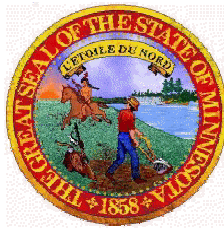


SENATOR LINDA BERGLIN, 61
Senator Paul E. Koering, 12
Senator Tony Lourey, 08
Senator John Marty, 54
Senator Julie Rosen, 24



85TH LEGISLATIVE SESSION
**THE LEGISLATIVE
COMMISSION ON
HEALTH CARE
ACCESS**

REPRESENTATIVE TOM HUNTLEY, 07A
Representative Jim Abeler, 48B
Representative Steve Gottwalt, 15A
Representative Diane Loeffler, 59A
Representative Paul Thissen, 63A

Health Care Access Commission Working Group Recommendation

Working Group Name: Cost Containment #2: Restructuring the system through identified savings

Representative Paul Thissen, Co-chair
Senator Linda Berglin, Co-chair

Working group charge: to translate identified savings in the health care system into lower premiums and costs; to determine what is "affordable" for a person/family to pay for health care.

Background: What is "affordable"?

The working group examined several other states' health care reform efforts, particularly the reform efforts in Massachusetts and Vermont. Although the two states offer very different examples of health care reform, they both determined that individuals and families at and below 300% of the federal poverty guideline (FPG) are eligible for some sort of subsidy to help make their health care costs affordable. As in Minnesota, it is the individuals and families who are just beyond the eligibility for public programs who are having the most difficult time paying for health coverage.

Current Programs

Medical Assistance (MA) is available to children under age two up to 280% of FPG,¹ children ages 2 through 18 up to 150% FPG, pregnant woman who are at or below 275% FPG, parents, relative caretakers and children ages 19 through 20 up to 100% of FPG, and the elderly and disabled who are at or below 100% FPG (\$10,210/year for an adult). Elderly and disabled individuals above 100% FPG must spend down to 75% FPG to become eligible. Individuals meeting these income standards must also meet asset limits (pregnant women and children are exempt) and other program eligibility criteria. With a few exceptions, Minnesota pays 50% of the cost; the federal government pays the other 50%.

General Assistance Medical Care (GAMC) is available to adults without children who are at or below 75% of poverty. Individuals with incomes greater than 75% but not exceeding 175% of

¹ Children with incomes greater than 275% and less than or equal to 280% of FPG are funded through the State Children's Health Insurance Program with an enhanced federal match.

FPG may be eligible for hospital-only coverage. Minnesota pays 100% of the cost of this program.

MinnesotaCare is Minnesota's health care program for working families. Enrollees pay premiums that are set on an income-based sliding scale, with the maximum premium currently set at 8.8% of income.² There are no deductibles. The current income eligibility limit is 275% FPG for families (\$47,232/year for a family of three) and 175% FPG for adults without children (\$17,868/year for an individual). The eligibility for adults without children goes up to 200% January 1, 2008.

There are other eligibility restrictions: 1) a person does not qualify if his or her employer offers to cover 50% or more of the cost of health insurance premiums; 2) a person must be uninsured for at least four months, unless he or she had been covered under MA, GAMC, or TRICARE (coverage for those serving in the military); 3) a person cannot have had access to employer-based coverage through the current employer for the previous 18 months; and 4) assets cannot exceed \$10,000 for an individual and \$20,000 for a family of two or more.³

Individual Market

The working group also examined products currently available in the individual market.⁴ The following are examples:

Table 1

<u>NO PREEXISTING CONDITIONS</u> <u>(PRIVATE MARKET)</u>	<u>TOTAL OUT OF POCKET</u> <u>SPENDING (PREMIUMS +</u> <u>DEDUCTIBLE)</u>	<u>PROPORTION OF INCOME SPENT ON HEALTH</u> <u>INSURANCE AND INCOME REQUIRED</u> <u>AT THAT LEVEL</u>		
		<u>6%</u>	<u>10%</u>	<u>15%</u>
27 Year Old Male:	\$3,622	\$60,366	\$36,220	\$24,146
57 Year Old Female:	\$6,112	\$102,000	\$61,200	\$40,746
61 Year Old Male:	\$6,520	\$108,700	\$65,200	\$43,480
Family of 4 (Parents 30s):	\$8,268	\$137,800	\$82,680	\$55,120
Family of 4 (Parents 50s):	\$11,221	\$187,016	\$112,210	\$74,740

Table 1 shows how unaffordable private individual market health insurance policies have become, even for middle-income individuals and families.

² The 2007 MinnesotaCare premium scale is attached.

