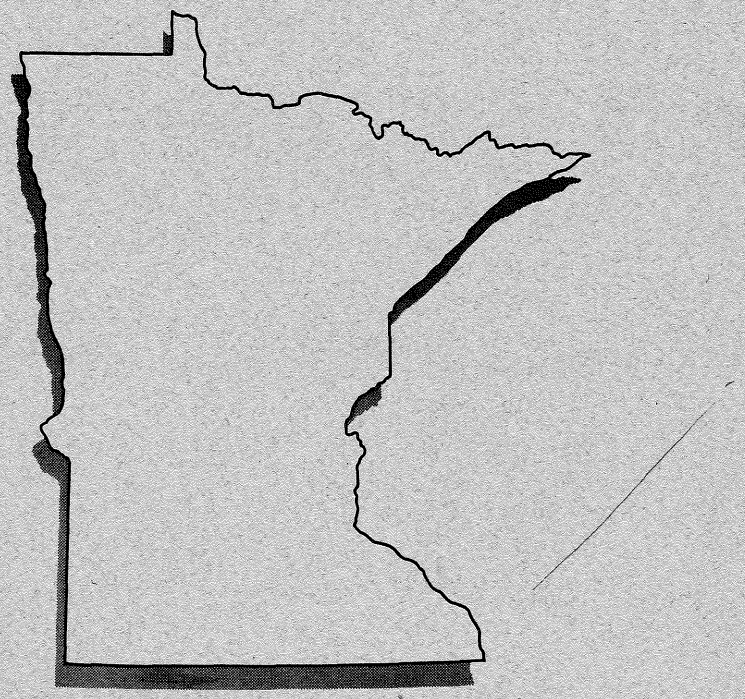
The Minnesota Health Care Access Commission

Final Report to the Legislature

Summary



January, 1991

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

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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.

A. COMMISSION STAFF.

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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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
Yvette Nakielski

State Planning Agency
Florence Anderson
Barbara Kochevar
Roger Volk

TABLE OF CONTENTS

Section 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.

Section 2
BACKGROUND

A. 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.

B. 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.

1. 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 included 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.

2. 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

3. 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.

Section 3

OVERVIEW OF KEY FINDINGS AND RECOMMENDATIONS

This section provides an overview of the Commission's key findings and recommendations. Sections 4 - 11 describe the recommendations in more detail.

A. KEY COMMISSION FINDINGS.

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

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

B. 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.

1. 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.

A. 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.

B. 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.

C. 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.

D. 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.

2. 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.

A. 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.

B. 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.

C. 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.

D. 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.

E. 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.

F. 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.

G. 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. 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.

H. 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.

I. 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.

J. 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.

K. 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.

Section 4

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.

Section 5

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.

Section 6
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.

Section 7

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.

Section 8

ADDRESS THE PARTICULAR ACCESS PROBLEMS OF 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.

Section 9

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.

Section 10
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" 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)

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.

Section 11
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.

THE MINNESOTA HEALTH CARE ACCESS COMMISSION

Final Report to the Legislature

-- Summary --

January 1991

This document is a summary of the Health Care Access Commission's Final Report to the Legislature, and highlights the Commission's key findings and recommendations. Copies of the Final Report can be obtained from the Commission office.

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