



An Affordable Step Toward Universal Coverage

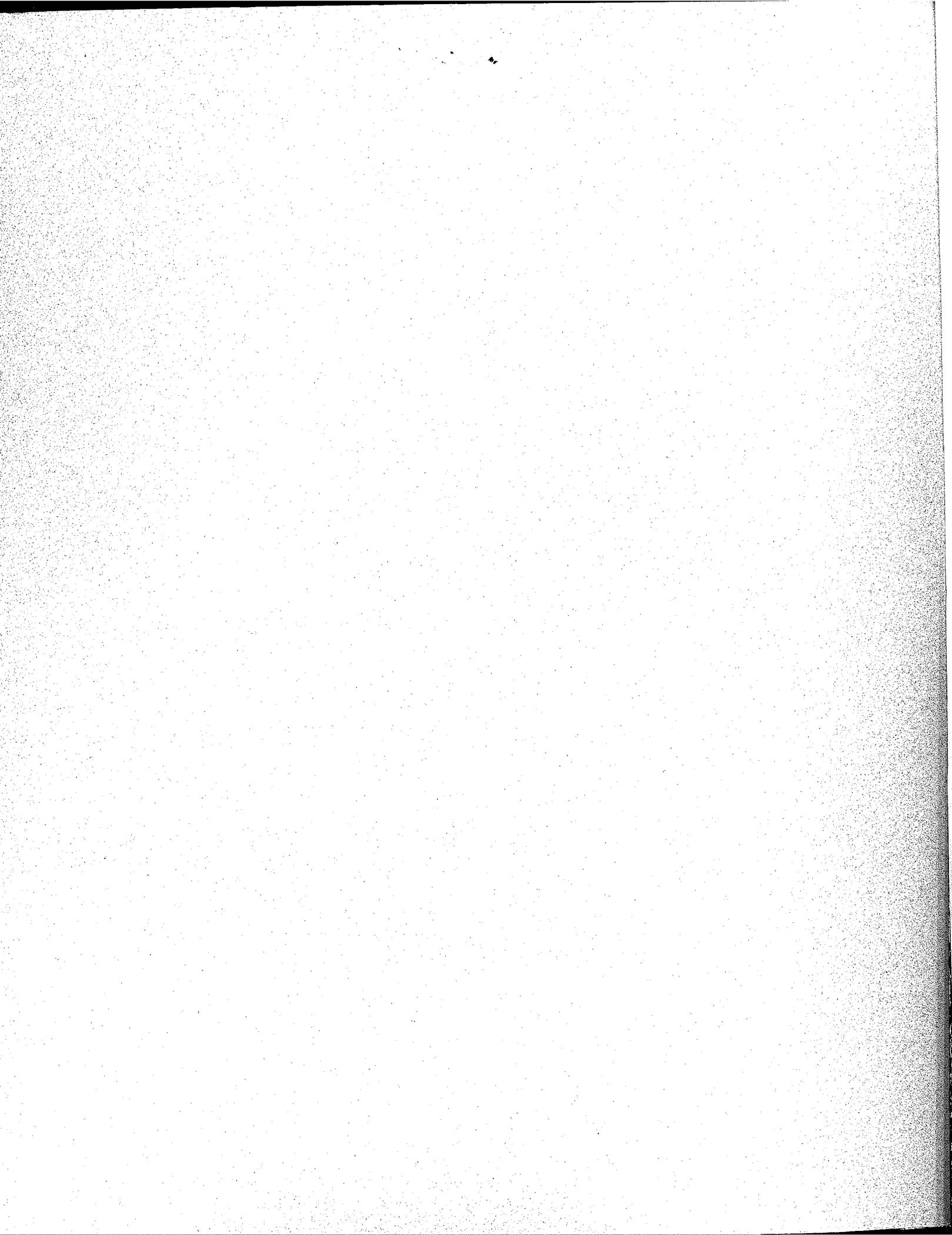
Summary



Minnesota
Health Care
Commission

January, 1995

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Summary

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The Minnesota Health Care Commission

The Minnesota Health Care Commission's 27 members represent consumers, labor, employers, health care providers, health plan companies, and state government. The commission was created in the original 1992 HealthRight Act (now known as "MinnesotaCare") to provide an opportunity for the major stakeholders to seek consensus on health care reform policies and programs. The commission reached consensus on a cost containment plan in 1992 and a universal coverage plan in 1993. Most of the commission's previous recommendations have been enacted into law and form the basis for the state's strategies to improve health care access, affordability, and quality.

Minnesota Health Care Commission Members

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Douglas Robinson, Minnesota Hospital Association Representative
Eileen Weber, Minnesota Nurses Association Representative

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Jeff Bangsberg, Consortium of Citizens with Disabilities
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Bill Conley, Minnesota Health Association Consumer Representative
Virginia Greenman, Consumer Representative
Jacqueline Smith, Consumer Representative
**Tom Swain, Consumer Representative
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**Health Plan
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Summary

An Affordable Step Toward Universal Coverage

Introduction

This report contains the Minnesota Health Care Commission's recommendations for a financing strategy to improve access to health coverage for uninsured Minnesotans. Minnesota has already taken major steps toward the ultimate goal of universal coverage. This report recommends another step toward this goal. The commission's recommendations are affordable, and the benefits to be gained outweigh the costs. They will improve access, will lead to greater fairness in the health care marketplace, and will promote individual responsibility. The costs will be more than offset by cost containment dividends enjoyed by Minnesota consumers as a result of existing health reform programs.

The commission developed this report in response to a mandate of the 1994 Minnesota Legislature. This legislation directed the commission to develop a financing plan that will lead to universal coverage by 1997. The commission developed its recommendations through research, analysis, and an open, public process of stakeholder discussion designed to achieve broad-based, bipartisan support for a financing strategy. The Commission is diverse, and there are differences of opinion among members. These differences have been openly discussed, providing the commission with a wide range of views and information to consider, and have helped focus and balance the debate.

The commission's financing recommendations build upon the universal coverage strategy it developed in 1993. That strategy calls for insurance reforms and market reforms to improve access to private coverage, and a streamlined and simplified state program to provide subsidized coverage to low-income

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Minnesotans. The commission's definition of "universal coverage" differs from concepts advocated in many other proposals. It envisions a primarily private-sector health care and delivery system rather than a new government entitlement program. It includes creative new strategies that will improve access to health coverage, reduce cost shifting, and promote personal responsibility. The strategy was described in much greater detail in the commission's 1994 Universal Coverage Report, a summary of which appears at the end of this report.

The commission's universal coverage strategy was enacted into law during the 1994 legislative session, but its full implementation is conditional on the enactment of adequate financing for the subsidy program, full implementation of insurance reforms, and other conditions. The commission continues to consider the recommendations set forth in the **Universal Coverage Report** to be the state's ultimate objective. However, the recommendations in this report will not result in universal coverage by 1997.

Our recommendations will improve access, reduce premium costs, and significantly reduce the number of uninsured Minnesotans, but they will not produce universal coverage without further steps in the future. We believe changes in the political climate and the lack of federal action justify the more moderate and sequential approach recommended in this report.

The commission's recommendations fall into the following categories:

- ▶ **Insurance reform:** Insurance law reforms to ensure fairness and enhanced access in the private insurance market for those who can afford to purchase private coverage.
- ▶ **Purchasing pools:** Voluntary purchasing pool opportunities for all consumers.
- ▶ **Subsidized coverage:** Expansion of the MinnesotaCare subsidized health coverage program for low-income persons who cannot afford to pay the entire cost of coverage.
- ▶ **Freeloader penalty:** A requirement that voluntarily uninsured persons pay into a fund to reimburse health care providers for the costs of treating uninsured persons.

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- ▶ **Community Health Insurance Pool (CHIP):** A funding pool to help defray the unreimbursed costs to providers (and ultimately purchasers) of treating uninsured persons.
- ▶ **Prevention:** Tobacco taxes to discourage smoking and other tobacco use, and to fund cost-effective prevention programs that will reduce the costs of health coverage.
- ▶ **Public health and local government programs:** Planning for the role and adequate funding of public health and local government activities under a reformed health system.
- ▶ **Evaluation:** An evaluation of the impact of health reform and ongoing monitoring of the size and characteristics of the uninsured population, to help policymakers determine if reform programs are working and whether changes are needed.
- ▶ **Adequate Financing for the MinnesotaCare Program**

Summary of Recommendations

Insurance Reform

Insurance reforms improve access to private health coverage and reduce premium costs for higher risk individuals and individuals with existing health problems, prevent job lock, and prevent growth in government programs due to lack of access to private coverage.

Recommendation: The insurance reforms that have been implemented so far are appropriate, have been successful, and should be retained.

- ▶ **Community rating**

Unless universal coverage is implemented, pure community rating, particularly on the age factor, could result in a net loss in the number of persons with private

Summary

coverage due to premium increases for healthy individuals and groups. Further study is needed to determine the appropriate next step.

Recommendation: The commission proposes to freeze current rate bands and intends to reevaluate additional steps toward community rating beyond the current rate bands.

► Guaranteed issuance

Without an effective strategy to prevent health insurance "freeloaders" (voluntarily uninsured persons who can afford to purchase coverage but who do not purchase it), guaranteed issuance will make insurance premiums unaffordable because only high-cost consumers will purchase coverage.

Recommendation: Guaranteed issuance in the individual market should be required at a future time when the freeloader penalty will prevent substantial premium increases due to adverse selection.

Purchasing Pools

Purchasing pools provide opportunities for all individuals and small groups to benefit from the advantages and efficiencies of large group purchasing of health coverage.

Recommendation: Continue current reforms that authorize and encourage public and private purchasing pool opportunities. If private sector insurance pools do not emerge in the future to serve individual purchasers, the state should allow individual purchasers to join an existing state-sponsored purchasing pool.

Subsidized Coverage

An expansion of MinnesotaCare will provide subsidized coverage to additional low-income uninsured persons who cannot afford to purchase coverage on their own.

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Recommendation: *Eligibility for the MinnesotaCare sliding scale subsidy program should be expanded to include all persons with incomes below 275% of the federal poverty guideline who meet other eligibility requirements (i.e., four months without health insurance, eighteen months without employer provided coverage).*

Freeloader Penalty

The freeloader penalty is needed to: prevent "freeloading" and cost shifting; to reduce premiums for currently insured persons; to promote individual responsibility; to require guaranteed issuance in the individual insurance market; to provide funding to pay for health care for uninsured persons. The individual mandate must be delayed until the state has gained experience with the freeloader penalty as a way of enforcing the mandate, and until guaranteed issuance can be required in the individual insurance market.

Recommendation: *Voluntarily uninsured persons should be required to pay a "freeloader penalty" which would serve as an incentive to encourage them to buy health coverage. The effective date of the requirement that all Minnesotans must purchase coverage (the "individual mandate") should be delayed until two years after the freeloader penalty is implemented, and following a study of the effectiveness of the penalty and the need for an individual mandate.*

Community Health Insurance Pool (CHIP)

CHIP is needed to offset providers' costs of treating uninsured patients who are unable to pay for their health care and to reduce cost shifting of uncompensated care costs to purchasers.

Recommendation: *Establish a fund to pay health care providers for unreimbursed costs of treating uninsured persons.*

Summary

Prevention

An increase in tobacco tax will reduce smoking, especially among children, and offset health care costs attributable to smoking (estimated at \$470 million a year in Minnesota)¹. It will provide revenues to fund cost-effective prevention initiatives.

Recommendation: Increase tobacco taxes and dedicate the revenues for existing access and prevention programs²

Public Health & Local Government Programs

It is important to ensure that public health programs and activities are adequately funded and to avoid unfunded state mandates on local government.

Recommendation: Continue efforts to evaluate the impact of health reform on public health and local government roles and activities, and plan for change.