³ Pregnant women and children are exempt from the asset requirement. Homes resided in by the enrollee, motor vehicles used for employment purposes, and other specified assets do not count against the asset limit. MINN. STAT. § 256L.17 (2007); *see also* MINN. STAT. § 256B.056, subd. 3c (2007) (MinnesotaCare asset limitations for families and children also exclude capital and operating assets of a trade or business up to \$200,000).

⁴ Based on a review of identical private health insurance policies available for purchase by Minnesota residents on eHealthinsurance.com as of August 2007. Deductibles are \$2,050 for adults and \$3,600 for families.

Table 2

<u>PREEXISTING CONDITIONS (MCHA)</u>	<u>TOTAL OUT OF POCKET SPENDING (PREMIUMS + \$2,000 DEDUCTIBLE)</u>	<u>PROPORTION OF INCOME SPENT ON HEALTH INSURANCE AND INCOME REQUIRED AT THAT LEVEL</u>		
		6%	10%	15%
27 Year Old Male:	\$3,882	\$64,700	\$38,820	\$25,880
57 Year Old Female:	\$6,912	\$115,200	\$69,120	\$46,080
61 Year Old Male:	\$7,474	\$124,556	\$74,740	\$49,826
Family of 4 (Parents 30s):	\$8,948	\$149,133	\$89,480	\$59,653
Family of 4 (Parents 50s):	\$12,617	\$210,283	\$126,170	\$84,113

Table 2 shows how private insurance is especially unaffordable for individuals who have pre-existing health conditions. Minnesota Comprehensive Health Association (MCHA) is a parallel private insurance market for Minnesota residents who are turned down for individual coverage due to a pre-existing health conditions. MCHA enrollees are guaranteed coverage but must pay premiums that are between 101 and 125 percent of the average market rate. MCHA does not receive government funding.

Ongoing Discussion

The working group thoroughly discussed affordability for Minnesotans who currently qualify for Minnesota’s public programs. A recommendation has been made only for that population.

The working group will continue to discuss a definition of affordability for: 1) Minnesotans who have access to employer-based coverage (as currently defined in the MinnesotaCare law) but find insurance unaffordable; and 2) Minnesotans who currently purchase insurance in the individual market.

In addition, the working group will finalize discussion on what out-of-pocket costs, such as premiums and deductibles, to include in the affordability definition.

Recommendation 1: Affordability for Minnesotans who Currently Qualify for Public Programs

Income Eligibility

MinnesotaCare should be available for all individuals and families up to 300% FPG (\$30,630/year for a single adult, \$61,950/year for a family of four).⁵

Premium Scale

A majority of working group members decided 6% of income would be an affordable maximum premium for MinnesotaCare enrollees. Premiums will remain on a sliding scale based on income, with the maximum amount set at 6% of income. For example, a family of four at 200% FPG will pay 4.6% of their income (about \$1,932 a year). A family of four at 300% FPG will pay at the 6% level of \$3,720 year. The proposed premium scale is as follows:

⁵ The working group will continue to discuss whether other limitations on MinnesotaCare eligibility should continue to apply as part of its ongoing discussion of an affordability standard for individuals who do not currently qualify for MinnesotaCare.

Premium Scenario for Expanding MinnesotaCare to 300% FPG with 6% Maximum Premium

Household size	Monthly gross income	FPG	Premium	Percentage of income
1	\$250	29%	\$4	1.1%
	\$500	59%	\$6	1.1%
	\$1,000	118%	\$24	2.4%
	\$1,500	176%	\$59	3.9%
	\$2,000	235%	\$108	5.4%
	\$2,300	270%	\$138	6%
	\$2,553	300%	\$350	6%
	(full cost)	\$3,000	353%	\$350
2	\$250	22%	\$8	3.2%
	\$500	44%	\$8	1.6%
	\$1,000	88%	\$16	1.6%
	\$1,500	131%	\$36	2.4%
	\$2,000	175%	\$78	3.9%
	\$2,500	219%	\$135	5.4%
	\$3,000	263%	\$180	6%
	(full cost)	\$4,000	351%	\$700
3	\$250	17%	\$10	4%
	\$500	35%	\$10	2%
	\$1,000	70%	\$12	1.2%
	\$1,500	105%	\$24	1.6%
	\$2,000	140%	\$58	2.9%
	\$2,500	175%	\$98	3.9%
	\$3,000	210%	\$138	4.6%
	\$3,500	245%	\$189	5.4%
	\$3,750	262%	\$225	6%
	(full cost)	\$5,000	349%	\$1050
4	\$250	15%	\$10	4%
	\$500	29%	\$10	2%
	\$1,000	58%	\$12	1.2%
	\$1,500	87%	\$24	1.6%
	\$2,000	116%	\$48	2.4%
	\$2,500	145%	\$73	2.9%
	\$3,000	174%	\$117	3.9%
	\$3,500	203%	\$161	4.6%
	\$4,000	232%	\$216	5.4%
	\$4,500	261%	\$270	6%
	(full cost)	\$6,000	349%	\$1,050

