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Minnesota Health Care Commission

Report

December 1996

Toward more equitable, stable, and integrated health care financing:

summary, recommendation and first steps

The mission of the Minnesota Health Care Commission is to help Minnesota communities, providers, group purchasers, employers, employees, and consumers improve the affordability, quality, and accessibility of health care.

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Executive Summary

Introduction

The Minnesota Health Care Commission has had long-standing interests in achieving policy goals of an **integrated, stable and equitable health care financing structure in order to help achieve universal coverage**. As part of its work plan for the fiscal year 1997, the Commission has focused much of its policy analysis and recommendations on issues of health care financing for acute care.

In carrying out its work, the Commission recognized that a health care financing and delivery continuum exists in Minnesota. The variety of health care programs, both public and private, that make up the current health care system, are supported by a complex patchwork of financing sources. In the absence of universal coverage, this financing continuum extends necessarily across both the public and private sectors. It varies widely in the level of individual and shared expenses, implicit and explicit types of funding, and levels of fairness and equity.

After recognizing the problems associated with the current financing system, the Commission adopted a number of tenets of an "ideal" financing structure that would help achieve the long term goals of an integrated, stable and equitable financing system for health care and universal coverage. Some of the tenets are:

- In moving towards universal coverage, the public and private sectors must work in partnership to provide coverage and health care services for individuals - therefore, both sectors are integral parts of this financing continuum and thus share responsibility for financing health care.

- Responsibility for financing the entire continuum and the infrastructure supporting it should, to the extent possible, be equitable and shared on an equitable basis, and should be based on ability to pay.

- Explicit funding sources are more appropriate than, and are preferred to, implicit sources. For example, the income tax is a source of revenue which is identifiable and quantifiable to the payer.

The Commission reviewed and adopted these principles as well as others for sound financing to address the problems posed by the current financing patchwork. These principles were developed previously by the Commission, through the application of the Department of Revenue's Model Revenue System and from other discussion and consensus. The Commission believes that these principles should guide future discussions of these recommendations to ensure that the Commission's goals for the health care system are achieved.

Financing Goal

The Commission's primary goal is **to develop an integrated, equitable and stable financing structure that supports health care for all Minnesotans, encompassing both acute and long term care to attain universal coverage.** As with health reform generally, incremental steps must be taken to attain this goal.

An Initial First Step Toward the Goal

The Commission has made a number of recommendations which together are just a first step in reaching the goal above. These recommendations begin to move Minnesota toward a financing system which utilizes general revenues rather than the current patchwork of financing sources. This step alone brings the financing system one step closer to a more integrated, equitable and stable structure.

The Commission recognizes that it does not recommend a specific funding stream within the general fund to replace the 2% provider tax, the MCHA assessment and premium taxes. The Commission does not recommend doing away with the current funding for MinnesotaCare until and unless the Legislature approves an equivalent replacement. However, more discussion is needed between other parties, such as the Legislature, to finalize a specific decision. The Commission is willing to forge ahead with that debate, but it will take buy-in from many parties and more research to develop a new, improved financing system.

The Commission proposes changes in the financing of health care with only minimal increases in overall new health care spending; for example, the expansion of MinnesotaCare is estimated to cost $20 million in the first year. While explicit health care program spending is not increased greatly by these recommendations, responsibility for financing it is being apportioned more fairly. These recommendations will cause increases in the general

revenue funds needed for health care but will also result in reductions in other taxes.

The Commission offers its recommendations for changes in the financing system as a package. Many of the recommendations, if considered separately, would not have been supported by a majority of the Commission. In arriving at these recommendations, the Commission achieved a delicate balancing of the interests of Commission members. Consistent with the Commission's original guiding principles, all stakeholders would share in the sacrifices. The recommendations were approved by the Commission, because as a package, they would make the current financing structure more integrated, equitable and stable. The initial, first step recommendations are summarized on pages 20-22.

Additional Steps to Achieve the Goal

The next phase will entail simplifying the state's public programs. Both on the state and the national level the "portability" of health coverage in the private sector is being implemented. Similar efforts need to be made in the public sector programs, enabling Minnesotans to move freely from one program to another as their needs change. Initial steps have been taken in the Department of Human Services' 1115 waiver efforts. Initiatives to simplify the administration, enrollment, eligibility and even benefits of our public health care programs have been and continue to be pursued. Simplifying these programs also requires the discussion of how these programs are to be financed.

Additionally, these initiatives are consistent with the Administration's goal of simplifying the State's health care programs by more closely aligning them. It is possible to realign the programs either first through enrollment, eligibility or benefit policies, or through merging of the funding mechanisms. The Commission chose to begin the simplification process by merging the funding streams.

The next step in achieving our long term goal must be to develop a strategy to finance long term care. The work group has specifically excluded long term care financing from its discussions. However, in light of the interrelationship which long term care has with the rest of the financing continuum, it is imperative that long term care financing is discussed.

While it will take more than these next two steps to reach a more integrated, equitable and stable financing structure to attain universal coverage, these incremental steps take us a long way toward reaching that goal.

Minnesota Health Care Commission Health Care Financing Report

Why the Health Care Commission Has Addressed Health Care Financing Issues This Year

- The Minnesota Health Care Commission has had long-standing interests in achieving an integrated, stable, and equitable health care financing structure as an important step toward achieving universal coverage, and these goals are frequently viewed as lynchpins to successful health care reform.

- As part of its work plan for the current fiscal year, the Commission has focused much of its policy analysis and recommendations on health care financing issues. These issues were felt to be especially relevant during the upcoming legislative session because of:

  - anticipated reductions in levels of health care financing from the federal government, and concerns about preparing for these reductions;

  - interest in resolving competing claims on uses of the state's Health Care Access Fund;

  - and concerns that the historical practice of financing charity care, medical education and research, public health, and other services by passing these costs through to purchasers and payers will not be sustainable, due to increasing market competition and cost-containment efforts.

How the Commission Has Studied and Addressed Health Care Financing Issues This Year

In the summer of 1996, the Commission recognized that, given the importance of health care financing to the health care system, and the expected difficulty in arriving at a solution to problems facing the current system, the responsibility for studying the problems and developing the solutions should be delegated to a special work group.

The Financing Work Group proceeded as follows:

- The work group began an analysis and discussion on this topic in an all day Commission meeting in June, 1996.
- It described and analyzed the current health care financing system.
- It identified key characteristics and tenets of an "ideal" financing system.
- It developed criteria reflecting the "ideal" system against which to evaluate the current health care financing system, and applied these criteria to the current system.
- It examined each part of the current health care financing system with regard to how well it met the criteria, and also with regard to how feasible changes were likely to be at this time. This analytical tool helped to identify which revenue sources would be most beneficial in attaining the long term goal. It also provided an objective framework by which a recommendation for financing sources and interim steps could be developed.
- It concluded that the Commission could have the most relevance and impact by addressing questions related especially to the use of the Health Care Access Fund, and the financing of the Minnesota Comprehensive Health Association (MCHA) (described in the attachments).
- It analyzed "what if" scenarios illustrating the potential impact on the current health financing care system with changes to any of its component parts.

- Finally, the work group made the recommendations described below for interim steps to address current financing inequities and inefficiencies, while at the same time proceeding toward the goal of a more broad-based, stable, and equitable health care financing system overall.

- The Financing Work Group provided the full Commission with frequent updates and reports on the progress of its deliberations. The Financing Work Group met 16 times in the period June 1996-December 1996.

- The Commission and the work group was greatly assisted in their deliberations by the ongoing technical and policy support of the state's Departments of Health, Commerce, Finance, Revenue, and Human Services.

The Health Care Financing and Access Continuum

- Absent universal health care coverage, Minnesota has developed a complex patchwork of programs, coverage arrangements, and financing sources which provide at least some level of access to health services for all Minnesotans.

- Financing for this patchwork extends across a continuum of private and public sources. It also encompasses wide variation in levels of individual and shared expenses, implicit and explicit types of funding, and levels of fairness and efficiency.