Evaluation

Evaluation and monitoring are needed to assess the impact of existing reforms and to determine whether modifications are needed.

Recommendation: Evaluate health reform programs. Establish a system of monitoring the uninsured population over time.

¹ Minnesota Department of Health, Press Release: *Economic and Human Costs of Smoking in Minnesota Continue to Rise*, January 11, 1995.

² The commission recommends that existing state revenues be used to pay for expanding the MinnesotaCare program rather than increasing taxes and government spending. However, if the Legislature does not use existing resources, the commission recommends a tobacco tax increase.

Universal Coverage

Universal coverage means:

- (1) a source of payment exists for every Minnesotan's health care, and
- (2) all Minnesotans pay into the system according to their ability.

This definition of universal coverage continues to be the goal; however, progress toward universal coverage must be moderate and sequential.

Recommendation: Continue toward universal coverage with the steps above, but delay the effective date of a requirement that every Minnesotan maintain coverage until the effects of the freeloader penalty and the need for the requirement, can be determined.

Financing Recommendations

Expansion of the MinnesotaCare Subsidy Program

If the waiver proposal that has been submitted to the federal government for approval is granted, the increased flexibility and federal financial participation will enable the state to make major progress toward achieving its health care access goals (see discussion of the waiver, page 25). However, the fate of the waiver proposal is uncertain. In the event the waiver is not granted, we recommend the following financing strategies:

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► *First preference: Use existing state revenues*

The cost of expanding the MinnesotaCare Program under the commission's plan is approximately \$99 million a year (Fiscal Year 1998 (FY98) estimate). The commission's plan can be financed without any increase in taxes or overall state spending, by reprioritizing existing state revenues. This is the responsible and fiscally prudent approach. Many of the commission's goals can also be achieved without a tax increase if the state's pending MinnesotaCare Health Care Reform waiver proposal is approved by the federal Health Care Financing Administration (HCFA).

Recommendation: The commission recommends using existing state revenues to cover the additional costs, without any increases in taxes or government spending.

► **Second preference: Tobacco tax increase**

The commission would not be fulfilling its statutory duty to recommend new sources of financing for universal coverage if it stopped with the recommendation that existing resources be used. Therefore, the commission recommends that, if the Legislature and the Governor choose not to reallocate existing resources, the new costs should be paid for with revenues from a tobacco tax increase. In addition to providing funding for the MinnesotaCare Program, the tobacco tax increase would produce a 10% reduction in smoking (a much higher reduction among children) to reduce the \$470 million spent annually in Minnesota on smoking-related health care costs.

Recommendation: If existing state resources are not provided to cover the new costs, the commission recommends a 40 cent per pack tax increase on cigarettes and a comparable tax increase on other tobacco products. This will produce an estimated \$120.6 million per year in new revenues by 1998. The tobacco tax should also be indexed to keep pace with inflation.

Summary

Transfers from the Health Care Access Fund to the General Fund

In the past, millions of dollars have been transferred from the Health Care Access Fund to the General Fund. The commission believes all revenues from the provider and premium taxes (and the tobacco tax increase, if enacted), should be dedicated to health care reform programs. None of this money should be transferred to the General Fund to finance other state programs.

Recommendation: Discontinue transfers to the general fund.

Prevention Programs

If the tobacco tax increase is enacted, the commission recommends earmarking a portion of the new revenues for prevention programs, including prenatal care, violence prevention, immunizations, smoking prevention and cessation, and wellness programs.

Recommendation: Earmark a portion of the tobacco tax revenues for prevention programs

CHIP Pool

The CHIP pool to pay health care providers for the unreimbursed costs of treating uninsured patients should be funded out of revenues generated by the freeloader penalty.

Recommendation: Fund the CHIP pool with revenues from the freeloader penalty.

Summary

Impact of the Commission's Recommendations

Preliminary results of the model developed by the commission's consultant indicate that the commission's recommendations are projected to have the following effects in 1998, compared to the "baseline"³ or status quo projected to 1998:

Improvements in cost and access to health care:

- ▶ An additional 54,500 persons will become enrolled in the MinnesotaCare subsidy program, at an additional cost of \$99 million.
- ▶ An additional 22,500 persons will obtain insurance in the private market.
- ▶ The number of uninsured Minnesotans will decrease by 77,000 persons.
- ▶ The small group insurance market (employers with 2-49 employees) will experience a *net gain* in enrollment of 4,500 persons.
- ▶ The individual insurance market will experience a *net gain* in enrollment of 18,000 persons.
- ▶ Because of the favorable net gain in enrollment in the small group and individual markets, premiums and out of pocket costs will be slightly lower, resulting in savings of over \$12 million to purchasers in these markets.
- ▶ As a result of the reduction in the number of uninsured, uncompensated care costs in the system will be reduced. Revenues from the freeloader penalty will further offset uncompensated care burdens. This reduction in uncompensated care costs will reduce cost shifts to purchasers, resulting in further savings to purchasers and taxpayers.

³ The "baseline" serves as a reference point. The baseline includes: the current projected MinnesotaCare subsidy program enrollment and costs; current implementation of insurance reform (the baseline assumes no guaranteed issuance, and maintenance of rate bands at current levels); and no implementation of the freeloader penalty. The baseline was used to compare the potential impact of new commission recommendations with current law.

Goals not accomplished:

- ▶ 214,000 Minnesotans will remain uninsured.
- ▶ Implementation of the guaranteed issuance requirement in the individual insurance market will be delayed -- health plan companies will continue to be allowed to deny coverage to persons in the individual market who have not maintained continuous coverage and who are considered a high risk.
- ▶ In the absence of guaranteed issuance, Minnesota's high risk insurance pool for medically uninsurable individuals, the Minnesota Comprehensive Health Association (MCHA) will continue. The current narrow MCHA funding base persists.
- ▶ In order to qualify for subsidized coverage through MinnesotaCare, low income, uninsured persons must still go four months without insurance, and 18 months since they last had access to employer-subsidized coverage.
- ▶ The lack of universal coverage will continue to result in some cost shifting and will handicap cost containment and quality improvement efforts.

Discussion

An Affordable Step Toward Universal Coverage

Introduction

This report contains the Minnesota Health Care Commission's recommendations for a financing strategy to improve access to health coverage for uninsured Minnesotans. The recommendations are integral to Minnesota's health care reforms initiated in 1992 under HealthRight (subsequently renamed MinnesotaCare) to improve costs, quality, and access to health care in the state.

The commission developed this report in response to a mandate of the 1994 Minnesota Legislature to develop a financing plan that will lead to universal coverage by 1997. The commission developed its recommendations through research, analysis, and an open, public process of stakeholder discussion from July through December 1994, designed to achieve broad-based, bipartisan support for a financing strategy.

Our financing recommendations build upon the universal coverage strategy that was developed by the commission in 1993. The commission's definition of "universal coverage" differs from concepts advocated in many other proposals. It envisions a primarily private-sector health care and delivery system rather than a new government entitlement program. It involves a set of creative new strategies that will improve access to health coverage, reduce cost shifting, and promote personal responsibility. The strategy is described in much greater detail in the commission's **Universal**

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Coverage Report, a summary of which is included at the end of this report.

The commission's universal coverage strategy was enacted into law during the 1994 legislative session, but its full implementation is conditional on the enactment of adequate financing for the subsidy program, full implementation of insurance reforms, and other conditions. The commission continues to consider the recommendations set forth in the **Universal Coverage Report** to be the state's ultimate objective. However, the recommendations in this report will not lead us to universal coverage by 1997. Our recommendations will improve access, reduce premium costs, and significantly reduce the number of uninsured Minnesotans, but they will not produce universal coverage without further steps in the future. We believe changes in the political climate and the lack of federal action justify the more moderate and sequential approach recommended in this report.

Minnesota is containing health care costs, improving quality, and assuring access as described below. These successes make it possible to take the further steps to improve coverage that the commission proposes. The remainder of this section of the report describes key principles and findings that have guided commission deliberations. A detailed description of the commission's recommendations begins on page 15.

The success of Minnesota's health reforms

Minnesota's health reforms are starting to pay off. Minnesota is making significant progress toward achieving the state's access, quality and cost containment goals. The success we have seen so far is due to a variety of factors, including new state programs, insurance law changes, the messages that have been sent as a result of the enactment of health reform legislation, and marketplace changes. The dividends are coming in many areas.

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Some examples of Minnesota's success are:

- Health care inflation has slowed dramatically. Minnesota is on track toward meeting the state's cost containment targets, which will save Minnesotans over \$7 billion⁴ in health care costs over the five years 1994-1998.
- Insurance reforms have made private coverage more affordable and accessible for many individuals and small employers, and health carriers are reporting a *net increase* in the number of small employers who offer coverage.
- Over 78,000 low-income, uninsured Minnesotans, the working poor, have obtained affordable health coverage through the MinnesotaCare subsidy program. All of them pay a premium for coverage, based on their ability to pay. Another 33,000 have obtained coverage in other health care programs as a result of the MinnesotaCare screening process.
- AFDC caseloads are *down 3.6%*⁵ (2,400 fewer AFDC recipients) because the availability of subsidized health coverage allows the working poor to stay off welfare, resulting in a net savings to the State of over \$700,000 per month, or \$8.4 million per year.
- Standardization of billing forms and electronic data systems have been enacted to reduce administrative costs.
- The Minnesota Health Data Institute and Minnesota Institute for Community Health Information, a unique public-private partnership, is developing health plan report cards, consumer satisfaction surveys, and other quality information for consumers and employers.
- A new state purchasing pool for small employers has enabled over 225 employers to benefit from the advantages and efficiency of large group

⁴ Minnesota Health Care Commission, *Containing Costs in Minnesota's Health Care System*, May 1993

⁵ Minnesota Department of Human Services, *Effects on AFDC Enrollment of MinnesotaCare*, 1994

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purchasing. Over 75% of these employers did not previously offer coverage before purchasing it through the pool. Law changes will also make it easier for more pools to form.

- ▶ A variety of activities are underway to strengthen the rural health care system, including provider recruitment, grants for financially distressed rural hospitals, loan forgiveness programs to encourage medical and nursing students to practice in rural areas, and rural residency programs, to name a few.
- ▶ New laws now make it easier for small, locally controlled health plans and provider networks to enter the market to give communities an alternative to the large statewide health carriers. Even though the law changes are recent, some health care coops and Community Integrated Service Networks (CISNs) have already formed.
- ▶ Non-regulatory technology assessments and practice parameters help providers practice more effectively and improve health outcomes and provide additional protection from malpractice liability.
- ▶ New collaborative relationships and planning requirements emphasize improving the health of the entire community and achieving public health goals.

The success of Minnesota's health reform efforts is well known nationally. Our successes should not be lost in the on-going debate over further reforms, debate which is a necessary part of the development of good public policy.

Guiding principles

The following general principles guided the commission in its development of a financing strategy:

- ▶ **Universal coverage:** A source of payment should exist for every resident's health care and every resident should pay into the system according to his or her ability.

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- ▶ **Minimize additional taxes and government spending:** Increases in taxes and government spending should be avoided or minimized.
- ▶ **Private health coverage:** Private health coverage should be encouraged and preserved.
- ▶ **Competition:** Competition on the basis of quality and efficiency should be promoted.
- ▶ **Consumer choice:** Consumers should have a wide range of choices and good information to guide their decisions.
- ▶ **State subsidies:** The state should provide financial assistance to low-income persons to enable them to maintain health coverage.
- ▶ **Financing:** State health care programs should be adequately financed through stable, reliable, progressive, and fair revenue sources.

Definition of "universal coverage"

The national health reform debate was mired in confusion about the definition of "universal coverage." To some, universal coverage means every person is enrolled in a health plan and has a health insurance card. To others, universal coverage means that everyone who wants health care can obtain it.

