80% coverage is provided for inpatient maternity care. 100% coverage is provided after $500 in out-of-pocket expenses per pregnancy. The maximum out-of-pocket expense for inpatient maternity care is separate from/ in addition to other maximums.
B. Hospital Outpatient -- Deliveries, Non-Deliveries. This benefit provides for hospital outpatient services for maternity non-delivery procedures. Such services include: 1. Miscarriages. 2. Therapeutic abortions. 3. Testing procedures such as amniocentesis and ultrasound.	Covered in full.
C. Physician -- Deliveries. This benefit provides for physician obstetrical care for normal deliveries, caesarean deliveries, and complications of pregnancy that result in normal or caesarean deliveries. Obstetrical care includes delivery care and anesthesia. This benefit exludes prenatal and post-natal visits---covered under item 1A.	Covered in full.
D. Physician -- Non-Deliveries. This benefit provides for obstetrical care by physicians or other qualified health professionals for pregnancies that do not result in a delivery due to a complication, miscarriage or therapeutic abortion. Obstetrical care includes surgical care and anesthesia. This benefit exludes prenatal visits---covered under item 1A.	Covered in full.

Benefit Description	Coverage Terms

6. EMERGENCY SERVICES.

A. Hospital -- Emergency Room. This benefit provides for services for emergency accident and medical care performed in the emergency area of a hospital outpatient facility or urgent care center.	$50 copayment, waived if admitted to hospital.
B. Physician - Emergency Room. This benefit provides for visits to either a primary care physician or a hospital staff physician in the emergency area of a hospital outpatient facility.	Covered in full.
C. Ambulance. This benefit provides for professional ambulance service. Ambulance service for maternity is not included, nor is service provided by a hospital in connection with the treatment of an illness or accident, except as provided for elsewhere in these benefits.	20% copayment.

7. HOSPITAL INPATIENT AND HOME HEALTH CARE -- GENERAL.

INPATIENT CARE -- TERMS OF COVERAGE: 80% coverage is provided for both general inpatient care and inpatient mental health care. 100% coverage is provided after $2,500 in out-of-pocket expenses per household per year, up to a maximum benefit of $70,000 per person per year ($72,500 in total expenses, including out-of-pocket). The maximum out-of-pocket expense for general inpatient care is a combined maximum with inpatient mental health care.

Maternity care and related well-child care are not included in this category---covered under item 5A. Confinements related solely to custodial care are not covered.

All of the services listed in category 7 are subject to the inpatient care terms of coverage.

A. Hospital -- Room, Board, Ancillaries. This benefit provides for daily semi-private room and board and ancillary services in short-term community hospitals. Ancillary services include use of surgical and intensive care facilities (charges that are in excess of an average semi-private room), inpatient nursing care, pathology and radiology procedures, drugs, supplies and other hospital-based services (e.g., physical therapy). Ancillary services do not include professional care by hospital-based physicians.	See above.

Benefit Description	Coverage Terms
B. Physician -- Surgery. This benefit provides for surgeries by a primary surgeon or assistant surgeon performed on an inpatient basis, including normal pre-surgical and post-surgical encounters with the surgeon. This benefit also provides for services by an anesthesiologist or anesthetist for inpatient surgeries, including normal pre-surgical and post-surgical encounters and usual monitoring procedures.	See above.
C. Physician -- Radiology, Pathology. This benefit provides for professional services by a physician when the x-rays or laboratory procedures are performed on an inpatient basis.	See above.
D. Physician -- Visits and Consultations. This benefit provides for physician visits to hospitals and approved extended care facilities. The benefit also provides for the care of critically ill patients in a variety of settings that require the constant attention of the physician (e.g., cardiac arrest, shock, bleeding, respiratory failure, etc.) Critical care is usually given in a critical care area, such as the coronary care unit, intensive care unit or respiratory care unit. The benefit also provides for consultations for inpatient care. A consultation includes services rendered by a physician or other appropriate professional for the further evaluation and/or management of the patient.	See above.
E. Extended Care Facility (non-custodial). This benefit provides for daily room, board and ancillary services in an approved extended care facility. The facility may be either the extended care ward of a community hospital or an independent skilled nursing facility. Confinements must be medically necessary, and not related solely to custodial care.	See above.
F. Private Duty Nursing/Home Health Care (non-custodial). This benefit provides for private duty nursing and home health visits by a home health professional if required by the attending physician. This benefit does not include care that is solely custodial.	See above.
8. DENTAL CARE.	
A. Preventive Services. This benefits includes oral examinations, x-rays, flouride applications, teeth cleaning and other laboratory and diagnostic tests.	*Children 0-17:* Covered in full. *Adults:* No coverage.

Benefit Description	Coverage Terms
B. Basic Non-Preventive Services. This benefit includes simple extractions, surgical extractions, oral surgery, anesthesia, restorations, emergency treatment, space maintainers, periodontics and endodontics.	*Children 0-17:* 20% copayments. *Adults:* No coverage.
C. Inlays, Crowns, Prosthetics. This benefit includes inlays and crowns, dentures and other removable prosthetics, bridges and other fixed prosthetics, denture and bridge repair (simple), and other prosthetics.	*Children 0-17:* 50% copayments. *Adults:* No coverage.
D. Orthodontic services. Orthodontic services are not covered.	No coverage.
E. TMJ and CMD Treatment. Treatment for temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD) is not covered.	No coverage.

9. EXCLUDED SERVICES.

The Intermediate Benefit Set does not cover services that are not medically necessary. In addition to those services listed as not covered in sections one through eight of this attachment, the following services will not be covered, regardless of medical necessity:

1. Experimental procedures.
2. Custodial care.
3. Personal comfort or beautification.
4. Treatment for obesity.
5. In vitro fertilization.
6. Artificial insemination.
7. Reversal of voluntary sterilization.
8. Transsexual surgery.