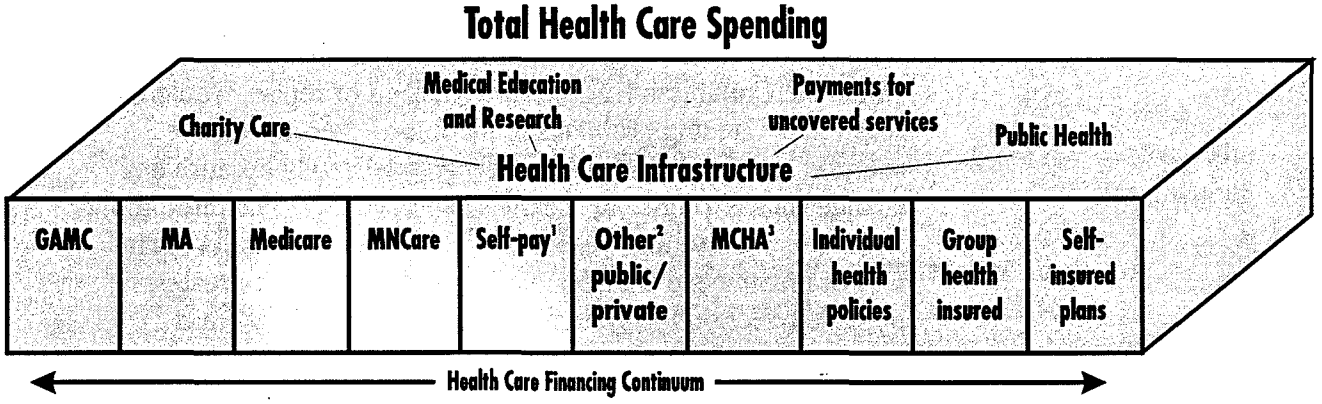
- The continuum also funds a "health care infrastructure" through a variety of direct and indirect means. This infrastructure includes programs and services which greatly influence health care costs, quality, and access, but which are usually viewed as being separate and distinct from services provided through health insurance arrangements or paid for directly out of pocket. The infrastructure includes, for example, public health, medical education and research, and charity care.

- Each part of the patchwork is interrelated to another part or parts, such that changes in one cause ripple effects felt elsewhere in the system. The "What If" scenarios discussed

later illustrate this point. These scenarios were developed by staff from state agencies assisting the work group. The scenarios are qualitative and are intended to illustrate the potential impact of changing the pieces of the health care financing continuum. These potential changes should not be viewed as "good" or "bad", but merely changes to the financing continuum.

- The way the current patchwork has been constructed has often resulted in inherent problems of inequity, inefficiency, and instability in health care financing.

Health Care Financing Continuum and Infrastructure



Principles of the health care financing continuum and infrastructure

The health care financing continuum and infrastructure, depicted above, operates according to the following principles:

- Total health care expenditures are driven by a fixed number of variables
- If pieces of the continuum are changed or disrupted, the alteration redistributes financing responsibility to another part of the continuum or infrastructure
- Inequity may exist in the financing of the infrastructure (formal v. informal funding)
- Total health care spending may increase but the continuum and infrastructure remain finite
- Elements of the continuum may change, but the service needs remain consistent
- Social services which enhance health outcomes may not be captured in the revenue sources
- The continuum has a macroeconomic impact on Minnesota
- Boxes on the continuum not drawn to scale–each has an implicit and explicit funding element

[1] Self-pay is defined as uninsured individuals and persons who pay for health care out-of-pocket.
[2] Other includes federal and other government programs and non-profit sources such as foundations.
[3] MCHA is the Minnesota Comprehensive Health Association, the State's high risk pool.

Scenarios Impacting the Health Care Continuum

The Commission was aided in its deliberations by the use of scenarios developed by the Departments of Health, Commerce, Human Services and Finance to illustrate the potential impact of changes to the financing continuum. As the discussion below will demonstrate, no change in a system as complex and interrelated as Minnesota's financing continuum occurs in a vacuum.

The scenarios helped impress upon the work group members (as well as other Commission members) both the gravity and the sensitivity of their assignment. Failure to fix the present system, which the Commission agreed was in need of repair, would only result in continuing problems in the future. Moreover, the solution had to be crafted carefully and delicately because any changes made to one part of the system would ripple throughout, with both positive and negative effect. The Commission's aim was to recommend changes that on balance had the greatest positive effect on the system and the lives of Minnesotans throughout the state.

Several scenarios best illustrate the complexity of the issue and the need to do something very soon to reform the current system. The scenarios are not meant to imply any specific value judgement about whether the changes should be perceived as "good" or "bad", but merely depict from an analytical perspective what may happen if any of the pieces of the continuum are changed. In addition, the Commission made two assumptions. First, any increase in the number of self-pay/uninsured will increase the amount of uncompensated care. Second, in the self-pay category, there will be a number of people who forego care. The impact of this on the continuum is uncertain.

Scenarios

Naturally, the first scenario considered by the Commission would have the state make no changes in the current financing system. Such a scenario would likely result in:

a. An increase in the number of self-insureds
b. An increase in the number of small group insureds
c. A decrease in the number of large group insureds
d. A decrease in the number of individual insureds
e. A decrease in MCHA enrollment

f. An increase in MinnesotaCare enrollment
g. No change in self-pay, Medicare, MA or GA.
h. An increase in the number of Medicare enrollees
i. An increase in the number of Medicaid enrollees (greater if the economy takes a downturn)

Another approach to reforming the current financing system might have involved significant cuts in current public programs. However, simply cutting programs is likely to only further shift costs, exacerbating the inequities and instabilities of the current financing arrangement. The Commission concluded that approach was unacceptable. Consider the following scenarios and the consequences of cutting programs.

Scenario: The MinnesotaCare subsidy program is repealed. The Commission concluded that the impact on the continuum would likely be:

a. An increase in Medicaid enrollment and costs
b. An increase in the number of uninsured (self-pay)
c. A potential increase in MCHA (although this would be minimal)
d. An increase in AFDC enrollment and costs

Scenario: Changes are made to the General Assistance Medical Care (GAMC) program to restrict enrollment. The Commission concluded that the impact on the continuum would likely be:

a. An increase in MinnesotaCare enrollment and costs
b. An increase in the number of self-pay
c. An increase in the need for "other" funding (Indian Health Services)
d. Stricter residency requirements may result in a reduction in expenditure for new enrollees
e. An increase in the number of self-pay

Scenario: Revisions are made to the Medicaid program so that it only met the minimum federal standards. The Commission concluded that the impact on the continuum would likely be:

a. An increase in the number of self-pay
b. An increase in MinnesotaCare enrollment and costs
c. A decrease in AFDC
d. A potential decrease in federal Medicaid matching money which includes a decrease in the health care access fund

The Commission also considered the impact of alternative financing of current programs, most notably with the Minnesota Comprehensive Health Association (MCHA).

Scenario: Changes are made in the MCHA funding mechanism so that the state provides funding to cover the deficit. The Commission concluded that the impact on the continuum would likely be:

a. A one-time decrease in premiums in the privately insured (less than 2%)
b. An increase in state funding obligations

In developing the recommendations contained in this report the Commission considered a number of other scenarios, which are set forth in an attached appendix. The reader is encouraged to review them to understand more fully not only the context in which the Commission's recommendations were developed, but also the little latitude given the Commission to develop a financing solution given the financing continuum that exists.

Goals and Tenets of Sound Health Care Financing

Universal coverage remains the overriding goal of the Commission. By statute, universal coverage is achieved when: every Minnesotan has access to a full range of quality health care services; every Minnesotan is able to obtain affordable health coverage which pays for the full range of services, including preventive and primary care; every Minnesotan pays into the health care system according to that person's ability. The recommendations contained in this report must be seen in this light -- that the ultimate goal of universal coverage first requires the creation of an integrated, equitable and stable health care financing structure. The tenets of such a system are:

- In moving towards universal coverage, there is an implicit partnership between both public and private sectors to provide coverage and health care services for individuals there is therefore a shared responsibility for financing the continuum between the public and private sectors.

- Responsibility for financing the entire continuum and the infrastructure supporting it should, to the extent possible, be equitable and shared, and should be based on ability to pay.

- Incentives toward the financing of universal coverage are preferred over mandates -- however, the incentives used should be as non-distorting to desirable behavior as possible and should include equity considerations.

- The role of government should be minimized to the extent possible, and should be appropriately defined.

- There should be a balance of competition and collaboration (coordinated optimization).

- Revenue sources should be sufficiently flexible to allow for multiple strategies for the financing of universal coverage, but the flexibility must not increase the number of uninsured.

- Financing mechanisms should be understandable to tax payers, public officials, and administrators, and should minimize administrative and compliance costs.

- Health care financing mechanisms should maintain or enhance the state's ability to compete, on a macroeconomic level, with other states and nations.

- The revenue flows from financing mechanisms should be sufficient and certain, and be able to sustain economic upturns and downturns.

- Explicit funding sources are more appropriate than, and are preferred to, implicit sources.

- Health care financing as it stands today in Minnesota is inequitable. Financing should be revenue-neutral and should strive to reduce inequities.

Health Care Financing Evaluation Framework

- An ideal financing system has qualities of fairness, efficiency, stability, and explicitness and understandiblity. These criteria were incorporated into an evaluation tool used in a structured process of assessing the current health care financing continuum.

- In addition, we also explored the relative contributions of the different parts of the financing continuum in funding the health care infrastructure briefly described above.

- Finally, we considered preliminary assessments of the relative feasibility and perceived interest in making changes to the current financing continuum.

- Based on our assessment and discussions, three policy areas emerged as priorities for the Financing Work Group: financing of the Minnesota Comprehensive Health Association (MCHA) annual operating deficit; use of the Health Care Access Fund (HCAF); and the self-pay category. The latter was subsequently incorporated into discussions of uses of the HCAF.