The commission's definition of universal coverage is:

- (1) A source of payment exists for every person's health care;
and
- (2) Every Minnesotan pays into the system according to his or her ability.

The commission does not believe "universal enrollment" -- where every person is actually enrolled in a health plan -- is achievable. Some persons

Discussion

will always remain uninsured, either voluntarily or involuntarily. "Universal access" to health coverage -- where every person can obtain affordable health coverage that covers pre-existing conditions -- is not workable without some form of universal coverage under which every person is also paying into the system. Otherwise, healthy people could drop existing coverage, knowing that if they get sick or injured they could immediately obtain health coverage that is subsidized by everyone else. In other words, they could buy coverage on the way to the hospital and drop it after they recover. Universal access to health coverage without universal coverage is likely to drive up premiums for insured persons by forcing them to pay more to cover the health care costs of persons who voluntarily choose not to maintain ongoing health coverage.

Why do we need universal coverage?

There are many reasons why universal coverage is important. It is important not only to the hundreds of thousands of uninsured persons, but also to all other Minnesotans who pay a price under the current nonuniversal system. We have a very rough and inefficient form of "universal access" to health care and treatment now -- when uninsured people need health care badly enough, they get it whether they can afford to pay for it or not. These costs are built into our taxes and health premiums. Since we are already paying for it, the real question is not "Can we afford it?" but "How can we pay for it more efficiently?"

Below are some of the many reasons why universal coverage is needed:

- ▶ Lack of health insurance can adversely affect an individual's health. Over 28% of uninsured persons report that they delayed care due to lack of coverage and of those, 70% reported delaying care for a serious health problem⁶.

⁶ Lurie, N., et.al. *Who are the Uninsured in Minnesota*, 1990

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- ▶ Lack of coverage puts individuals at risk of serious financial difficulties and bankruptcy.
- ▶ The costs of health care for the uninsured are already built into the system, but we pay these costs inefficiently. Uninsured persons are less likely to obtain preventive care and tend to delay treatment until their problem becomes more serious and more costly to treat. In addition, uninsured persons tend to use more expensive emergency rooms to obtain care.
- ▶ When uninsured persons are unable to pay their catastrophic health expenses, the costs are shifted onto insured persons and taxpayers through provider uncompensated care and government programs. These invisible shifts can neither be controlled nor contained.
- ▶ Insurance reforms designed to improve access to health coverage for persons who are at higher risk of needing health care or who have existing health conditions do not work effectively if healthy individuals can "freeload" by remaining uninsured until they actually need treatment, then shift the costs to someone else.
- ▶ To keep health coverage affordable for everyone, young, healthy uninsured persons must begin paying their fair share for coverage. This will ensure that they have access to affordable coverage when they grow older or become sick or injured.
- ▶ Under the current system, some health care providers bear an unfair share of the burden of providing uncompensated health care to uninsured persons. Purchasers who use these providers may pay a higher price to cover these costs.
- ▶ Quality monitoring systems and health care data programs do not work as effectively when a large number of patients are not in the system.
- ▶ The current system is often unfair. Very low income persons are often eligible for public programs, and middle and upper income persons often have access to employer provided health coverage. The working poor who do not qualify for public programs are at highest risk for being uninsured, but can afford it the least.

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Who are the Uninsured?

As part of the commission's universal coverage financing project, the commission undertook a major effort to determine the size and characteristics of Minnesota's uninsured population. According to the commission's research, about 400,000 persons (8.9% of Minnesota's population) are now uninsured at any given point in time⁷. In sharp contrast to national trends, Minnesota's uninsurance rate has remained stable over the last several years. Compared to insured Minnesotans, the uninsured are more likely to be male, unmarried, between the ages of 18 and 35, and to have lower incomes. About 72% of uninsured adults are currently employed. About 53,000 uninsured Minnesotans are children.

The findings of this analysis of the uninsured population significantly affected our recommendations. Our research showed that the uninsured population is made up of three different categories of individuals, each requiring a different strategy to improve their insurance status.

Three categories of the uninsured

1. Voluntarily uninsured persons.

Approximately 31% of the uninsured (124,000 persons) have incomes above the upper limit for the MinnesotaCare subsidy program. (The income limits of the MinnesotaCare subsidy program and the amount of subsidy at various levels of income are described in greater detail on page 22). In comparison to the insured population, a disproportionately large number of these individuals are young, single males, most of whom could afford the cost of coverage they would pay at current premium levels. These individuals do not require a state subsidy and already benefit from access to affordable private coverage. Because they are young and

⁷ Minnesota Health Care Commission, *Preliminary Estimates of the Number of Uninsured Minnesotans*, October 4, 1994

working, many are healthy and use few health care services. Many of these individuals choose not to buy coverage, but are unable to pay the full costs of a serious illness or injury. The unpaid costs are shifted onto others through higher premiums and taxes. Bringing these individuals into the insurance system could reduce the cost of health coverage for insured persons.

2. Persons eligible for Medical Assistance (MA) or General Assistance Medical Care (GAMC).

About 52,000 persons (13% of the uninsured)⁸ have low enough incomes that they already qualify for MA or GAMC, but have not enrolled in these programs. It is likely that many of these individuals cycle in and out of state programs as they need health care. Since they are not required to pay a premium, the state experiences no loss of revenue as a result of their failure to maintain continuous enrollment. In addition, MA and GAMC generally provide reimbursement to health care providers for treatment provided to these individuals during the three months prior to their application for enrollment, so providers get paid the same whether the patient was already enrolled or signs up after beginning treatment.

3. The target population for subsidies: low-income working persons.

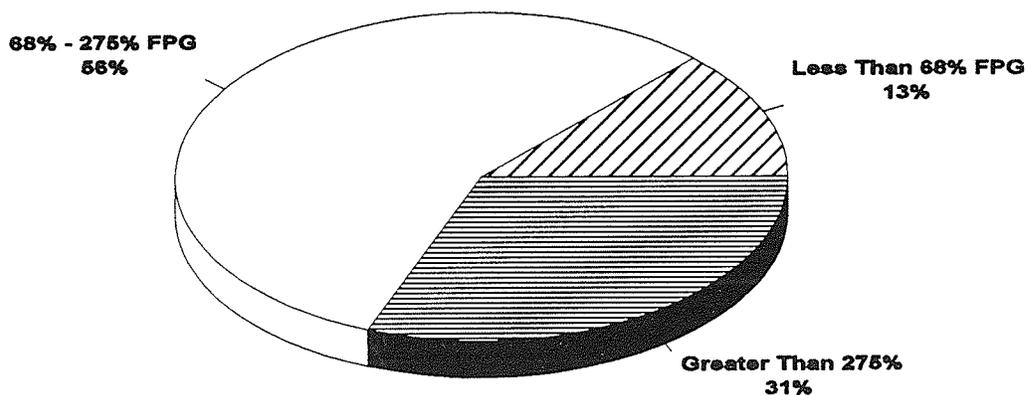
The third major subgroup of the uninsured are persons in the target population for the state MinnesotaCare subsidy program. These generally low-income working individuals earn too much to qualify for MA and GAMC, but cannot afford to pay the full cost of private health coverage. Approximately 224,000 uninsured individuals (56% of the total) have incomes between 68% of the Federal Poverty Guideline (FPG) and 275% of FPG. Nearly three-fourths of this target group have incomes less than

⁸ It is difficult to estimate precisely the size of this group because eligibility criteria vary with income, asset, and family characteristics. Our estimate underestimates the size of this group because it counts only the uninsured below 68% of the Federal Poverty Guideline (FPG), the income eligibility limit for GAMC, even though a sizeable number of individuals with incomes higher than this are also eligible.

Discussion

200% of the FPG. Many of these uninsured persons are currently eligible for MinnesotaCare but have not enrolled. Others are not eligible because they have not gone four months without insurance or because they have had access to employer-subsidized coverage sometime in the past 18 months.

INCOME AS A PERCENTAGE OF FPG AMONG THE UNINSURED IN MINNESOTA



Source: Bureau of Census, 1993 Current Population Survey

The "Safety Net" Model

The commission evaluated several different models for providing subsidies to low-income uninsured persons. The models that were considered ranged from a system of universal subsidies for all persons below a certain income threshold to a safety net program targeted for low-income uninsured persons. The commission ultimately chose the safety net model. The safety net model was chosen because it results in the smallest increase in government spending and taxes and avoids expansion of the government's role in the health care system. The commission chose to build upon the existing MinnesotaCare Program, which was designed to serve a safety net function.

Erosion of private health coverage

The safety net model is designed to provide government subsidies only to low-income uninsured persons who do not have access to private coverage. If the safety net program is not designed properly, it could prompt insured persons (or their employers) to drop existing coverage to qualify for a subsidy, thus greatly increasing the size of the population served by the program. The commission spent a considerable amount of time evaluating different methods of targeting the subsidy program for the uninsured persons who need it the most and avoiding erosion of private coverage into publicly subsidized coverage.

The architects of the 1992 HealthRight Act (later renamed MinnesotaCare) grappled with these same issues in designing the existing MinnesotaCare Program. They built into the program two "barriers" designed to prevent currently insured persons from entering the state's program:

- ▶ To be eligible, a household must have been uninsured for four months.
- ▶ To be eligible, a household must not have had access to employer-subsidized coverage within 18 months.

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In addition, MinnesotaCare coverage of inpatient hospital treatment was capped at \$10,000, to make the subsidy program unattractive to persons who have private coverage with higher coverage limits, as well as to contain state costs.

The commission's recommendations are designed to prevent erosion of private coverage and preserve the role of the MinnesotaCare Program as a safety net for the chronically uninsured who are unable to obtain private coverage.

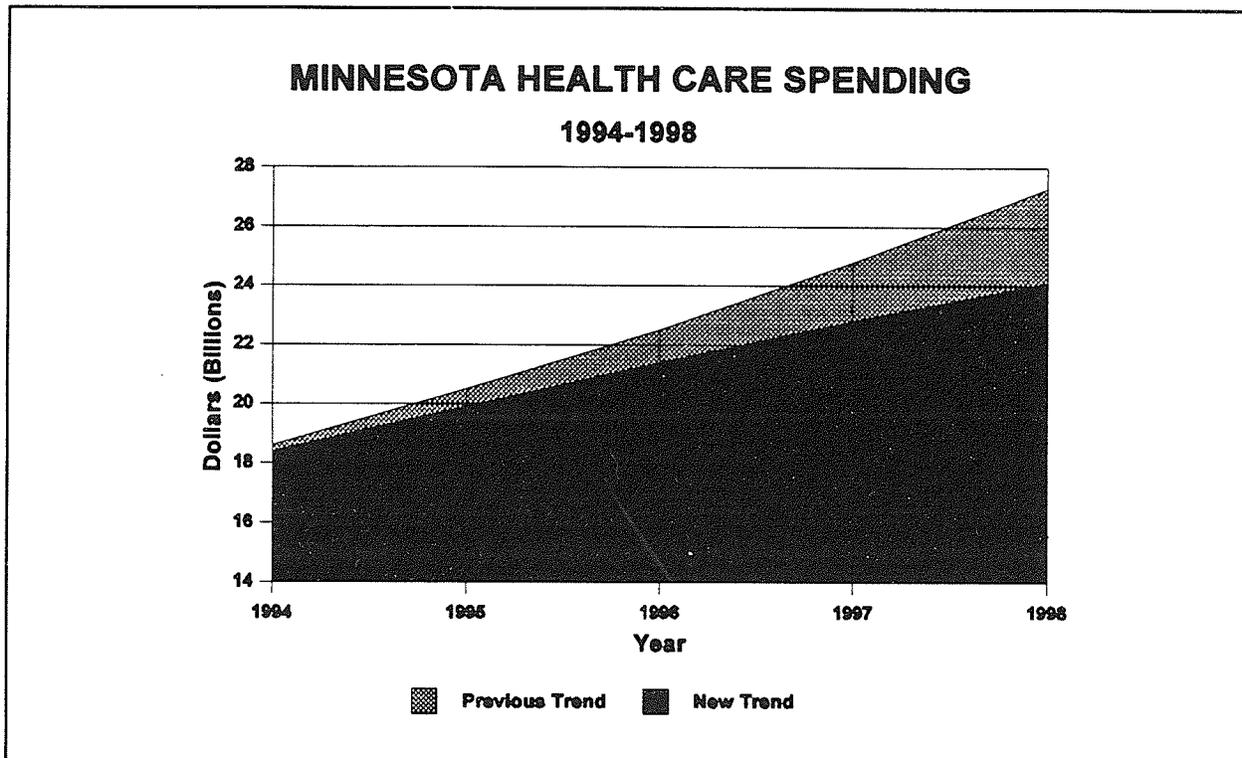
Capturing Savings to Offset the Costs of Universal Coverage

As part of the commission's financing project, the commission considered ways of capturing savings that will be experienced under health reform and reallocating the savings to reduce the costs of universal coverage. For example, health care providers' existing fee schedules have the cost of uncompensated care built in. Purchasers already pay for care provided to uninsured persons through higher provider fees and higher health plan premiums. Under universal coverage, providers will begin receiving payment for uninsured persons. If purchasers continue to pay current rates, with the costs of uncompensated care built in, but providers begin receiving additional reimbursement from previously uninsured patients who have become insured, then purchasers and the public potentially pay twice for the same patients. In order to assure that this double payment does not occur, the commission considered whether the "savings" in lower uncompensated care costs to providers due to fewer uninsured persons should be captured through a tax or assessment to offset the costs of the state's subsidy program.