Source: "Premium Scenario for Expanding MinnesotaCare to 300% of FPG", prepared by David Godfrey, Senate Fiscal Analyst

Regional Cost of Living Differences

The working group discussed whether income eligibility for MinnesotaCare should vary by region. The working group also discussed whether the maximum percentage of income should vary by region (i.e., 6% in the metropolitan area and a higher percentage of income in another region of the state). The working group recommends further analysis of regional differentiation

of income eligibility and/or premium levels. Documentation of the premium scale and regional cost-of-living differences is found in the attached "Affordability and Premium Chart, 11.05.07".

Time Frame for Recommendation

The working group suggests that the recommendation be phased in, and become effective, in the 2010-2011 biennium.

Cost

The working group notes that it has not yet received a fiscal note on this recommendation. Since this is an expansion of MinnesotaCare, the recommendation may be funded through the Health Care Access Fund.

The working group also notes that federal waivers will be required in order to implement this recommendation.

Recommendation 2: Potential Financial Recapturing Mechanisms

The following is a list of possible financing mechanism options that the working group recommends for further discussion by the Health Care Access Commission. These mechanisms were discussed in terms of exploring the realignment of existing funding mechanisms and creating new ones in order to capture and maximize savings to reinvest within the health care system. This list is by no means exhaustive nor does it indicate the endorsement by the working group members for any one of these options. The working group acknowledges that further discussion is necessary especially in terms of the financial impact both on the cost of implementing these mechanisms and on the potential revenue to be generated. Without more fiscal information available at this time, the working group did not prioritize this list.

List of potential recapturing mechanisms for health care reinvestment are as follows:

- 1. Establish a savings recapture assessment to be paid by health insurance carriers and third party administrators.** The assessment would be determined by taking a percentage of the savings realized from reform initiatives that would either eliminate or greatly reduce uncompensated care and bad debt through an assessment on health carriers and third party administrators. This proposal is similar to the savings offset payment (SOP) that Maine has established. In Maine the Dirigo Board calculates an “aggregate measurable cost savings” based on an analysis of savings that are deemed to be reasonably supported. The SOP is paid on a quarterly basis and is a percentage of claims paid during the relevant year by the health insurance carrier, third party administrator, or employee benefit excess insurance carrier (for 2006 the payment was 2.408% of annual paid claims).
- 2. Reexamine the Disproportionate Share Hospital (DSH) payments.** The basis for this option is that, in part, the DSH payments have been established to compensate safety net hospitals that have a disproportionate share of uncompensated care. In theory, if the state achieves universal coverage, the portion of DSH that is provided to compensate for a disproportionate share of uncompensated care could be redirected within the health care system. The working group did acknowledge that not all of DSH is provided to compensate for uncompensated care, that some of it is to offset the higher portion of Medicaid and Medicare patients that these hospitals serve. Also, the group recognized that the state may not be successful in achieving universal coverage for all and that bad debt and charity care to some extent may continue to exist.
- 3. Create a community benefit pool that hospitals would be required to contribute to in order to retain their not-for-profit status.** This proposal requires examining the possibility of creating a “community benefit” pool that could be contributed to in order to retain nonprofit exemption status, especially if health care initiatives eliminate or significantly reduce the need for charity care and other hospital-subsidized services.

Currently, in order to qualify for nonprofit status, hospitals must meet a broad “community benefit” standard. Recent focus has been on whether nonprofit hospitals demonstrate community benefits in proportion to the value of tax exemptions. This has led to discussions on how to measure and quantify “community benefits”. The Catholic Health Association/ VHA standards have been used by many as the baseline in determining what elements should be considered in determining “community benefits”. An estimate of “community benefit” provided by Minnesota hospitals in 2005 compiled by the Minnesota Department of Health showed that the net total in

community benefits provided was \$607.2 million. This included charity care, (\$80.3 million), payment shortfall and taxes (\$357.8 million), other quantifiable community benefits (\$235 million), minus DSH payments. The estimated value of tax exemptions totaled \$482 million.⁶

4. Eliminate the state tax deduction for health care expenses for the top five percent income earners. This proposal recognizes that the nontaxation of health insurance plays a central role in determining the costs of health coverage. Longstanding federal and state tax policies have led to large state subsidies for health insurance provided by employers to employees. The total value of tax subsidies for all employer-sponsored insurance in Minnesota is currently \$760 million in state funds (Minnesota Department of Revenue, Tax Research Division). An additional \$102 million in subsidies results from the use of the following: high deductible health savings accounts (\$3.3 million); itemized deductions for medical or long-term care expenses (\$56.5 million); deductions for health insurance by the self-employed (\$34 million); the long-term care insurance credit (\$8.9 million).