Consensus

The work group reached agreement on the following:

- The most appropriate long term funding source for health care is general revenues (sales and excise taxes, property tax, income tax), although there is not agreement on the preferred tax to be used; and

- A tobacco tax is an appropriate funding source for health care.

Financing Recommend-ations

Following the steps above, the work group developed health care financing recommendations for uses of the Health Care Access Fund and for financing MCHA. The recommendations represent:

1) a commitment to greater the funding of health care through broad based general revenues over a 3-5 year period;

2) proposed changes to improve financing of important components of the current health care access and financing continuum as a first step in the transition to general fund financing.

The Commission's financing recommendations should be viewed only as an interim, first step toward the larger goal of general fund financing for health care. The proposed financing recommendations were constructed to receive the fullest support possible. The recommendations are described in greater detail below.

The following health care financing recommendations were approved by the Minnesota Health Care Commission at its November 20, 1996 meeting.

A. A multi-year transition plan for funding health care through the general fund should be developed and implemented. The plan should address the inequities of existing health care funding mechanisms and taxes with more equitable financing through the general fund.

B. The transition to general fund financing of health care should begin January 1, 1998 and should be completed by January 1, 2000. As part of the transition, the current 2% provider tax should be reduced to 1% on January 1, 1998 and replaced completely by January 1, 2000. This action reflects a tax decrease for consumers and purchasers as a result of eliminating the 2% provider tax, MCHA assessment and premium tax. Recognizing that there are other obligations which the general fund must meet, a corresponding increase in general fund revenues may be needed. Simultaneously, measures must be taken to generate any savings possible so as to minimize the impact of this transition.

C. In recommending this transition plan, the Health Care Commission continues to support the goal currently in statute of reducing the percent of uninsured Minnesotans to 4% by the year 2000. The Commission supports the on-going implementation of the MinnesotaCare subsidized insurance program to serve persons with incomes up to the 275% of federal poverty level.

D. The transition plan should be initiated with the steps below, leading to financing of health care through the general fund. The following transition steps are listed in priority order. Each successive step listed below should be undertaken only if step(s) previous to it, or a related action as specified, has been taken. **Recommended interim, first phase steps leading to financing of health care through the general fund:**

Interim Step #1: Expand Eligibility for the MinnesotaCare Subsidized Health Insurance Program

a. Expand eligibility for single adults and families without children to 175% of federal poverty level, effective 7/1/97.

b. Enhance promotion and outreach of the MinnesotaCare program.

   i. Recommend a legislative proposal calling for public/private collaboration to enhance awareness of the MinnesotaCare program and increase enrollment of those currently eligible.

c. Study the potential impact of changes in the subsidy level as a means to increase enrollment in MinnesotaCare.

   i. Recommend a legislative proposal for study language (see attached) of the potential impact of changes in the subsidy level on enrollment in MinnesotaCare and on the number of uninsured.

d. Encourage greater enforcement of the pass-through provisions of the 2% provider tax.

   i. Recommend a legislative proposal (see attached) for greater enforcement of the pass-through provisions of the 2% provider tax.

Interim Step #2: Redirect a portion of the tobacco tax to the Health Care Access Fund

a. Redirect $.05 per pack of the current tobacco tax from the general fund to the health care access fund.

i. This redirection of the tobacco tax results in a transfer of approximately $18 million out of general fund and into the health care access fund.

Interim Step #3: Minnesota Comprehensive Health Association (MCHA) Financing

Note: Changes recommended below regarding MCHA financing are contingent upon redirecting the $.05 tobacco tax as described in #2 above.

a. Transfer the revenues of the 1% premium tax on nonprofit health service corporations, CISNs and HMOs out of the Health Care Access Fund to the general fund.

   i. Revenues to the health care access fund will be reduced by $22 million as a result of this transfer of the premium tax to the general fund.

   ii. General fund revenues will be increased $22 million as a result of this transfer.

b. Institute a premium tax offset, with a credit toward 1% of premium tax as an offset against MCHA assessments.

   i. The general fund will be reduced by a net of $6 million (following transfer of $22 million premium tax on nonprofit health service corporations, CISNs and HMOs from the Health Care Access Fund to the general fund, plus a reduction of $6 million in premium tax paid by commercial health plans).

c. Institute a general fund commitment to pay for persons on Medical Assistance who are enrolled in MCHA.

   i. The general fund will be reduced $12 million as a result of this payment.

d. Disallow future premium payment for MCHA by Medical Assistance.

e. Direct the Minnesota Departments of Health and Commerce to recognize the reduction in the MCHA obligation in rate approvals (see attached language).

f. Acknowledge MCHA as a transition program within the reforming market; support more aggressive management and cost containment strategies in MCHA; establish new MCHA governance reflecting changed financing with the majority of the MCHA governing body being enrollees.

g. Recommend a legislative proposal for a study (see attached) of reinsurance, risk adjustment and changes in federal law (Health Insurance Portability and Accountability Act of 1996) which may eliminate the need for MCHA in the future.

Interim Step #4: Increase the tobacco tax

a. Increase the cigarette tax by $.10 per pack of cigarettes to limit consumption, particularly among youth, and increase the tobacco tax on other tobacco products proportionately.

    i. The increased tax raises approximately $34 million in the general fund.

b. Fund medical education ($10 million annually) and family health through public health initiatives ($7 million annually).

c. Analyze the uses of the tobacco tax

    i. Include legislative proposal for study of uses of tobacco tax revenues.

Interim Step #5: Replace the provider tax with general fund revenues.

a. Reduce the current 2% provider tax to 1% beginning January 1, 1998, and replace the loss in provider tax revenue with general funds to the extent they are needed.

b. Complete the replacement of the provider tax, MCHA assessment and premium taxes with general funds by January 1, 2000.

Attachments

1. Scenarios Impacting the Health Care Continuum

2. Enhancing enforcement mechanisms for pass-through of the 2% provider tax

3. Rate review and approval language

4. Study language

5. Changes in Current Taxes and Assessments as a Result of the Commission's Recommendations

6. Description of the Minnesota Comprehensive Health Association (MCHA)

7. Description of the Health Care Access Fund (HCAF)

8. Minority Reports

Scenarios Impacting the Health Care Continuum

The scenarios below were developed by the Departments of Health, Commerce, Human Services and Finance to illustrate the potential impact of changes to the continuum. They are not meant to imply any specific value judgement about whether the changes should be perceived as "good" or "bad", but merely depict from an analytical perspective what may happen if any of the pieces of the continuum are changed.

Assumptions -

Any increase in the number of self-pay/uninsured will increase the amount of uncompensated care.

In the self-pay category, there will be a number of people who forego care. The impact of this on the continuum is uncertain.

Scenarios

1. If the MinnesotaCare subsidy program were repealed, the impact on the continuum would likely be:
a. An increase in Medicaid enrollment and costs
b. An increase in the number of uninsured (self-pay)
c. A potential increase in MCHA (although this would be minimal)
d. An increase in AFDC enrollment and costs

2. If all of the MinnesotaCare health care reforms, including insurance reforms and other initiatives were repealed, the impact on the continuum would likely be:
a. All of the above under #1
b. An increase in costs to the privately insured (cost shifting as a result of the increased number of self-pay)
c. An increase in premiums for the privately insured
d. A one-time decrease in premiums for the privately insured as a result of the repeal of the 2% tax

3. If changes were made to the General Assistance Medical Care (GAMC) program to restrict enrollment, the impact on the continuum would likely be:
a. An increase in MinnesotaCare enrollment and costs
b. An increase in the number of self-pay
c. An increase in the need for Indian Health Service (IHS) funding

d. Stricter residency requirements may result in a reduction in expenditure for new enrollees
e. An increase in the number of self-pay

4. If revisions were made to the Medicaid program so that it only met the minimum federal standards, the impact on the continuum would likely be:
a. An increase in the number of self-pay
b. An increase in MinnesotaCare enrollment and costs
c. A decrease in AFDC
d. A potential decrease in federal Medicaid matching money which includes a decrease in the health care access fund

5. If changes were made in the MCHA funding mechanism so that the state provides funding to cover the deficit, the impact on the continuum would likely be:
a. A one-time decrease in premiums in the privately insured (less than 2%)
b. An increase in state funding obligations

6. If changes were made to the enrollee cost-sharing scheme for MCHA, the impact on the continuum would likely be:
a. An increase in the self-pay
b. A minimal increase in MinnesotaCare enrollment and costs

7. If the Legislature were to enact more mandated benefits, the impact on the continuum would likely be:
a. An increase in the number of self-insured
b. A decrease in the number of group insured
c. A decrease in the number of individually insured
d. An increase in the number of self-pay
e. An increase in Medicaid costs (PMAP)

8. If the Legislature revised the existing insurance statutes to encourage pooled purchasing, the impact on the continuum would likely be:
a. An increase in the number of group insureds
b. A decrease in the number of individual insureds
c. A decrease in the number of self-pay
d. A decrease in the number of self-insureds
e. A decrease in MCHA enrollment (minimal)

f. A decrease in growth of MinnesotaCare (minimal and high income)

9. If the Legislature revises the insurance reforms (community rating and guaranteed issue in all markets), the impact on the continuum would likely be:
a. A decrease in the number of individual and group insureds (affordability)
b. An increase in the number of self-insureds
c. An increase in self-pay
d. An increase in MinnesotaCare enrollment
e. The need for MCHA would be eliminated, if enrollees were directed to seek coverage elsewhere.
f. An increase in Medicaid costs (minimal and a result of decreased third party coverage)

10. If the Legislature revises the insurance reforms (extend the small group reforms to employers with 50 to 100 employees), the impact on the continuum would likely be:
a. A decrease in the number of self-insureds
b. An increase in the number of group insured
c. A decrease in the number of individual insureds
d. A decrease in self-pay
e. A decrease in growth in MinnesotaCare (minimal)

11. If the government restricts eligibility for Medicaid recipients who are families and children, the likely impact on the continuum would be:
a. An increase in GAMC enrollment
b. An increase in MinnesotaCare enrollment
c. An increase in self-pay
d. An increase in other commitments (IHS, school clinics, others????)