After considerable discussion, we rejected the concept of specifically recapturing these savings or other savings that may result from health reform, through taxes or assessments. We concluded that in the current highly competitive marketplace, any windfalls or savings will be extracted

Discussion

in negotiations between providers and payers, ultimately reducing the cost of subsidized health care as well.⁹ While the cost of health care is still increasing at a pace greater than the general rate of inflation, we believe that the costs of universal coverage proposed in this report are more than offset by cost containment dividends. These dividends, which benefit both consumers and purchasers, are the result of market forces and other factors including MinnesotaCare's cost containment initiatives. Minnesota is on track toward reducing the rate of growth in health care costs below the growth limits established under MinnesotaCare. The following table compares the health care inflation trend projected before growth limits with the new trend projected under the growth limits.



Source: Minnesota Health Care Commission, "Containing Costs in Minnesota's Health Care System," May 1993

⁹ The commission is in the process of developing "balance sheets" to better assess the various costs and savings for each of the major stakeholders. The balance sheets and a discussion of our methodology will be provided later in a subsequent report to the 1995 Legislature.

Discussion

MinnesotaCare's cost containment initiatives and market forces have contributed to the slower rate of growth in costs. As a result of lower health care inflation, by 1998, Minnesotans will have saved a cumulative total of nearly \$7 billion dollars over what they otherwise were projected to spend for the period 1994-1998 under the previous higher inflation rates. The fact that purchasers and consumers are paying significantly less for health care than they would have paid under the old trend is relevant to a discussion of the affordability of universal coverage.

Recommendations

The Commission's Recommendations

Introduction

The commission's recommendations fall into the following categories:

- ▶ **Insurance reform:** Insurance law reforms to ensure fairness and enhanced access in the private insurance market for those who can afford to purchase private coverage.
- ▶ **Purchasing pools:** Voluntary purchasing pool opportunities for all consumers.
- ▶ **Subsidized coverage:** Expansion of the MinnesotaCare subsidized health coverage program for low-income persons who cannot afford to pay the entire cost of coverage.
- ▶ **Freeloader penalty:** A requirement that voluntarily uninsured persons pay into a fund to reimburse health care providers for the costs of treating uninsured persons.
- ▶ **Community Health Insurance Pool (CHIP):** A funding pool to help defray the unreimbursed costs to providers (and ultimately purchasers) of treating uninsured persons.
- ▶ **Prevention:** Tobacco taxes to discourage smoking and to fund cost-effective prevention programs that will reduce the costs of health coverage.

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- ▶ **Public health and local government programs:** Planning for the role and adequate funding of public health and local government activities under a reformed health system.
- ▶ **Evaluation:** An evaluation of the impact of health reform and ongoing monitoring of the size and characteristics of the uninsured population, to help policymakers determine if reform programs are working and whether changes are needed.
- ▶ **Adequate financing for the MinnesotaCare program:**

Insurance Reform

Insurance reform is an important part of the commission's financing strategy. Minnesota has made good progress in insurance reform, but some steps remain to be taken. Since the state's health reform strategy is built upon a private sector health care delivery and financing system, health plan companies must operate within a legal framework that ensures that every Minnesotan who can afford a reasonable premium is able to enroll and maintain private coverage. Our goal is to maximize the number of persons who maintain health coverage without government involvement and minimize the number who enroll in the state's programs.

Prior to 1992, many individuals and families were unable to obtain private coverage because insurance companies considered them a high risk due to health history, age, occupation or other factors. Private coverage was unavailable for these Minnesotans because they were denied coverage outright, because the plan they were offered would not cover preexisting conditions, or because the premium was unaffordable¹⁰. Insurance reforms enacted in the 1992 MinnesotaCare Act and subsequent legislation represent significant progress toward reforming insurance laws for the small group and individual insurance markets. Small group reforms include guaranteed

¹⁰ Medically uninsurable persons may purchase health coverage through the Minnesota Comprehensive Health Association (MCHA). However, MCHA premiums are allowed by the law to be slightly higher than the market average cost of similar coverage, and thus MCHA premiums may be unaffordable for some medically uninsurable persons.

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issuance to all applicants, guaranteed renewability of coverage, limitations on rate variation due to health status and risk (community rating bands), and elimination of preexisting condition limitations for persons who maintain continuous coverage.

Most of these same reforms have been extended to the individual insurance market as well. However, guaranteed issuance and the elimination of preexisting condition coverage limitations for uninsured persons entering the market for the first time have not been required because of the adverse selection that is likely to occur if health plans are required to issue community-rated coverage with no preexisting condition limitations in a voluntary individual insurance market.

Adverse selection occurs if a disproportionately high number of higher cost persons enroll, thus driving up the cost of coverage. Universal *access* to coverage in a voluntary system will lead to many persons buying coverage on the way to the hospital, then dropping it when they no longer need treatment. These "freeloaders" do not pay into the system when they are healthy, but they shift the costs of treatment onto others when they become sick or injured. Insurance reform will only work effectively if both healthy and sick people are paying premiums. If healthy people do not maintain coverage in sufficient numbers, premiums will become unaffordable for those who need it the most.

We recommend addressing the freeloader problem by requiring all Minnesotans with incomes above a specified threshold to either maintain coverage or pay a penalty. We recommend implementing this concept through the freeloader penalty described later in this report. The penalty is designed as an incentive for healthy people to maintain coverage. We believe the insurance reforms described above cannot be fully implemented without some mechanism to address freeloaders.

The commission also intends to revisit the issue of pure community rating. Reports from the commission's actuarial consultants and preliminary reports from the Minnesota Department of Commerce indicate that pure community rating might actually result in a net *decrease* in the number of insured Minnesotans because the premium increases that would

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be experienced by healthy individuals and groups might prompt them to drop existing coverage (also see the section on the freeloader penalty later in this report).

In its Universal Coverage Report last year, the commission proposed a mandate that all Minnesotans have health coverage beginning July, 1997 (the "individual mandate"). This mandate assumed that guaranteed issuance and community rating insurance reforms would also take place to make the mandate feasible. The "freeloader" issue must be addressed to make these reforms possible. In addition, the state cost of subsidizing a larger number of the uninsured under a mandate will be significantly higher than the commission's current proposal. As a result, the commission recommends that the effective date of the individual mandate be delayed until two years after the freeloader penalty is implemented, and that a study be completed to assess the effectiveness of the freeloader penalty and the need for an individual mandate.

Recommendations: Insurance reform

- ▶ Retain those insurance reform laws that have already taken effect.
- ▶ Phase in a freeloader penalty, and require guaranteed issuance and the elimination of preexisting condition coverage limitations in the individual market at the point that the freeloader penalty effectively addresses adverse selection and prevents excessive premium increases.
- ▶ Freeze current rate bands and reevaluate additional steps toward community rating beyond the current rate bands.
- ▶ Delay the effective date of the statutory requirement that every Minnesotan maintain coverage (the "individual mandate") until two years after the freeloader penalty is implemented, and require a study to assess the effectiveness of the freeloader penalty and the need for an individual mandate.

Recommendations

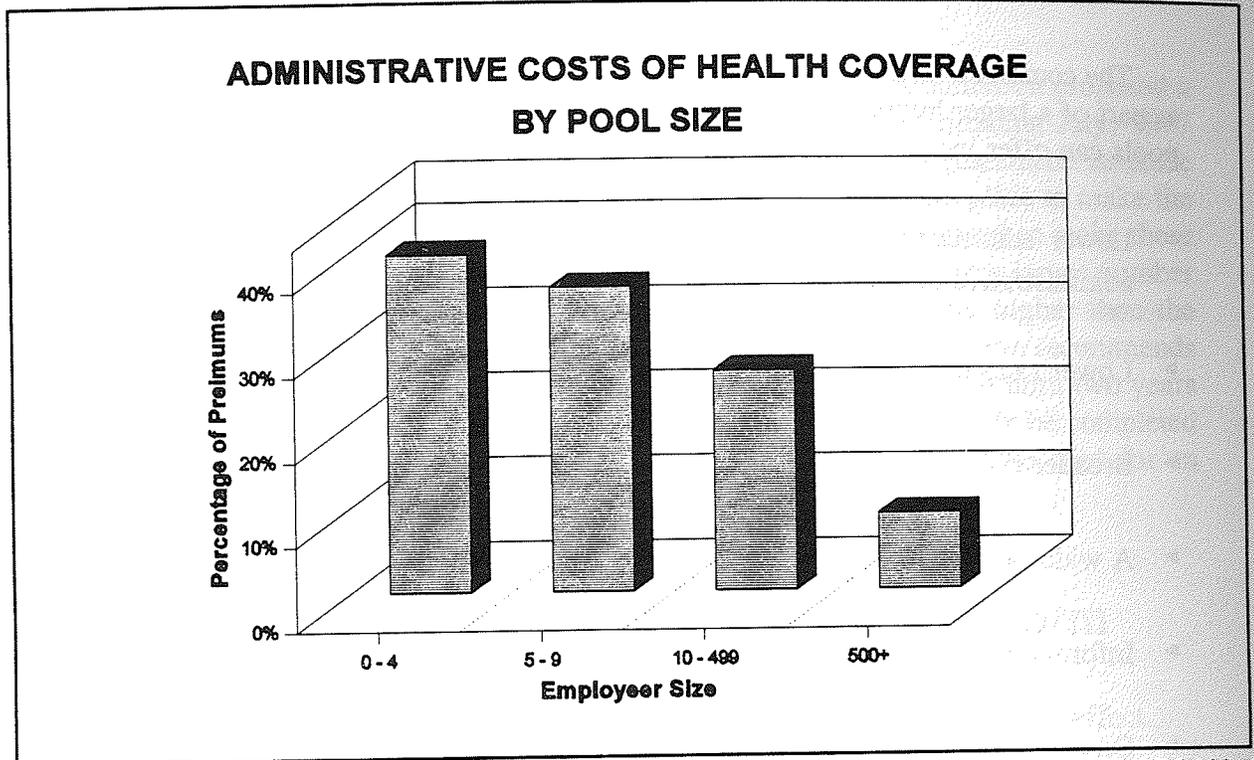
Purchasing Pools

The commission recognizes the benefits of purchasing health coverage as part of a larger buying group. Some of the advantages that purchasing pools can offer include:

- ▶ Lower administrative costs due to economies of scale (see chart on administrative costs of health coverage by pool size)¹¹
- ▶ Lower rates due to greater bargaining power
- ▶ Broader risk spreading
- ▶ A wider array of health plan choices
- ▶ Information and advocacy services for consumers
- ▶ One-stop shopping

¹¹ The information displayed in the chart is based on national data, and is for illustrative purposes only. Minnesota law (MS 62A.021) requires that, beginning in 1994, insurance in the individual and small employer markets meet aggregate minimum loss ratios. For the small employer market, the aggregate minimum loss ratio required begins at 75%, and increases annually at the rate of additional 1% per year to 82% by the year 2000. In the individual market, the aggregate minimum loss ratio required begins at 65%, and increases annually to 72% in the year 2000.

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Source: Hay & Huggins study by the U.S. House of Representatives, Subcommittee on Health (1990); as published in "Building Blocks for Change: How Health Care Reform Affects our Future," 1993

Both public and private purchasing pool opportunities currently exist for many purchasers. A state-administered purchasing pool is available for public employers and for small private employers. Purchasing pool opportunities are currently limited or nonexistent for persons who buy coverage individually.

In the current marketplace and regulatory environment, a voluntary purchasing pool for individual purchasers may be unworkable due to the risk that only high-cost individuals will seek coverage through the pool, which will make the cost of coverage unaffordable. With the implementation of insurance reform in the individual market, however, purchasing pools for individuals are more likely to be successful.

Recommendations: Purchasing pools

- ▶ Continue current reforms that authorize and encourage public and private purchasing pool opportunities.
- ▶ If private sector insurance pools do not emerge in the future to serve individual purchasers, the state should allow individual purchasers to join an existing state-sponsored purchasing pool.

Subsidized Coverage

A variety of state health care reforms have been established to improve access to private health coverage for individuals who have sufficient resources to pay a reasonable premium. These reforms include insurance law changes and purchasing pool opportunities. Even with these reforms, however, some low-income Minnesotans will be unable to pay the entire cost of health coverage themselves. Subsidy programs are needed to help defray the cost of coverage for low-income Minnesotans.

The MinnesotaCare Program was created in the 1992 health care reform law to provide subsidized health coverage to low-income uninsured persons. To qualify, individuals and families must have incomes below specified limits, must have gone without health coverage for at least four months, and must not have had access to employer-subsidized health coverage for at least 18 months. The current income limits are 275% of the Federal Poverty Guidelines (FPG) for households with children, and 125% of the FPG for households with no children (see information on the Federal Poverty Guidelines below).

Persons who enroll in the MinnesotaCare Program pay a premium that varies according to their ability to pay. As a household's income approaches the upper end of the premium scale, most of the costs of coverage are paid for by the household rather than the state. The program's sliding premium scale is summarized in the table below.

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The commission recommends that the state subsidy programs be consolidated, simplified and modified to more effectively provide financial assistance to these individuals.

Federal Poverty Guidelines (FPG): This report frequently refers to the Federal Poverty Guidelines. The following table shows various percentages of the FPG at different income levels and for different family sizes.

Family Income at Various Levels of the 1994 Federal Poverty Guidelines (FPG)

Family Size	68% of FPG	100% of FPG	125% of FPG	133% of FPG	150% of FPG	200% of FPG	275% of FPG
1	\$5,005	\$7,360	9,200	\$9,789	\$11,040	\$14,720	\$20,240
2	\$6,691	\$9,840	\$12,300	\$13,087	\$14,760	\$19,680	\$27,060
3	\$8,378	\$12,320	\$15,400	\$16,386	\$18,480	\$24,640	\$33,880
4	\$10,064	\$14,800	\$18,500	\$19,684	\$22,200	\$29,600	\$40,700
5	\$11,750	\$17,280	\$21,600	\$22,982	\$25,920	\$34,560	\$47,520
6	\$13,437	\$19,760	\$24,700	\$26,281	\$29,640	\$39,520	\$54,340

MinnesotaCare Sliding Scale: The MinnesotaCare program sliding scale is used to determine the amount an eligible household must pay to obtain coverage. The sliding scale has been set to direct the most subsidy to those with the lowest income. Enrollees are required to make at least a nominal contribution to the cost of their coverage at even the lowest income levels. The amount of subsidy diminishes rapidly as incomes increase over 225% of the FPG, to nearly zero subsidy at incomes approaching the

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maximum of 275% FPG.¹² The MinnesotaCare sliding scale subsidy has incorporated this phaseout of the subsidy at higher income levels to encourage individuals to seek employment or better paying jobs that ultimately may lead them off the program. Without the current gradual phase out of the subsidy, a MinnesotaCare enrollee who was faced with a large loss of subsidy when making even slightly higher income may reject additional work or better paying jobs to continue to qualify for the subsidy. Currently, the majority of persons enrolled in MinnesotaCare are at the lower end of the income eligibility scale.

The following table summarizes the MinnesotaCare sliding scale. The table shows the premium contribution by the state and by enrollees, for different family sizes and at various income levels. The chart is based on the current actuarially determined full premium for MinnesotaCare in 1994, which is \$138 per month for individual coverage, \$275 per month for a two person family, and \$413 per month for families with three or more.

¹² At present, 225% of FPG is approximately \$16,560 for a single individual, \$22,140 for a two person family, and \$27,720 for a family of three.

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MinnesotaCare Program Example Average Monthly Household Premiums For Households with Children

Family size	Federal Poverty Guideline (and dollar equivalent gross annual income)	State share of MinnesotaCare premium	Enrollee share of MinnesotaCare premium
1	100% (\$7,360)	\$124	\$14*
	150% (\$11,040)	\$103	\$35*
	200% (\$14,720)	\$66	\$72
	250% (\$18,400)	\$3	\$135
2	100% (\$9,840)	\$256	\$19*
	150% (\$14,760)	\$229	\$46*
	200% (\$19,680)	\$178	\$97
	250% (\$24,600)	\$94	\$181
3	100% (\$12,320)	\$389	\$24*
	150% (\$18,480)	\$354	\$59*
	200% (\$24,640)	\$292	\$121
	250% (\$30,800)	\$188	\$225

* Children in families with income at or below 150% of FPG pay a \$4.00 monthly premium.

Recommendations: State subsidized health coverage

The commission has two different plans for providing state subsidized coverage to low-income Minnesotans. **Plan A** is based on the federal waiver proposal (MinnesotaCare Health Care Reform Waiver) the state has

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submitted to the federal government. **Plan B** is a contingency plan that would be implemented if the federal waiver is not granted. Plan B can be implemented without changes in federal laws or regulations.

Plan A: The Federal Waiver Proposal. The commission's "Plan A" is the state's federal waiver proposal. The waiver proposal seeks federal approval to modify state and federal health care programs to achieve Minnesota's health reform goals, including the consolidation and simplification of state programs and expansion of managed care contracting.

If the waiver is granted, state programs would be combined and modified according to the waiver proposal. However, the future of the waiver proposal is uncertain. Until a decision on the waiver is made, the commission recommends that the state plan for and implement "Plan B," which could be implemented without a federal waiver. We have designed Plan B to be reasonably consistent with the waiver strategy so that any necessary mid-course corrections can be made more easily in the event the waiver is approved.

Plan B: State Subsidized Health Coverage Under Existing Federal Law. Plan B can be achieved without changes in federal laws or regulations. As with Plan A, the goal is to simplify and combine the state's health coverage programs and increasingly provide coverage through managed care contracts rather than fee-for-service reimbursement for certain populations.

If the waiver is not approved:

- ▶ Increase the MinnesotaCare income limit for households without children to 275% of FPG.
- ▶ To the extent feasible, combine General Assistance Medical Care (GAMC) and MinnesotaCare programs into a single, streamlined MinnesotaCare program.
- ▶ Continue efforts to move from a fee-for-service system to managed care contracting, and consider the possibility of a voucher arrangement that could be used to purchase coverage in the private market.

Recommendations

- ▶ Continue to use the current sliding scale to determine enrollee premiums, but even out the steps between different income levels to allow a smoother transition between income levels.
- ▶ Establish a transition program to enable MinnesotaCare enrollees who have the opportunity to purchase private coverage to continue to receive a partial subsidy to facilitate the movement from the public program to private coverage.
- ▶ Make some additional refinements and improvements to the program to correct inequities and problems with the existing program.

Freeloader Penalty

A sizeable group of the uninsured are persons who can afford to purchase health coverage but choose not to do so. Nearly 31% of the uninsured (approximately 124,000 individuals) have incomes above 275% of the FPG¹³. A disproportionately large percentage of these individuals are young, healthy, single males. The state's insurance reforms will make health coverage more affordable and available to these individuals when they grow older, get married and have children, or become sick or injured. To keep health coverage affordable for everyone, all Minnesotans must pay into the system according to their ability -- when they are healthy as well as when they are sick. Bringing young, healthy, uninsured males into the system will reduce premium costs for everyone else.

The commission recommends establishing a financial penalty that will serve as an incentive for voluntarily uninsured individuals to fulfill their obligation to protect themselves and others from the risk of catastrophic illness or injury by purchasing health coverage. The purpose of the penalty is to prevent "freeloaders." Freeloaders are persons who can afford

¹³ Minnesota Health Care Commission, *Preliminary Estimates of the Number of Uninsured Minnesotans*, October 4, 1994

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coverage but choose not to buy it. However, when in need of health care, they receive it at the expense of others.

There are two types of freeloaders. Some freeloaders remain uninsured but are unable to pay the entire costs of their treatment when they receive it. When this happens, the costs of their treatment are shifted onto others in the form of higher premiums to offset providers' unreimbursed costs or taxes for government programs. The second type of freeloader includes persons who do not buy health coverage until they think they will need it. They do not pay into the system when they are healthy, but when they are sick or injured they purchase coverage and the costs of their treatment is subsidized by premiums paid by those who have maintained coverage all along.

If insurance reforms such as guaranteed issuance and community rating bands are implemented in the individual insurance market without an effective incentive for healthy individuals to maintain coverage, significant erosion of private coverage is likely and the cost of coverage may increase substantially¹⁴. This will occur because the new insurance reforms will make it even easier to freeload on the system.

We propose to require voluntarily uninsured persons above a certain income level to pay into a fund to pay providers for care provided to uninsured persons. The penalty would be designed to serve as an incentive for persons to obtain health coverage. Ideally, the penalty will not produce *any* revenue because people will choose to obtain coverage rather than pay the penalty. However, any revenues that are raised would be used to offset the burden on providers of uncompensated care provided to uninsured patients.

¹⁴ According to the commission's actuarial consultants, implementing guaranteed issuance and pure community rating, without an effective freeloader penalty, would have significant adverse impact in the small group and individual markets, and on the number of the uninsured. The individual market would be particularly affected, primarily due to the reenrollment in the individual market of individuals from the state's high risk pool for medically uninsurable persons, the Minnesota Comprehensive Health Association (MCHA). Based on the model prepared by the actuaries, in the absence of an effective freeloader penalty, implementing both guaranteed issuance and pure community rating would result in: premium increases of over 50% in the individual market; loss of enrollment in the small group and individual markets; and a corresponding net increase in the number of the uninsured, from the current level of 400,000 uninsured, to nearly 460,000.

Recommendations

According to the commission's actuarial consultants, an effective freeloader penalty will produce a slight *decrease* in premiums for persons in the small group and individual coverage markets. These decreases result because the influx of healthy individuals (the potential "freeloaders") into the insurance system reduces the average cost of coverage.