12. If the government restricts benefits* for Medicaid recipients, the likely impact on the continuum would be:
a. An increase in self-pay
b. Significant changes in the infrastructure, particularly in public health, charity care and payments for uncovered services

*For discussion purposes we assumed a restriction of dental, chiropractic and podiatric benefits.

13. If the status quo remains, the following trends are likely to continue:
a. An increase in the number of self-insureds
b. An increase in the number of small group insureds
c. A decrease in the number of large group insureds
d. A decrease in the number of individual insureds
e. A decrease in MCHA enrollment
f. An increase in MinnesotaCare enrollment
g. No change in self-pay, Medicare, MA or GA.
h. An increase in the number of Medicare enrollees
i. An increase in the number of Medicaid enrollees (greater if the economy takes a downturn)

14. If Minnesota achieves universal coverage as defined in 62J, the impact on the continuum would likely be:
a. A decrease in self-pay
b. A decrease in MCHA enrollment
c. A decrease in charity care
d. To determine other changes, it is necessary to know the various mechanisms used to attain universal coverage.

15. If the Legislature were to authorize the use of medical savings accounts, the impact on the continuum would likely be:
a. An increase in the number of individual insureds
b. It is unknown whether there would be an increase or decrease in self-pay.
c. It is unknown whether there would be an increase or decrease in the number of group insureds.

Enhancing Enforcement Mechanisms for Pass-Through of the 2% Provider Tax

1. Add language to MN Stat. 295.582 to clarify that the Departments of Health and Commerce have authority to enforce the pass through provision for those health plan companies which the Departments regulate.

Insert after 295.582 (b) ..documentation indicating compliance with paragraph (a).
... A hospital, surgical center, pharmacy or health care provider that is subject to a tax under section 295.52 may file a complaint with the commissioner responsible for regulating the third party purchaser if at any time the third party purchaser does not comply with paragraph (a)....

2. Add language to MN Stat. 62Q to specifically allow the commissioners of health and commerce to take enforcement action against a regulated health plan company which does not allow a provider to pass-through the 2% tax.

New Section - 62Q. __ Enforcement of Pass-Through

The commissioners of health and commerce shall by order, fine or censure a health plan company or revoke or suspend the certificate of authority or license of the health plan company to do business in this state, if the commissioner finds at any time that the health plan company has not complied with section 295.582.

Rate Review and Approval Language

62A.02 Policy forms.

Subdivision 1. Filing. For purposes of this section, "health plan" means a health plan as defined in section 62A.011 or a policy of accident and sickness insurance as defined in section 62A.01. No health plan shall be issued or delivered to any person in this state, nor shall any application, rider, or endorsement be used in connection with the health plan, until a copy of its form and of the classification of risks and the premium rates pertaining to the form have been filed with the commissioner. The filing for nongroup health plan forms shall include a statement of actuarial reasons and data to support the rate. For health benefit plans as defined in section 62L.02, and for health plans to be issued to individuals, the health carrier shall file with the commissioner the information required in section 62L.08, subdivision 8. For group health plans for which approval is sought for sales only outside of the small employer market as defined in section 62L.02, this section applies only to policies or contracts of accident and sickness insurance. All forms intended for issuance in the individual or small employer market must be accompanied by a statement as to the expected loss ratio for the form. Premium rates and forms relating to specific insureds or proposed insureds, whether individuals or groups, need not be filed, unless requested by the commissioner.

Subd. 2. Approval. The health plan form shall not be issued, nor shall any application, rider, endorsement, or rate be used in connection with it, until the expiration of 60 days after it has been filed unless the commissioner approves it before that time.

Subd. 3. Standards for disapproval. The commissioner shall, within 60 days after the filing of any form or rate, disapprove the form or rate:

(1) if the benefits provided are not reasonable in relation to the premium charged;

(2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the health plan form, or otherwise does not comply with this chapter, chapter 62L, or chapter 72A;

(3) if the proposed premium rate is excessive or not adequate or **does not take into consideration the decrease of the Minnesota Comprehensive Health Association assessment**; or

(4) the actuarial reasons and data submitted do not justify the rate.

The party proposing a rate has the burden of proving by a preponderance of the evidence that it does not violate this subdivision.

Proposed Study Language

1. The Departments of Human Services and Health shall conduct a study regarding the potential impact of changes in the level of subsidy for the MinnesotaCare subsidized health program. The study shall provide at least two new subsidy schedules with the corresponding impact on enrollment. The study shall be submitted to the Minnesota Health Care Commission and the Legislature by November 15, 1997.

2. The Departments of Commerce and Health and the Minnesota Comprehensive Health Association are directed to conduct a study to determine whether, and the extent to which, a risk adjustment mechanism and/or the use of reinsurance will reduce the need for the Minnesota Comprehensive Health Association. The study shall make a recommendation regarding the future existence of MCHA. The study shall be submitted to the Legislature by January 15, 1998.

3. The Department of Revenue shall provide to the Minnesota Health Care Commission and the Legislature a full analysis of the uses of the tobacco tax. The analysis shall be submitted by December 30, 1997.

Changes in Current Taxes and Assessments as a Result of the Commission's Recommendations

The Minnesota Health Care Commission's initial, first stage recommendations for changing health care financing will have impacts on the Health Care Access Fund (HCAF) and the General Fund. Table 1 below shows the potential impacts on revenue streams funding each of the funds. For example, while the Commission's recommendations increase the obligations for health care funding from the general fund, there are also reductions in other current taxes and assessments. Table 1a shows the net impact of the Commission's recommendations on current taxes and assessments.

Table 1. Changes in Taxes or Assessments as a Result of the Commission's Recommendations

The Commission's recommendations would lead to changes not only in the HCAF and General Fund balances, but also to changes in the assessments and taxes which are paid. As shown in the table below, the result is not only increased obligations from the General Fund, but also reductions in other taxes and assessments.

[All figures in Millions unless otherwise noted. Reductions taxes or assessments are shown in the top half of the table; demands on the general fund arising from the Commission's recommendations are shown in the bottom half of the table.]

Reductions in Tax or Assessment	FY98	FY99	FY00	FY01	Comment
Premium tax offset	30	32	33	34	Lowers premium taxes (1% of premium taxes credited as offset against MCHA assessment)
MCHA assessment	12	12	12	13	MCHA assessment reduced as a result of the transfer to the general fund of the costs of MA enrollees in MCHA
2% provider tax	40	83	130	182	2% provider tax phased out and replaced with general fund
Total of reductions above	**82**	**127**	**175**	**229**	This is the total of reductions in explicit taxes and assessments from the Commission's recommendations (additional offsets might be possible through such measures as decreases in uncompensated care with the expansion of MinnesotaCare)
Obligations to the general fund					
Costs of MinnesotaCare expansion, more enrollment of those already eligible	*18*	*36*	*45*	*54*	*Costs of MNCare expansion to 175%FPL for families without children, additional enrollment*
General fund costs of premium tax offset	*30*	*32*	*33*	*34*	
General fund payment for persons on MA enrolled in MCHA	*12*	*12*	*12*	*13*	
Medical education funding	*10*	*10*	*10*	*10*	
Public health funding	*7*	*7*	*7*	*7*	
General fund replacement of the provider tax as it is phased out	*40*	*83*	*130*	*182*	
Total obligations to the general fund	***117***	***180***	***237***	***300***	

Table 1A. Net Changes in Taxes or Assessments as a Result of the Commission's Recommendations

Total of reductions in Table 1 above	82	127	175	229	
Total obligations to the general fund (from Table 1)	117	180	237	300	
Net change in overall taxes and assessments	**+35**	**+53**	**+62**	**+71**	The overall increase in current taxes and assessments shown here reflects a number of recommendations, including those for increased enrollment in the MinnesotaCare program. The Health Care Access Fund has accumulated a large operating surplus which could potentially fund a significant level of the new enrollment. In addition, the Commission's recommendations include spending for medical education and public health, to be met with an increase in the tobacco tax. The reductions in assessments or taxes arising from the Commission's recommendations calculated here do not take into account other reductions in health care spending which may also occur. For example, by expanding MinnesotaCare enrollment, uncompensated care may decline, leading to potential reductions in cost-shifting now used to help pay for uncompensated care. The MinnesotaCare program has also been shown to reduce the use of the AFDC program, with corresponding savings of more than a $2 million per month to Minnesota taxpayers. In like manner, more explicit funding of medical education and public health may also reduce similar cost-shifting which now fund these areas.