The commission is developing specific recommendations on the amount of the penalty and implementation and enforcement methods. At least initially, the penalty should be low enough to be perceived as reasonable and not draconian. However, the penalty eventually must be large enough to act as a strong incentive for voluntarily uninsured persons to purchase health coverage. The commission therefore recommends that the penalty be phased in over several years, beginning with a relatively modest penalty and increasing the penalty amount until it exceeds the cost of purchasing health coverage.

Recommendations: Freeloader penalty

- ▶ Establish a freeloader penalty to encourage voluntarily uninsured persons with incomes above 275% of FPG to obtain coverage.
- ▶ Set the penalty as a percentage of income, so that persons with higher incomes pay a larger penalty.
- ▶ Administer the freeloader penalty system separately from the income tax system, but use income tax mailings to simplify distribution of notices and forms.
- ▶ Phase in the freeloader penalty over time, beginning with relatively modest penalties and increasing until the penalty exceeds the cost of purchasing private coverage.

Recommendations

- ▶ Delay the effective date of the statutory requirement that every Minnesotan maintain coverage (the "individual mandate") until two years after the freeloader penalty is implemented, and require a study to assess the effectiveness of the freeloader penalty and the need for an individual mandate.
- ▶ Deposit revenues from the freeloader penalty in the CHIP pool (see description below) to reimburse health care providers for the costs of providing health care to uninsured persons who are not eligible for state health care programs and are not able to pay their bills.
- ▶ Establish public education programs to educate Minnesotans regarding their obligation to maintain health coverage and the consequences of failing to do so.

Community Health Insurance Pool (CHIP)

Even with effective public education efforts and financial incentives to encourage voluntarily uninsured persons to obtain coverage, some persons will remain uninsured. The burden of uncompensated care provided to uninsured persons falls inequitably on health care providers with a higher proportion of uninsured patients. The CHIP pool is designed to spread the burden of uncompensated care more broadly across the entire community and to partially offset the costs of treating uninsured persons that otherwise would be shifted onto other purchasers or government programs. CHIP also serves as a gateway to health coverage for uninsured persons, because health care providers and the state would provide uninsured persons with information and assistance on how to obtain health coverage.

Recommendations

Recommendations: Community Health Insurance Pool (CHIP)

- ▶ Establish a funding pool to pay for health care for uninsured Minnesotans.
- ▶ Authorize payments from the pool to Minnesota health care providers who provide treatment to uninsured patients who are unable to pay their bills and are not eligible for retroactive coverage under state health care programs.
- ▶ Require providers to make reasonable efforts, using standard collection procedures for a period of at least three months, to collect from uninsured patients the unpaid balance before becoming eligible for CHIP reimbursement.
- ▶ Authorize providers to seek CHIP payments by submitting quarterly reports with their unreimbursed costs of treating uninsured patients.
- ▶ Distribute money in the pool to providers who have submitted reports in proportion to their share of the total claims submitted, up to a maximum of 50% of their unpaid charges (the 50% limit preserves the incentive for providers to make a serious effort to collect from the patient).
- ▶ If a surplus exists at the end of the fiscal year, the surplus should be transferred to the Health Care Access Fund.

Public Health and Local Government Roles

Public health and local government programs and activities are an important part of the health care delivery and financing system. Existing MinnesotaCare legislation increases the obligation of private health plans to be partners in community-wide efforts to improve the health of the entire population. However, progress toward universal coverage may result in a smaller role for public health and local governments as a safety net for uninsured persons and as a provider of services that are currently not provided in the private sector. Changes in the health care system must be made in a way that does not weaken the ability of government programs and public health systems to provide important public health services that benefit the entire community.

The 1994 MinnesotaCare Act established a process for planning for the future role of public health. Among other activities, this process will include the development of recommendations for adequate funding.

Recommendations: Public health and local government roles

- ▶ Continue existing efforts to evaluate the impact of the changes in the health care system on the public health system and on local governments.
- ▶ Continue existing efforts to plan for the future role of the public health system and of local governments, including the development of specific recommendations for ensuring that necessary and appropriate public health functions are adequately funded.

Recommendations

- ▶ Evaluate health care reforms and financing strategies to ensure that they do not result in unfunded mandates upon local governments, or cost shifts onto persons who purchase health insurance.

Prevention

A significant portion of Minnesota's health care costs are preventable. According to the Health Project Consortium and others, approximately 70%¹⁵ of health care costs are preventable. The health care financing system should include incentives for individuals to act responsibly and discourage unhealthy practices that tend to increase health care utilization and costs. Taxes have been shown to be an effective technique for reducing smoking and alcohol abuse. States and countries that have increased tobacco taxes significantly have experienced measurable decreases in the tobacco use. Studies have shown that every 10% increase in the price of cigarettes produces a 4.5% reduction in smoking¹⁶ (14% reduction among young people)¹⁷.

In developing its financing recommendations, the commission considered not only the revenue-raising potential of different taxes, but also their ability to further the state's interest in improving the health of the community and reducing health care costs, not only for public programs but also for private purchasers.

The commission recommends funding the costs of expanding the MinnesotaCare subsidy program through existing state revenues without increases in taxes or government spending. However, if the Legislature

¹⁵ Reduction in health care costs by reduction in demand, *The Health Project Consortium*, October 1992.

¹⁶ Manning, W.G., Keeler, E.B., Newhouse, J.P., et. all. *The Costs of Poor Health Habits*, Harvard University Press 1991. and U.S. Department of Health and Human Services: *Reducing the Health Consequences of Smoking: 25 Years of Progress*. A Report of the Surgeon General 1989. USDHHS, PHS, CDC, Office on Smoking and Health. DHHS Publ. No. (CDC) 89-8411. Washington DC: Government Printing Office, 1989; 529-537.

¹⁷ Lewit, E.M., Coate, D., Grossman, M.. The Effects of Government Regulation on Teenage Smoking: Are There Economic Causes? *J Law Econ.* 1981; 24:545.

Recommendations

chooses not to use existing revenues, the commission recommends increasing the tobacco tax and using the proceeds for the MinnesotaCare program and for cost-effective prevention programs.

Recommendations: Prevention

- ▶ Reduce smoking related diseases by increasing tobacco taxes (a 40 cent a pack increase on cigarettes and a corresponding increase on other tobacco products)¹⁸
- ▶ Invest a portion of the revenues from the tobacco tax increase in cost effective health promotion, prevention, and early intervention strategies, including smoking prevention and cessation, violence prevention, immunizations, prenatal care, and wellness programs.
- ▶ Reduce consumption of alcoholic beverages by increasing excise taxes on beer, wine, and spirits (the commission generally recommends this approach, but we are not including a specific proposal in our recommendations for 1995 legislation).

Evaluation of Health Reform Programs

Minnesota has made exceptional progress in health reform. Many reform strategies are already having a positive impact on health care accessibility, quality, and affordability. The time has come to plan for a major evaluation of the impact of existing reforms. Future reform steps should reflect the findings of this evaluation.

¹⁸ The commission recommends that existing state revenues be used to pay for expanding the MinnesotaCare program rather than increasing taxes and government spending. However, if the Legislature does not use existing resources, the commission recommends a tobacco tax increase.

Recommendations

Recommendations: Evaluation of health reform programs

- ▶ Evaluate all major MinnesotaCare health care reform programs at appropriate intervals to determine their impact, and the need for possible changes, eliminations, or additions of health care reform programs.
- ▶ Monitor Minnesota's uninsured population annually to identify trends in the number and characteristics of the uninsured.
- ▶ Evaluate the changes that have occurred in the marketplace and determine whether any legislation is needed to address problems or guide future changes.
- ▶ Evaluations should make use of objective consultants who do not have a vested interest in the outcome of the evaluation

Adequate Financing for the MinnesotaCare Program

Any discussion of financing for health reform programs requires attention to the federal ERISA (Employees Retirement Income Security Act) law. The commission's **Universal Coverage Report** contains a lengthy discussion of the ERISA issue. ERISA significantly limits the range of policy options available to Minnesota to finance health care programs, and numerous financing strategies to replace or supplement the existing provider and health plan taxes funding the MinnesotaCare subsidy program would not survive an ERISA preemption challenge. The commission discussed the ERISA issue, but made no recommendation on ERISA waivers in preparing this report.

Recommendations

The commission reaffirms the safety net approach taken by the current MinnesotaCare program. Therefore, our goal is to provide supplemental revenues to fully fund the existing program, rather than to replace the existing system with a major new program and new taxes to fund it. If the waiver proposal that has been submitted to the federal government for approval is granted the increased flexibility and federal financial participation will enable the state to make major progress toward achieving its health care access goals (see previous discussion of the waiver, page 25). However, the fate of the waiver proposal is uncertain. In the event the waiver is not granted, we recommend the following financing strategies:

First preference: use existing resources. The commission prefers that the Legislature pay for universal coverage out of existing state revenues. Over the past several years, we have repeatedly heard legislative leaders and state officials state that access to health care is a top priority. We agree that access is a high priority. The state currently spends millions of dollars on services and programs that are not as important as health care. We believe universal coverage can be financed without any increase in taxes or overall state spending by reprioritizing existing resources to provide the necessary funding. We believe this is the responsible and fiscally prudent approach.

Fallback: tobacco tax. However, the commission is aware that legislators and the Governor are faced with many other requests for additional state funding, each claiming to be the highest priority. We do not believe we would be fulfilling our statutory duty to recommend financing for universal coverage if we stopped with our recommendation that existing resources be used. Therefore we recommend that, if the Legislature and the Governor choose not to reallocate existing resources to fund universal coverage, it should be paid for with revenues from an increase in the tobacco tax. The CHIP fund to reimburse health care providers for unpaid treatment of uninsured persons is self-funded with revenues from the freeloader penalty.

Recommendations

The Current MinnesotaCare Budget

Most of the financing needed to pay for the commission's recommendations already exists as a result of the health care provider taxes and the premium tax increase that were approved in the 1992 health care reform legislation. When fully phased in, these taxes will produce revenues of approximately \$280 million a year (FY99). The commission recommends continuing these taxes at their current level, but does not recommend increasing them.

We are disturbed by the fact that some money from the health care access fund continues to be transferred to the General Fund to cover costs of other state programs. The latest report released by the Department of Finance shows planned transfers of over \$23 million for the upcoming biennium. The provider and premium taxes were enacted with the promise that revenues would be placed in a separate fund and dedicated for health reform programs. Every dollar that is transferred out of the Health Care Access Fund reduces our ability to provide subsidized health coverage to low-income uninsured Minnesotans. We recommend that all money raised by the provider and premium taxes be retained in the health care access fund.

The following page contains a balance sheet for the health care access fund that shows all revenues and expenditures between FY92 and FY99. If current income limits are retained (275% of FPG for families with children, 125% of FPG for households with no children), the fund will be solvent at least through FY98. Therefore, the commission has focused on obtaining sufficient revenues to increase the income for households without children to 275% of FPG, as was originally envisioned when the 1992 law was passed.

MinnesotaCare
Health Care Access Fund
December, 1994
(\$ in Thousands)

	Actual FY92	Actual FY 93	Actual FY 94	Enacted FY 95	Planning Estimate FY 96	Planning Estimate FY 97	Planning Estimate FY 98	Planning Estimate FY 99
Actual & Estimated Resources								
Balance Forward From Prior Year	0	(105)	13,423	29,099	53,646	60,480	58,832	31,157
Prior Year Adjustments			66					
Subtotal	0	(105)	13,489	29,099	53,646	60,480	58,832	31,157
Receipts:								
Cigarette Tax: 5 cents		18,886	10,781					
Hospital Tax: 2% of gross revenue as of 1-1-93		11,843	42,700	45,092	48,953	54,702	59,080	64,000
Other Provider Tax: 2% of gross revenue as of 1-1-94			14,600	95,145	98,457	105,062	113,460	122,536
MnCare Premium: Individuals		1,723	10,408	14,307	20,034	24,908	29,930	32,861
HMO Gross Premium Tax: 1% as of 1-1-96					8,334	16,126	16,900	17,900
Non-profit Gross Premium Tax: 1% as of 1-1-96					4,792	9,367	10,115	10,924
DOER Payback for MEIP Advances						2,075		
Miscellaneous Receipts			2					
MDH: Filing Fee			1	167	256	1,885	1,885	1,885
Subtotal Gross Receipts	0	32,452	78,492	154,711	180,826	214,125	231,370	250,106
Revenue Refunds			3,176	1,000				
Subtotal Net Receipts	0	32,452	75,316	153,711	180,826	214,125	231,370	250,106
Total Resources Available	0	32,347	88,805	182,810	234,472	274,605	290,202	281,263
Actual & Estimated Uses								
Expenditures:								
Higher Education Coordinating Board		59	488	707	728	750	776	803
University of Minnesota		2,200	2,277	2,357	2,428	2,501	2,588	2,679
DHS: HCAF Grants (Direct Appropriation)		193	22,892	59,978	118,632	150,987	184,668	231,570
DHS: HCAF Grants (Statutory Appropriation)		1,723	10,408	14,307	20,034	24,908	29,930	32,861
DHS: Administrative	45	3,694	5,320	12,632	11,224	11,561	11,965	12,384
Health, Department of		2,216	4,695	9,977	9,246	9,524	9,857	10,202
Commerce, Department of		568	0	0	0	0	0	0
Legislature		120	90	175	180	186	192	199
Administration, Department of		27	0	0	0	0	0	0
Revenue, Department of		367	1,157	1,800	1,410	1,452	1,503	1,548
Total Expenditures	45	11,167	47,327	101,933	163,883	201,868	241,480	292,247
Transfers to Other Funds:								
DHS: Special Revenue Fund for MAXIS	60	1,497	189	239	239	239	239	239
DHS: Special Revenue fund for MMIS		1,367	733	150	150	150	150	150
DOER: Employer Insurance Trust Fund		525	550	1,000	0	0	0	0
MA/GAMC General Fund Costs		4,368	10,907	25,842	9,720	13,516	17,176	21,601
Total Transfers	60	7,757	12,379	27,231	10,109	13,905	17,565	21,990
Total Uses	105	18,924	69,706	129,164	173,992	216,773	259,045	314,237
Balance Before Reserves	(105)	13,423	29,099	53,646	60,480	58,832	31,157	(32,974)
Premium Reserve - 5% of direct appropriated grants	0	10	1,145	2,999	5,932	7,549	9,233	11,579
Reserve for Incurred But Not Reported Claims	0	1,916	11,200	15,634	7,868	2,308	2,394	1,940
Balance After Reserves **	(105)	11,497	16,764	35,013	46,681	48,975	19,530	(46,492)

** The fund balance reflects enrollment of adult-only households up to 125% of the federal poverty level beginning October, 1994.

Recommendations

Recommendations: Financing the commission's recommendations

- ▶ Continue the existing provider and health plan taxes at current rates.
- ▶ Discontinue transfers out of the Health Care Access Fund into the General Fund.
- ▶ Pay for the expansion of the MinnesotaCare subsidy program out of existing state resources, without any increase in taxes or government spending.
- ▶ If the Legislature and the Governor choose not to pay for the expansion out of existing resources, fund the expansion with a tobacco tax increase of 40 cents per pack of cigarettes and a comparable increase in the tax on other tobacco products.
- ▶ Establish a freeloader penalty to fund the CHIP pool to partially reimburse providers for unpaid treatment of uninsured patients.

The Financing Model

In previous years, policymakers' decisions regarding health reform programs and financing were severely handicapped by inadequate information about the impact of their decisions. During 1994, the commission contracted with Milliman and Robertson, an actuarial consulting firm, to develop a sophisticated model to assess the impact of different combinations of decisions about insurance reform, eligibility for state programs, and financing. The model was used to guide the commission in its decision making. The model will be refined and further results will be made available to the Minnesota Legislature, the Governor, and

Recommendations

state agencies to help them make informed decisions about health care reform policies during the 1995 legislative session¹⁹.

The consultant's model is designed to determine the impact of reform strategies on state program costs and health insurance premiums and enrollment. It will estimate the likely changes that will occur in the market under different reform scenarios, including movement between insurance markets and changes in the rate of uninsurance in the state. The model includes a "baseline" scenario that will allow comparisons of proposed reforms to the status quo. Some of the variables that can be changed in the model are:

- ▶ The income limits for the MinnesotaCare Program
- ▶ The barriers to erosion in the MinnesotaCare Program (4 months uninsured, 18 months without employer-subsidized coverage, \$10,000 inpatient hospital limit)
- ▶ Guaranteed issuance in the individual insurance market
- ▶ Community rating
- ▶ A freeloader penalty

The commission's model was developed for the very specific purpose of modeling the impact of different combinations of assumptions regarding subsidy program eligibility requirements, a freeloader penalty, and insurance reforms. The model is designed to estimate the impact of the commission's proposals on state program costs and enrollment and premiums in various insurance markets. The model is capable of factoring in different assumptions about insurance reform, but it was not designed to

¹⁹ The model was developed based on suggestions of the commission and commission staff working with the consulting actuaries. A more detailed discussion of the underlying assumptions of the model will be provided in a separate report. Some assumptions which were not included in the model to date include: the potential decrease in health care utilization from reduced tobacco use if a tobacco tax is imposed; the potential impact of any "user fees" that might be instituted under the Regulated All Payer Option (RAPO) of health care delivery; the possible impact of a risk adjustment methodology in offsetting adverse selection; and the level of erosion of private sector coverage and the number of uninsured in response to universal coverage as a result of a strictly enforced individual mandate.

Recommendations

evaluate the overall impact of different insurance reforms. Our consultant strongly cautioned us against using the model as the basis for broader discussions of the appropriateness and effects of various forms of community rating and guaranteed issuance. Other models that have been developed by the Department of Commerce and others are more suitable for this purpose.

Balance sheets:

To the extent feasible, balance sheets showing major costs and savings under the commission's proposal will be developed for the following major stakeholders:

Consumers

- Uninsured persons
- Individually insured persons
- Persons with employer-sponsored coverage

Employers

- Small employers
- Medium-sized and large employers
- Self-insured employers

Health care providers

- Hospitals
- Physicians
- Other providers

State government

Local government

All Minnesotans (total health care spending)

These balance sheets are expected to be completed in February 1995.

Impact of the commission's recommendations

Preliminary results of the model developed by the commission's consultant indicate that the commission's recommendations are projected to have the following effects in 1998, compared to the "baseline"²⁰ or status quo projected to 1998:

Improvements in cost and access to health care:

- ▶ An additional 54,500 persons will become enrolled in the MinnesotaCare subsidy program, at an additional cost of \$99 million.
- ▶ An additional 22,500 persons will obtain insurance in the private market.
- ▶ The number of uninsured Minnesotans will decrease by 77,000 persons.
- ▶ The small group insurance market (employers with 2-49 employees) will experience a *net gain* in enrollment of 4,500 persons.
- ▶ The individual insurance market will experience a *net gain* in enrollment of 18,000 persons.

²⁰ The "baseline" serves as a reference point. The baseline includes: the current projected MinnesotaCare subsidy program enrollment and costs; current implementation of insurance reform (the baseline assumes no guaranteed issuance, and maintenance of rate bands at current levels); and no implementation of the freeloader penalty. The baseline was used to compare the potential impact of new commission recommendations with current law.

Recommendations

- ▶ Because of the favorable net gain in enrollment in the small group and individual markets, premiums and out of pocket costs will be slightly lower, resulting in savings over \$12 million to purchasers in these markets.
- ▶ As a result of the reduction in the number of uninsured, uncompensated care costs in the system will be reduced. Revenues from the freeloader penalty will further offset uncompensated care burdens. This reduction in uncompensated care costs will reduce cost shifts to purchasers, resulting in further savings to purchasers and taxpayers.

Goals not accomplished:

- ▶ 214,000 Minnesotans will remain uninsured.
- ▶ Implementation of the guaranteed issuance requirement in the individual insurance market will be delayed -- health plan companies will continue to be allowed to deny coverage to persons in the individual market who have not maintained continuous coverage and who are considered a high risk.
- ▶ In the absence of guaranteed issuance, Minnesota's high risk insurance pool for medically uninsurable individuals, the Minnesota Comprehensive Health Association (MCHA) will continue. The current narrow MCHA funding base persists.
- ▶ In order to qualify for subsidized coverage through MinnesotaCare, low income, uninsured persons must still go four months without insurance, and 18 months since they last had access to employer-subsidized coverage.
- ▶ The lack of universal coverage will continue to result in some cost shifting and will handicap cost containment and quality improvement efforts.

Recommendations

Commission vote on this report

The commission met January 18, 1995 for final review and comment on this report. A roll call vote of the members to determine support for the report was requested, to be included in the report.

The vote was taken, and the final tally on the report is as follows:

Voting in Support:	23
Voting Not in Support:	3
Abstaining:	1

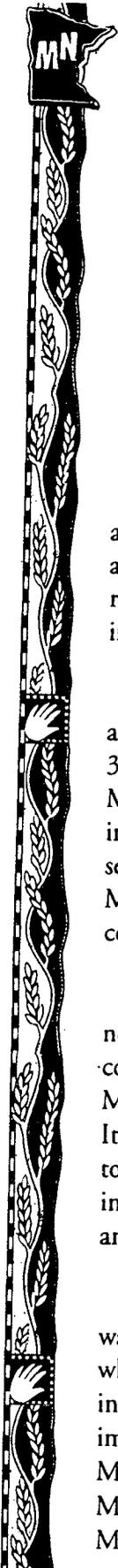
The vote of each member is provided below:

Gerald Brost, Provider Representative	Support
Ray Christensen, Rural Physician Representative	Support
Jasper Daube, Minnesota Medical Association Representative	Support
Gayle Hallin, Provider Representative	Support
Eileen Weber, Minnesota Nurses Association Representative	Support
Dolores D'Aquila, Consumer Representative	Support
Douglas Robinson, Minnesota Hospital Association Representative	Support
Jeff Bangsberg, Consortium of Citizens with Disabilities Consumer Representative	Support
Bill Conley, Mental Health Association Consumer Representative	Support
Virginia Greenman, Consumer Representative	Support
Jacqueline Smith, Consumer Representative	Support
Tom Swain, Chair/Consumer Representative	Support
Diane Wray-Williams, Consumer Representative	Support
James Ehlen, Health Plan Company Representative	Support
George Halvorson, Minnesota Council of HMOs Representative	Support
Richard Niemiec, Blue Cross Blue Shield of Minnesota	Support
Eric Netteberg, Insurance Federation of Minnesota Representative	Not in Support
Catherine Anderson, Employer Representative	Support
Joy Barbre, Minnesota Chamber of Commerce Representative	Support
Wayne Holtmeier, Minnesota Chamber of Commerce Representative	Support
Bernard Reisberg, Employer Representative	Support
Peter Benner, AFSCME Representative	Support
Judy Schaubach, Labor Union Representative	Support
William Peterson, AFL-CIO Representative Commissioner of Employee Relations	Abstain
Maria Gomez, Commissioner of Human Services	Not in Support
James Ulland, Commissioner of Commerce	Not in Support

Appendix A

Universal Coverage Report Summary

Minnesota Health Care Commission
February 1, 1994



Universal Coverage Report Summary

Minnesota Health Care Commission
February 1, 1994

Minnesota is making good progress toward improving the quality, accessibility, and affordability of health care for its citizens. As a result of the 1992 HealthRight Act (now known as "MinnesotaCare"), many programs addressing each of these three major goals of health care reform are currently being implemented. While all of the state's health care reforms are interrelated, the primary focus of this report is access.