Minnesota Comprehensive Health Association (MCHA)

What is MCHA?

- MCHA is a non-profit corporation established by the Legislature in 1976. It provides a source of guaranteed issue health insurance, primarily to Minnesota residents who have been rejected for individual health insurance due to preexisting conditions. Individuals who have been treated for particular medical conditions are also eligible. MCHA has also provided "a place of last resort" coverage in the event of insolvencies of some employer-based health insurance arrangements.

- MCHA is the largest high risk health insurance pool in the nation, with over 30,000 covered lives.

- MCHA is regulated by the state Department of Commerce like other indemnity insurance companies. It is not a state agency, and does not receive funding from the State of Minnesota.

How is MCHA financed?

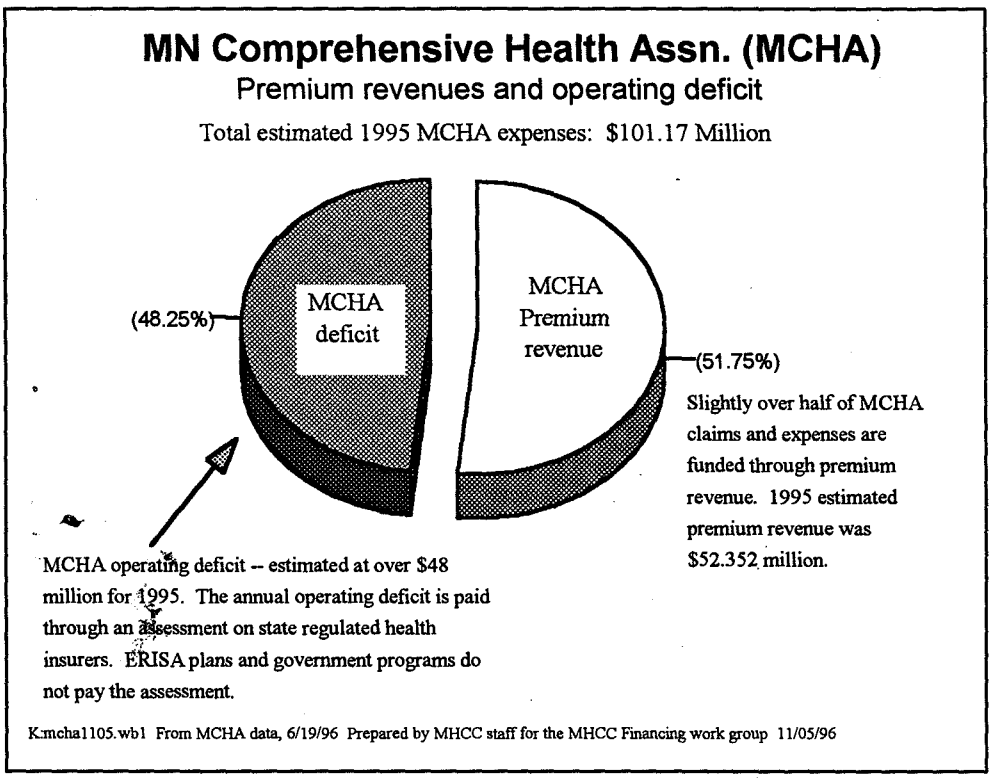
- MCHA premiums are set by law to be no more than 125% of the entire regulated market. MCHA premium revenues do not cover the costs of MCHA claims and expenses. Fifty-two percent of MCHA costs are financed through premiums.

- Forty-eight percent of MCHA's costs are paid through an annual assessment on all indemnity insurance companies, HMOs, Community Integrated Service Networks (CISNs) and Blue Cross and Blue Shield of Minnesota selling insured products in the state. Each company's assessment is based on its percent of total health care insurance premium collected in Minnesota.

- **Self-insured firms are exempt from paying MCHA assessments due to ERISA, as are government programs such as Medicaid.**

MCHA policy issues

- A key policy issue is the financing of MCHA. The assessments used to finance MCHA are presumed to be passed through to the customers buying coverage through the health plan companies that are assessed. Because slightly more than half of the current private market is enrolled in self-insured ERISA plans that are not subject to the assessment, about one half the market, but not the other half, is paying extra to support MCHA. The employers and individuals purchasing coverage through health plans paying the assessment pay about 1.75% more for their insurance as a result of the assessment. As the number of employers who self-insure continue to grow, the MCHA financing base is steadily eroding, while MCHA operating losses continue to climb.



The Health Care Access Fund (HCAF)

What is the HCAF?

- The HCAF is a statutorily dedicated fund for health care reform efforts to improve the costs, quality, and access of the health care system.

How is the HCAF funded?

The HCAF is funded through the following sources:

- Premiums paid by enrollees in a subsidized health insurance program for the uninsured known as MinnesotaCare;
- 2% tax on gross hospital revenues and 2% tax on the gross revenues of physicians and other health care providers;
- 1% premium tax on HMOs and nonprofit health service plans;
- A small amount of federal financial participation

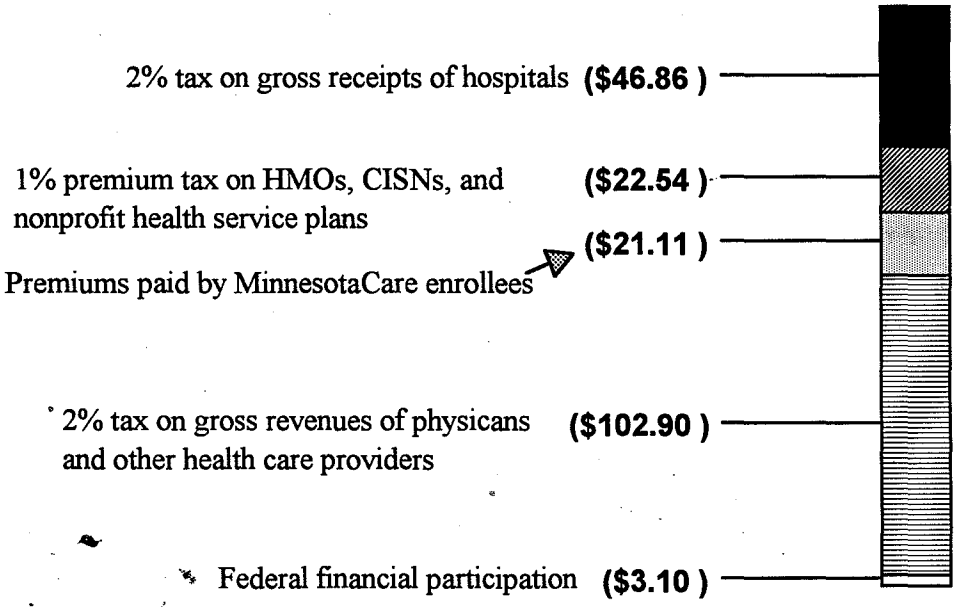
What is funded through the HCAF?

- Over 80% of the HCAF pays for direct patient care of enrollees of the MinnesotaCare subsidized health insurance program.
- The remainder is used to fund a variety of health care reform efforts, including: rural health programs to aid in recruitment and retention of rural providers and assistance to small isolated rural hospitals; administration of the MinnesotaCare program; data collection and analysis to improve health care quality and costs; information to aid consumers and purchasers through the Health Information Clearinghouse; public input in the reform process through the Minnesota Health Care Commission, Regional Coordinating Boards, Rural Health Advisory Committee, Health Technology Advisory Committee; and other efforts to improve health care cost, quality, and access.