According to research conducted by the Minnesota Health Care Access Commission in 1990, about 280,000 Minnesotans (6.5%) are uninsured at any given point in time. Approximately 370,000 Minnesotans (8.6%) are uninsured at some time each year. Long-term uninsured Minnesotans live both in metropolitan areas and in greater Minnesota. They tend to be lower-income working people. Many reported that they had delayed health care, including care for serious health problems, because of the cost. In addition to those who are uninsured, many Minnesotans are underinsured, which means that they have very high deductibles or limited coverage, or that they are paying a premium that is very high in relation to their income.

Every Minnesotan is entitled to access to quality health care. However, universal access is not just a matter of fairness and equity; universal access is critical to the success of Minnesota's cost containment efforts. Cost containment programs cannot be fully effective until all Minnesotans are in the system, have health coverage, and pay a fair share of the costs of coverage. It is also necessary to address nonfinancial barriers to access to health care, such as limited access to providers due to geography; cultural, language and racial barriers; or a shortage of providers in the community; so that all Minnesotans can obtain the services they need, including primary and preventive services which will lower overall costs.

Minnesota took an important step toward universal access when the MinnesotaCare Program was created in the 1992 HealthRight Act to provide subsidized health coverage to Minnesotans who cannot afford the entire cost of coverage. Other health care reform initiatives, such as insurance reform, cost containment strategies, and rural health programs, are also designed to improve access. However, even when all of these existing programs are fully implemented, Minnesota will fall short of universal access. This report presents a comprehensive plan to take Minnesota the remaining distance to the goal. Under the plan presented here, by July 1997, every Minnesotan will have health coverage and access to quality health care services.

Universal Coverage Summary

A Vision for the Future

The plan presented here is based on the Minnesota Health Care Commission's vision for universal coverage. Our vision is that, by 1997, the following goals will have been achieved:

- **Universal coverage**
Every Minnesotan has health coverage and contributes to the costs of coverage based on ability to pay.
- **Availability of coverage**
No one is denied coverage or forced to pay more because of their health status.
- **Universal access to services**
Quality health care services are accessible to all Minnesotans.
- **Equal purchasing power**
All health care purchasers are placed on an equal footing in the health care marketplace.
- **Comprehensive, affordable benefits**
A comprehensive yet affordable health benefit plan is available to all Minnesotans.

An integrated package of recommendations

This report is an integrated package of specific strategies that cannot be implemented effectively unless all of the strategies are implemented as a package. Piecemeal implementation of some, but not all the components of the plan, will not take us to the goal of universal coverage and may make the goal harder to obtain.

Universal Coverage Plan Components

The following are the components of the Minnesota Health Care Commission's implementation plan for achieving universal coverage for all Minnesotans by July 1, 1997:

Universal Coverage Goal

- The goal of the state is to reduce the number of uninsured Minnesotans each year according to the following schedule until universal coverage is achieved by July 1, 1997:

July 1, 1994	--	300,000 persons
July 1, 1995	--	250,000 persons
July 1, 1996	--	150,000 persons
July 1, 1997	--	-0- persons

- A process will be established for annually evaluating the state's progress toward achieving the annual access goals.
- State agencies will be charged with the responsibility of recommending, to the Legislature and the Governor, corrective action if it is determined that the state has fallen short of an annual access goal.

General strategy and timing

- We recommend that the 1994 Legislature enact all components of a universal coverage strategy that will lead to universal coverage by 1997.
- The Minnesota Health Care Commission will coordinate research which will be conducted during 1994 to update and improve our knowledge of Minnesota's uninsured population, to determine who has been helped by existing reforms and who remains uninsured, and to

evaluate whether the MinnesotaCare Program and other reforms have reduced the number of uninsured and underinsured Minnesotans.

- The Minnesota Health Care Commission and appropriate state agencies will conduct a major study of government health care financing during 1994 and submit to the 1995 Legislature a plan for reforming the system.
- National reform activities will be monitored and analyzed throughout 1994 and beyond.
- The Minnesota Health Care Commission, in consultation with appropriate state agencies, will develop and submit to the 1995 Legislature recommendations for modifying and refining the 1994 legislation and reforming the health care financing system, based on new information about the uninsured, evaluation of the MinnesotaCare program and other reforms, and national reform developments.

Universal Enrollment

The guiding principle of universal coverage involves much more than universal access. Currently, Minnesota has a rough and imperfect form of universal access, particularly for acute and emergency health care services. When health care needs reach the point where treatment is essential, Minnesotans generally receive treatment whether or not they are enrolled in a health plan. To the extent an uninsured person is unable to pay for their care themselves, the costs are paid by others.

The 1993 legislation that required the Minnesota Health Care Commission to develop a plan for universal coverage makes it clear that the goal of the state is to achieve not simply universal access to health coverage, but a system of universal coverage under which every Minnesotan is enrolled in a health plan that is responsible for providing their health care. To ensure that the costs of health care

are shared more equitably, every Minnesotan should be required to contribute to the costs of that coverage based on their ability to pay.

- Beginning July 1, 1997, all Minnesotans will be required by law to enroll in a health plan and to contribute to the cost of coverage based on their ability to pay.
- The mandatory coverage requirement will become effective after the full implementation of insurance reforms, market reforms, and government subsidies that will ensure that health coverage is available and affordable for every Minnesotan.
- Mechanisms will be developed to identify those individuals who do not enroll in a health plan and to enforce the state's mandate.

Availability of coverage

To ensure that affordable health coverage is available to every Minnesotan by July 1, 1997, the requirements listed below will apply to all types of health plan companies who enroll Minnesotans. However, these reforms cannot be fully implemented simultaneously without causing premium increases for many Minnesotans, as costs are evened out between low and high-risk Minnesotans and as high-risk uninsured persons enter the insurance market. Therefore, we recommend that the changes be phased-in gradually until all of the requirements are fully implemented by July 1, 1997.

Some of the recommendations below are *preliminary*. Actuarial work will be completed to determine the impact of the changes. The Minnesota Health Care Commission may modify these recommendations based on the results of the actuarial analysis.

- **Guaranteed issuance and renewability.** All health plans, including Integrated Service Net-

Universal Coverage Summary

works (ISNs) and all-payer insurers, must provide health coverage to anyone willing to pay the premiums, without conditions or restrictions (guaranteed issue is currently required only in the small employer market). (Effective 7/1/97)

- **Underwriting eliminated.** Underwriting based on the health status, risk, or characteristics of individuals seeking coverage will be prohibited, except to the extent the Legislature authorizes discounts for healthy lifestyle factors. (Effective 7/1/97)
- **No preexisting condition restrictions.** Carriers will not be able to impose preexisting condition limitations and exclusions with the exception of persons who previously chose not to obtain group or individual coverage when it was available and affordable. (Effective 7/1/97)
- **Community rating.** The amount of variation that is allowed between the premiums charged to different individuals or groups will be reduced annually until July 1, 1997, when everyone must be charged the same premium amount for a particular health coverage product.
- **Portability of coverage.** Effective July 1, 1994, insured individuals may move from public programs to private health plans, and from one product to another within a health carrier's business, without restrictions or exclusions. Effective 7/1/97, individuals will also be able to move between carriers, without restrictions or exclusions. (This recommendation may be modified after actuarial analysis.)
- **Individual coverage required.** All carriers will be required to offer health plan products to those who purchase coverage individually, rather than as a member of a group. (Effective 7/1/95) (This recommendation will be analyzed further before it is implemented to determine whether it should be modified and whether waivers should be allowed.)

- **Uniformity of products.** The number of health coverage products offered by carriers will be limited and all carriers will offer products from a standardized array of options. (Details and implementation dates will be determined in the ISN and the Regulated All-Payer Option (RAPO) implementation plan.)
- **Reinsurance.** Reinsurance mechanisms will be established in all markets.
- **Minimum loss ratios.** In the year 2000, loss ratios will increase to 72% for the individual market and 82% for the small group market, and a loss ratio floor will be established for non-ISN health plans.
- **MCHA.** The Minnesota Comprehensive Health Association (MCHA) will be closed to new enrollees (Effective 7/1/97).

Access to health care services

- The Department of Health, in consultation with the Minnesota Health Care Commission and appropriate agencies and organizations, will develop a permanent process to examine nonfinancial barriers to access to health care services, such as rural provider shortages and social and cultural barriers, and take action to overcome these barriers.

Market reform

- **Short-term strategy.** Existing laws governing private purchasing pools will be modified to make it easier for private pools to form in the existing health care market.
- **Permanent strategy.** By July 1, 1997, large purchasing pools will be available to all purchasers, regardless of employment status or group membership, thereby eliminating cost shifting in the marketplace.

- The Minnesota Health Care Commission will submit recommendations prior to the 1995 legislative session on whether some or all purchasers should be *required* to obtain coverage through purchasing pools and whether a state-administered purchasing pool should be established to serve all Minnesotans who do not have access to other purchasing pools (either by expanding the existing purchasing pool operated by the Department of Employee Relations or by establishing a different pooling mechanism).
- The Minnesota Health Care Commission will submit to the 1995 Legislature detailed recommendations for permanent market reform strategies based on evaluations of existing reforms and responding to national reform initiatives.
- Supplemental or wraparound benefit packages and services will be developed to meet the unique needs of populations served by government programs.
- The subsidy program will be financed by stable, equitable, long-term funding sources as part of an overhaul of the government health care financing system to be enacted during the 1995 legislative session based upon recommendations to be developed during 1994.

Financing

Affordability: subsidized health care programs

- The current MinnesotaCare program will continue its phase-in according to the schedule in current law.
- In 1994, the Minnesota Health Care Commission will coordinate a new survey of the uninsured and the Department of Human Services will survey the MinnesotaCare population.
- The Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare programs will be consolidated into a single health care program for low-income Minnesotans, which will be mainstreamed into the reformed health care system to prevent the development of a two-tiered health care system and to prevent erosion from private sector programs to government programs. The Department of Human Services will request authorization from the 1994 Legislature to seek federal waivers to accomplish the consolidation.
- The Minnesota Health Care Commission and appropriate state agencies will conduct an inventory and analysis of the existing system of government financing of health care in 1994 and submit specific recommendations for overhauling the system to the 1995 Legislature.
- The recommendations for financing reform will be based on specific goals and guiding principles for health care financing to be enacted by the 1994 Legislature.
- The cigarette excise tax should be increased by 40 cents per year over the next 5 years to reduce the health costs associated with tobacco use and to provide supplemental financing for the MinnesotaCare Program for uninsured Minnesotans until the entire system of government financing of health care can be reformed.
- Any temporary shortfall that may occur in the funding for the MinnesotaCare program should be covered by revenues from the cigarette tax increase and by using the anticipated state revenue surplus.

Universal Coverage Summary

Benefit set

- By January 1, 1997, a universal, comprehensive benefit set will be the minimum standard of coverage for all Minnesotans.
- The universal benefit set will be the basis for coverage under state health care programs, with additional wraparound programs to meet the special needs of populations served by government programs.

Education and Outreach

- Both public and private education and outreach programs will be established and maintained to educate individuals regarding their need for health care and to assist them in obtaining health coverage.

Minnesota Health Care Commission

The Minnesota Health Care Commission is a 25-member commission that was established in the 1992 HealthRight Act to advise the Legislature and the Governor on health reform policy. The commission's members represent consumers, employers, health care providers, health plan companies, labor unions, and state government. The commission's first major task was the development of a comprehensive cost containment plan. The commission's cost containment plan was developed by consensus. The commission's plan, which calls for a restructured health care delivery system of integrated service networks and a regulated all-payer option, was enacted by the Legislature during the 1993 session.

The 1993 MinnesotaCare Act directed the commission to develop a comprehensive plan for achieving universal coverage by 1997. The Universal Coverage Plan, like the cost containment plan, was developed by consensus and has the support of all 25 commission members.

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