Health Care Access Fund Revenues

FY97 Total Revenues: $196.51 Million

HCAF Revenues and Sources, in Millions



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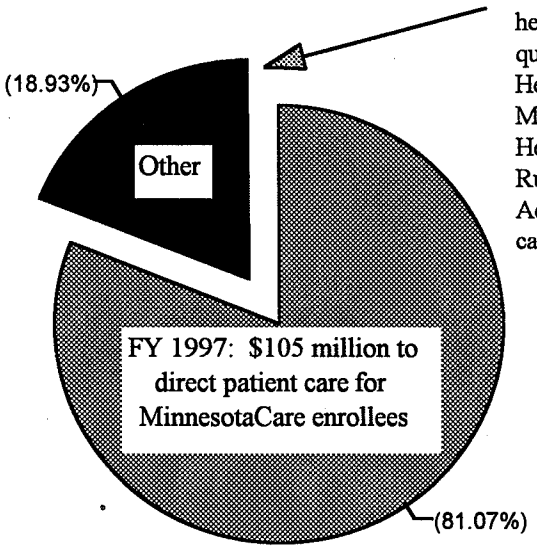
Uses of the Health Care Access Fund

Total FY 1997 Uses: $126.110 Million



FY 97: $24.68 million for other uses, including: rural health programs; research and analysis on cost and quality; public information and assistance through the Health Information Clearinghouse; administration of the MinnesotaCare programs; public input via the MN Health Care Commission, Regional Coordinating Boards, Rural Health Advisory Committee, Health Technology Advisory Committee; and other efforts to improve health care costs, quality, and access.

Note: Unexpended funds are carried forward. A positive HCAF balance of over $231 million is projected after all uses and expenses at the end of FY97.

K:hcafdesc.wb2 Prepared for the MHCC financing workgroup

Minnesota Health Care Commission
Health Care Financing Recommendations
December 18, 1996

MINORITY REPORT

This report summarizes a dissenting opinion regarding key components of the Commission's financing recommendations to the legislature for 1997, specifically those that would result in the instability of the Health Care Access Fund (HCAF) and thus the insolvency of MinnesotaCare. As MinnesotaCare is not an entitlement, but rather dependent on the financial security of the HCAF for its continued existence and expected expansion, the Commission's recommendations seriously jeopardize the MinnesotaCare program.

Since its creation by the legislature in 1992, the Minnesota Health Care Commission has repeatedly expressed a commitment to seeing that every Minnesotan has access to affordable, quality health care. In a system emphasizing third party payment, this has meant a goal of universal coverage, wherein every Minnesotan has quality health care coverage and contributes to the cost of that coverage, based on their ability to do so.

MinnesotaCare is highly consistent with these policy goals and has been the cornerstone of a multi-faceted strategy for achieving universal coverage. With over 90,000 enrollees, mostly children and families, it is a key reason Minnesota has been able to differentiate itself from the national trend of rising uninsurance. MinnesotaCare has been a very successful program, in both its very cost-effective financing and high degree of consumer satisfaction, and should be expanded to fulfill its original intent.

Therefore, we do not concur with the Commission's package of financing recommendations for the following reasons:

1) **It promotes the insolvency of the Health Care Access Fund by:**
   a) repealing the 2% provider tax, the chief source of HCAF revenue,

   b) failing to replace the provider tax with an equally reliable, politically viable funding source:
      - higher cigarette taxes have not been accepted by the legislature in recent sessions, and
      - cigarette taxes are an unreliable source of revenue, as raising their price is expected to decrease the volume purchased in Minnesota,

   c) shifting premium tax revenue from the HCAF/MinnesotaCare to the Minnesota Comprehensive Health Association (MCHA), which further de-stabilizes an account whose revenue would already be severely crippled by the Commission's proposed repeal of the provider tax,

   d) shifting the HCAF into the state's general fund:
      - without a mandate for universal health care coverage or a statutorily mandated schedule to expand MinnesotaCare eligibility to 275% of the

federal poverty level for households without children, shifting MinnesotaCare's funding source into the general fund will dilute its dedication to the program;

2) **This financing package represents a diminishing commitment to universal health care coverage in Minnesota:**
   a) increasing the demands on the HCAF, i.e., to fund MCHA, while severely constricting its revenue means the sick and the poor will essentially compete for diminished financing,

   b) the Commission's emphasis on structural deficits, which it has previously not emphasized, exceeds the fiscal rigor mandated in statute:
      - MinnesotaCare was designed to expand until it spends down to a reserve balance of 5% of expected expenditures,

      - there are already mandatory steps to take to constrain the program, once it reaches that level of spending, in order to keep the HCAF solvent,

      - the Commission was not called upon to make this regulation more stringent, but has, nonetheless, submitted full expansion of MinnesotaCare to this harsher standard, further delaying and discouraging universal coverage;

   c) current welfare recipients who go to work in jobs without health care benefits may need to purchase MinnesotaCare coverage, but diminished financing for the program would make it much less available, since it is not an entitlement program,

   d) without a sufficiently appropriated, dedicated fund, Minnesota's conditional commitment to subsidizing insurance for the working poor will be placed in competition with programs whose entitlement to the general fund is more firmly established, resulting in a growing number of uninsured working poor Minnesotans;

3) **The above actions (1 & 2) are detrimental to health care cost containment:**
   a) as Jim Schowalter, Executive Budget Officer from the Dept. of Finance, reminded the Commission's Finance Workgroup, the HCAF's separation from the state's general fund encourages its fiscal discipline,

   b) as pointed out in previous Commission reports and in the scenarios developed by health department staff, costs for expensive uncompensated "crisis" care increases when people are unable to secure affordable health care coverage.

The Commission's current financing recommendations sharply contradict its previous policy statements and goals:

- Minnesota's Model Revenue System Criteria, which the Commission has embraced, calls for a revenue system that is reliable, i.e., "stable, sufficient and certain." The Commission's current recommendations make the HCAF unstable, insufficient and uncertain;

- The Commission's long-standing commitment to shared sacrifice among all stakeholders is not exemplified by re-configuring current financing to ease the burden on providers and insurers, while threatening the accessibility to affordable coverage for the uninsured;

- The Commission's 1995 report, "An Affordable Step Towards Universal Coverage," strongly recommends adequate financing for the MinnesotaCare program:

  > 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 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.** (p. 36; emphasis added)

  The Commission's current recommendations thus represent a reversal of its own recommendations from less than two years ago.

Minority Report Recommendations

In contrast to the Commission's current proposal, we recommend that the legislature do the following regarding financing for MinnesotaCare and MCHA:

A. Expand eligibility to MinnesotaCare to its fullest original intent, consistent with the financial solvency standards outlined in previous legislation. This recommendation is consistent with previous, consensus-based Commission proposals. Furthermore, we recommend that the legislature codify the conditional schedule for that full expansion of eligibility.

B. Consider the options offered by the Minnesota Comprehensive Health Association, e.g., in its June 19, 1996, presentation to the Health Care Commission, for broadening its non-premium funding base:

1. Amend the definition of MCHA's "contributing member" in a broad way that includes self-insured companies (Minn. Stat. 62 E.02, subd. 23),

2. Replace MCHA's current assessment process with an increase in Minnesota's provider tax, building off of the 1995 U.S. Supreme Court Travelers Insurance Co. decision (and other pertinent judicial precedents),

3. Increase other broad-based state tax, i.e., income tax,

4. Tobacco tax.

C. Maintain the Health Care Access Fund's financial solvency and dedication to MinnesotaCare. Also consider redirecting savings to the general fund, resulting from MinnesotaCare, into the Health Care Access Fund to support the necessary education, outreach and evaluation necessary to increase enrollment of families and individuals who are already eligible for the program.

This minority report is submitted by the following Health Care Commission members:

Eileen Weber, RN
Provider Representative

Diane Wray-Williams
Consumer Representative

Bill Conley
Consumer Representative

Jeff Bangsberg
Consumer Representative

MINNESOTA HEALTH CARE COMMISSION

HEALTH CARE FINANCING RECOMMENDATIONS

MINORITY REPORT

OVERVIEW

The Minnesota Health Care Commission's (MHCC) report on health care financing, entitled, *"Toward more equitable, stable and integrated health care financing: Summary, recommendation and first steps,"* was adopted by a vote of 14 to 8, on November 20, 1996. The final report was adopted by a vote of 14 to 5, with two members abstaining, on December 18, 1996.

This Minority Report summarizes and explains the views of the undersigned members on key issues raised by the Commission Report. Specifically, we wish to express our strong reservations about key elements of the package which, if passed by the legislature, would push the Health Care Access Fund into an immediate and ongoing structural deficit.

In brief, the Commission report recommends:

- A multi-year transition, during which the funding of key state health care programs, including the MinnesotaCare program for the uninsured, and the Minnesota Comprehensive Health Assurance pool for the uninsurable, is transferred to the General Fund;
- Replacing the existing revenue for the above mentioned programs with new, largely unspecified sources of revenue from the General Fund, and eventually eliminating the Health Care Access Fund;
- Reducing, and eventually eliminating, the existing 2% Provider Tax;
- Expanding eligibility for the MinnesotaCare program;
- Promoting the MinnesotaCare program to expand enrollment;
- Redirecting the 5¢ per pack tobacco tax, originally instituted as part of the MinnesotaCare bill, back to the Health Care Access Fund;
- Raising an additional 10¢ per pack tax on tobacco products;
- Increasing spending on medical education and research by $10 million annually;
- Increasing spending on public health by $7 million annually.

We unanimously endorse the commission's core recommendation to transition the responsibility for financing public health care programs, including MinnesotaCare, to the state's General Fund over the next three-to-five years.

Fundamentally, we do not support the creation of so-called "dedicated funds," like the Health Care Access Fund, within the state budget— even when the purpose is as laudable as insuring the uninsured. We believe that competing priorities, like education or public safety or health care, should be subject to the ongoing scrutiny of the legislature, which must weigh each program's merits and fund the necessary expenditures within the taxpayers' ability and willingness to pay the taxes to fund these programs.

That is the essence of the Commission's report— and some of our members felt so strongly about that point that they supported the report on final passage.

However, reviewing the specific recommendations, we find the report impractical and probably impossible to implement. Briefly, here are our main concerns:

1. **Expanding eligibility for MinnesotaCare to 175% of federal poverty guidelines for single adults would bring the Health Care Access Fund into structural deficit.** Though such an expansion may advance the goal of universal access, it is not a prudent use of limited dollars— and it is not where Minnesota should place its emphasis.

   The initial priority of the MinnesotaCare program was to ensure families with children. To date, approximately 50 percent of currently eligible Minnesotans (families w/incomes of 275% of FPG and below) are not enrolled. Is it because the subsidy is inadequate? Is it because the benefit package is unattractive? Is it because they don't know about the program? Neither the state, nor the commission, knows why we have failed to enroll more substantial numbers of the initially targeted population— vulnerable families with children. With federal Medicaid cuts looming on the horizon— and the impact on Minnesota's public health care budget all but certain— expanding eligibility for single adults, while 50 percent of families with children remain uncovered, seems like expansion for expansion's sake.

   ALTERNATIVE RECOMMENDATION: We recommend a sustained effort to increase penetration of the MinnesotaCare program among the initially targeted population— families with children— by 5 percent per year for the next four years. Additionally, we would support an expansion of eligibility to 150% for single adults within two years, or when penetration among families with children reaches 60 percent, if funds are available to do so.

Enrolling vulnerable, low-income families with children before expanding eligibility for single adults appropriately focuses our limited resources on those who need it most and who can best benefit from MinnesotaCare's preventive package of health care services. The commission's recommendation to immediately expand eligibility for single adults to 175 percent of FPG does nothing to expand enrollment among families with children. And, while we believe the enrollment projections for these newly eligible single adults are probably optimistic, this new expansion of the program would immediately outstrip on an annual basis the current revenues available to fund MinnesotaCare. In making this their primary recommendation, we believe the MHCC would inappropriately shift the emphasis of the MinnesotaCare program from expanding coverage among families with children to expanding eligibility to single adults. We do not agree with this critical change in emphasis.

2. **The Commission's recommendation for enhanced promotion and outreach to expand enrollment among families is insufficient and misplaced.**

   First, the Commission report inappropriately makes expansion of enrollment among the original target population secondary to expansion of eligibility for single adults. Then, it suggests (by omission of any alternative direction) that a state agency would undertake the promotion and outreach. We do not know if the current enrollment of 50 percent of the targeted population is an heroic success or a dismal failure. But it would seem that further penetration among the populations not yet enrolled will require alternative channels, new players and different strategies.

ALTERNATIVE RECOMMENDATION: We recommend that the expansion, outreach and promotion activities recommended in the report be conducted not by a state agency, but through alternate channels, including public health officials, insurers, agents and employers, to increase coverage among families with children.

3. **Redirecting a portion of the tobacco tax back to the Health Care Access Fund runs counter to the broader goal** of moving toward General Fund funding for all public health care programs. Interim steps should move us in the proper direction and away from reliance on dedicated funds.

ALTERNATIVE RECOMMENDATION: We should establish and put in place a long-term plan for phasing out the Health Care Access Fund, replacing the financing for the MinnesotaCare program with General Fund appropriations.

The MHCC final report recommends a shift of the responsibility for funding MinnesotaCare and other health care programs to a more equitable funding source, specifically the General Fund. But it goes on to suggest a series of transfers to and from the Health Care Access Fund— and a huge amount of new spending from both the HCAF and the General Fund. The decision to shift away from the HCAF to the General Fund was not uniformly supported by Commission members. It shows a number of the other recommendations.

4. **We support the Commission's recommendations for funding the Minnesota Comprehensive Health Association (MCHA) annual shortfall,** consistent with the intent to shift such programs to the General Fund. **However, MCHA funding should not be contingent upon shifting cigarette taxes to the HCAF.**

MCHA is a critical part of maintaining access for those Minnesotans unable to secure private insurance because of illness or disease. MCHA's annual deficit (approximately $50 million in 1995 and projected at $42 million in 1996) is currently funded through an assessment on insurers and HMO's, which is passed-on to premium payers in the insured market. This increases the cost of insurance for those employers and individuals who are doing the "right thing" in voluntarily paying insurance premiums. Because MCHA provides a societal benefit, protecting each of us should we someday become uninsurable, it should be funded through an equitable, broad-based vehicle, like the General Fund, to which all taxpayers contribute based on ability to pay.

ALTERNATIVE RECOMMENDATION
Fund the MCHA deficit as follows:

1. Premium tax credit/offset of up to 1% for contributing members.
2. All MA-eligible enrollee costs paid from general fund.
3. Any remaining unmet need appropriated from the General Fund.
4. Conduct a thorough audit and policy review to ascertain how this annual deficit can be stabilized.

The HCAF has been an authorized source of funds for MCHA since the fund's initial creation, but no moneys have ever been appropriated for MCHA. Though this proposal would impact the revenue available to the HCAF (by effectively eliminating the 1 percent HMO/BCBS premium tax), using HCAF funds to maintain access through MCHA is consistent with the legislative intent obvious in the inclusion of MCHA in the enabling HCAF statute.

Furthermore, the policies and administration of the MCHA pool should be regularly reviewed and compared to private sector plans to assure that, as efficiencies and competitiion improve health care and associated costs, such improvements are applied to MCHA as well. In this regard, MCHA would benefit from having private purchasers on its governing board.

5. **In a year when the state's surplus is projected to be $1.5 billion and the Health Care Access Fund has been able to amass a reserve of $580 million, proposing a tax increase— even a 10-cent cigarette tax increase— is impractical.** Raising tobacco taxes might inhibit the consumption of cigarettes, but it would also have unintended, negative consequences for many Minnesota retailers, particularly in border communities, as purchases and business moves across state lines.

ALTERNATIVE RECOMMENDATION: Consider the negative business impact of unilateral tobacco tax increases on Minnesota retailers, particularly in border communities. **Make any increase in Minnesota's tobacco taxes equal to and contingent upon similar increases in bordering states.**

Increases in tobacco taxes do not and would not occur in a vacuum. The Minnesota Chamber of Commerce and other impacted associations would oppose such an increase because of its impact on Minnesota retailers.

6. Tobacco tax increases, which may or may not be achieved, should not be immediately spent, as the Commission recommends, on additional health care-related spending. **More spending, without sustainable sources of financing, is not what our health care system needs.**

It may be wise to support the Commission's recommendation to appropriate $10 million for medical research. The Governor recommended a similar appropriation for applied medical research, which continues to yield obvious benefits to the state's economy in new jobs and new wealth. However, the merit of additional spending for medical education and public health is not immediately obvious. This portion of the Commission's spending recommendations deserves additional scrutiny. Public health spending obviously promotes the greater good. But are the additional funds necessary? What would be done that is not now being done? And what benefit would it yield, particularly weighed against the competing demand for expanded eligibility within MinnesotaCare? The real issue is... How do we satisfy the demand for public health spending if the costs continue to grow? What do we do when additional resources cannot be raised? We believe, consistent with the main thrust of the Commission's report, that the need for public health programs should be met with General Fund appropriations— not through the HCAF— but that such spending should be carefully scrutinized by the legislature.

ALTERNATIVE RECOMMENDATION: Support applied Medical Research with an appropriate level of funding from the General Fund in the next biennium. **Scrutinize the request for additional public health program spending on the merits** of the programs and their performance.

7. **More than 18.9 percent of the all the revenue raised for the Health Care Access Fund is being spent on administration and "other."** Spending on the programs, initiatives and bureaucracy spawned by the MinnesotaCare program is not being adequately scrutinized. We should turn the light of introspection on our own administrative expenditures before recommending additional taxes and spending elsewhere.

   The Commission report recommends significant tax increases, program expansions, eligibility changes and tens of millions of dollars in additional spending. It spends no time or energy examining how existing revenue within the HCAF is being spent. Admittedly, that was not the charge of the Finance Work Group when it began this task— but it should be a focus of attention in the future. Reducing the cost of administration would not eliminate the structural deficit the Commission's proposal would create, but it would help. And it's probably overdue. Since its original enactment, some aspects of the state's health care reform agenda have changed. The ill-advised Regulated All-Payer Option (RAPO) system was scuttled, for example. Should the Department of Health be investing as before in cost data collection? Are other aspects of the program's administration in line with private sector costs? Is the Minnesota Health Care Commission itself over-funded, in light of its current charge from the Legislature? Are such questions being adequately addressed by the MHCC? Not in our opinion.

ALTERNATIVE RECOMMENDATION: Initiate an outside review of existing administrative spending, with a report to the MHCC and the legislature of opportunities to reduce or eliminate unnecessary administrative spending.

8. **Phasing-out the 2 percent provider tax by the year 2000 may be too quick a transition—** though we do agree that the provider tax should be gradually replaced with broader-based funding.

   Providers obviously hate the provider tax. Doctors and hospitals consider it a tax on doctors and hospitals. But in fact, employers and individuals pay the bulk of the tax in the form of increased costs for medical services and insurance premiums. Nevertheless, we do support the Commission's call for stronger pass-through provisions. However, we also tend to side with providers, in keeping with our overall philosophy, in seeking to replace the provider tax.

   Inasmuch as the provider tax increases the overall cost of insurance, we are penalizing the very individuals and employers who are doing what we want them to do. If our goal is to increase the number of insured Minnesotans, we should not choose as our funding source the various tax mechanisms that increase the cost of insurance— or health care. That's essentially like saying, "no good deed goes unpunished" and it leads employers to do what we do not what them to do— namely, drop their insurance.

ALTERNATIVE RECOMMENDATION: Begin the process of replacing the provider tax with general fund moneys by reducing the provider tax to 1.75 percent. Make additional reductions in the provider tax each biennium, while transitioning the MinnesotaCare program to the general fund.

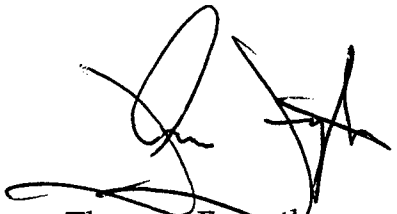
Though we do not want to see the program pushed into a structural operating deficit, if we are to eventually replace inequitable and counterproductive premium taxes and provider taxes by shifting those costs to the General Fund, we have to begin sometime. Gradually cutting off the inequitable revenue stream is probably the best way to ensure that more equitable funding sources replace them. We make this recommendation with the caveat that we do not want to see currently enrolled MinnesotaCare enrollees threatened by a decrease in the funding necessary to maintain enrollment in this program.

CONCLUSION

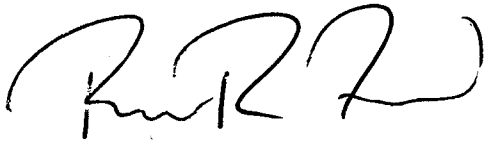
We believe it is important to state that the majority report of the Minnesota Health Care Commission is not a consensus position. In truth, it may be impossible to reach a consensus on so controversial an issue. Many groups represented on the Commission find themselves in the uncomfortable position of strongly disagreeing with key aspects of the final recommendations— including many of the undersigned members. Achieving 14 to 5 passage, with two abstentions, probably does represent the kind of horse-trading and political compromise the Legislature would be forced to entertain to pass a supportable bill. We question the value of that— but if the Legislature finds value in having those discussions pre-staged at the MHCC, then the majority report may serve a purpose.

However, we do not believe that the Health Care Commission exists solely to pound out compromise documents. Rather, we believe that advancing the kind of public dialogue necessary to understand competing, equally well-motivated proposals is important to the process.

Therefore, we believe the Legislature is better served by being able to read and consider equally the views that did not prevail in the final report. We offer this Minority Report in that spirit and in the interest of achieving a better final outcome for all Minnesotans.


Thomas Forsythe


Steve Wetzell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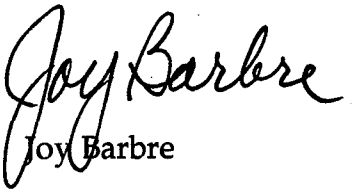
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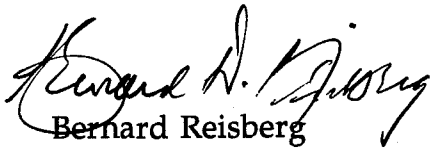
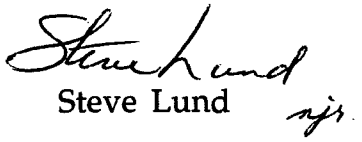

Bernard Reisberg


Steve Lund

AN ALTERNATIVE PERSPECTIVE ON THE PROVIDER TAX.

This paper is submitted to offer additional comment and a dissenting opinion on the long-term financing component of the Minnesota Health Care Commission Report to the legislature for 1997. We strongly support the work of the Commission in health care financing and believe that the interim steps recommended by the Commission make sense and are an important step towards improvement in the finance and access continuum. These recommendations were the result of significant discussions and varied perspectives on the best solution. The proposed steps reflect a mutually agreed upon starting point to begin to fix existing inequities in health care financing. As a package we supported all steps, however, we are compelled to articulate an alternative perspective on the final recommended interim step. We cannot support the recommendation to phase out the provider tax and move towards general fund financing. We believe that the provider tax remains a very useful and appropriate mechanism for MinnesotaCare financing. We are not suggesting the provider tax as the mechanism to finance the entire health care access continuum, and in fact believe that would be inappropriate at this time.

The current health care financing patchwork is very difficult to understand and complicated to reform. As pointed out in the report, it results in complex cause and effect scenarios when change is contemplated. With this context, the Commission put together a recommendation to begin to straighten out some of the inequities of the current finance and access continuum. The two most problematic areas, from the Commission's vantage point, were the Minnesota Comprehensive Health Association (MCHA) and the use of the Health Care Access Fund (HCAF). This paper primarily focuses on the HCAF.

In 1992, when MinnesotaCare was enacted and financed by a provider tax there was a great deal of speculation as to how much the MinnesotaCare program and reforms would cost. There were not any indications of how much money the reforms would save. The result was a very cautious approach towards expanding eligibility for the MinnesotaCare program. Over the past four years eligibility has been increased slightly and the costs of the program have been far less than originally anticipated. The result is a HCAF with a large surplus. This has raised the question of what is the appropriate use of the HCAF.

The other experience gained in the past four years relates to the technical implementation of the provider tax. Although the tax successfully withstood an ERISA challenge and can legally be passed through to all payers, several providers claim that providers are not able to always pass the tax through. This has resulted

in concerns about the narrow application of this tax. We believe that steps should be taken to improve the provider tax and broaden its application.

We believe there is sound policy rationale for keeping the provider tax as a dedicated source of financing for the MinnesotaCare program.

- Properly structured the provider tax can be broad in application and fairly and efficiently collected. It has the qualities of fairness, efficiency, stability, explicitness and understandability.

- As a dedicated funding source, there is greater stability and continued health care access for MinnesotaCare enrollees. General fund financing would jeopardize access to health care since MinnesotaCare enrollees would have to compete with education, criminal justice, transportation, environment and other pressing state needs.

- A dedicated funding source enables expenditures and revenues to be matched up and ensures greater scrutiny and accountability for costs.

- It is appropriate to pay for health care costs out of health care dollars. The provider tax is a mechanism to keep costs within the system. This tax mechanism affords some protection to consumers and some payment assurance to providers. We believe this is a logical way to balance interests and work towards achieving universal coverage.

We are not suggesting that the provider tax be utilized to finance the entire health care access continuum and all of the infrastructure. To the contrary, we believe that the HCAF should be utilized to support MinnesotaCare and the necessary education, outreach and evaluation. We do not support redirecting HCAF dollars to pay for other purposes.

RECOMMENDATIONS:

1. **We strongly support the Commission's recommendations on MCHA financing reform and the Commission's recommendation to increase MinnesotaCare eligibility to 175% of federal poverty guidelines. (We believe the permanent cigarette tax reallocation to the HCAF is an appropriate exchange for the movement of the premium tax to the general fund.)**

2. **We support the HCAF as a dedicated funding source which should be used to finance MinnesotaCare access. We do not support using HCAF to fund health care infrastructure costs such as public health, medical education or as a replacement for general fund financing of Medical Assistance, General Assistance Medical Care (GAMC) or welfare reform.**

3. **We support "right-sizing" the provider tax so that the revenue raised meet the costs of covering those eligible for MinnesotaCare.**

4. **We support identifying technical changes to retain the provider tax and ensure it functions as a broad-based tax. These steps may include itemization of the tax, improved enforcement, and modification of the growth limits.**

5. **We support gradual steps to restructure and reform health care financing. The goals and tenets of health care financing articulated in the Commission's report should provide the framework for further steps in the future. Each step should be taken in a manner to assure continuity of coverage for Minnesotans and achieve universal coverage.**

This perspective and these recommendations are submitted as an addendum to the Commission's report by the following Commission members:

George Halvorson
Andrea Walsh
Mn. Health Plan Council Representative

Delores D'Aquila
Consumer Representative

Virginia Greenman
Consumer Representative

Richard Niemiec
Deborah Glass
Blue Cross Representative

Chuck Kehrberg
Labor Union Representative, Alternate