National level data suggests that by 2009, the average value of the health insurance tax subsidy for the top five percent of earners will be \$4,790 per household⁷. This translates to more than \$128 million in health care related tax subsidies going to the top five percent of all earners in Minnesota (households with income in excess of \$180,000 per year).⁸

Such changes would add complexity to the tax system because it would require computing adjusted gross income differently for purposes of calculating Minnesota state income taxes. Also, this would require adding at least one line if not more to the tax form, a change usually opposed by the Department of Revenue. Finally, employers would be required to provide each employee with the cost of the health care provided in order for the taxpayer to make an adjustment to their taxable income.

5. Increase the health impact fee on tobacco products. Currently, the health impact fee is 75 cents per pack and 35 percent on tobacco products. For fiscal year 2007, the Department of Revenue estimated that \$225.4 million would be collected. Raising the fee by 25 cents would raise approximately a third of this amount (\$75 million), less the loss of revenue due to a decrease in smoking.⁹

6. Create a forecast mechanism that would recognize the savings from health care initiatives and recapture these savings to be used for health care purposes. The Commissioner of Finance would be required, when preparing the budget forecast for health and

⁶ Minnesota Department of Health, *Minnesota Hospitals: Uncompensated Care, Community Benefits, and the Value of Tax Exemptions*, Table 6 and Table 7 (Jan. 2007). Appendix 2 of the report details the great variation in community benefits by hospital, from 1.3% to 32.6% of operating expenses among government hospitals, and from 1.5% to 19.9% of operating expenses among private nonprofit hospitals.

⁷ This means that the tax benefit represents 35 percent of an average health insurance subsidy of \$13,685. Assuming these taxpayers are subject to Minnesota's top marginal rate of 7.85 percent, the tax expenditure for Minnesota is \$1,039 per taxpayer on average, for the 123,589 taxpayers in the top five percent of earners. Tax Policy Center, *Current Law Tax Benefits for Health Insurance*, Table T07-0055 (Feb. 2007).

⁸ This assumes that the top five percent of tax units in Minnesota receive the average health insurance-related tax subsidy that is estimated by the Tax Policy Center for the top five percent of tax units nationwide. It also assumes that average health insurance-related tax subsidies are the same in Minnesota as nationwide. It could, however, be the case that Minnesota employers provide either more or less generous subsidies than are provided in the rest of the nation.

⁹ The Department of Revenue's projections already estimate a 1 to 2 percent annual decline in the revenue generated by health impact fee to \$223 million in FY 2008 and \$219 million in FY 2009.

human services programs administered by the Commissioners of Human Services and Health, to calculate any savings that result from implementation of legislatively authorized initiatives to reduce health care costs. The commissioner would determine these savings by subtracting forecasted costs based on implementation of the legislative initiative to reduce health care spending from forecasted costs that would otherwise be incurred if the legislative initiatives were not implemented. The resulting cost savings would be appropriated to the Commissioners of Human Services and Health to fund ongoing or new initiatives to improve access to care and the quality of care.

7. Increase the Medical Assistance rate for primary care providers who practice in rural or underserved areas thereby receiving federal match. This proposal could incorporate the funds currently used in the loan forgiveness program that provides loan payments for physicians who commit to practice in rural and underserved areas. Physicians who meet the same criteria as in the current loan forgiveness program (establishing a practice in rural or underserved areas) would be eligible for a higher reimbursement MA rate. This higher rate would draw a dollar-for-dollar match from the federal government.

8. Require the Department of Human Services to aggressively negotiate growth limits and cost controls in the managed care contracts with health plans. Last session, the Senate omnibus bill proposed establishing growth limits to health plan premiums of approximately six percent. Based on this proposal, DHS provided a preliminary fiscal note that assumed that since health plan rate increases were to be capped as proposed, DHS could negotiate lower than forecasted rate increases in the managed care rates. The expectation was that with the caps the increase would be estimated at 6% instead of 7.5%, generating projected savings of approximately \$7 million in fiscal year 2008, \$24.6 million in fiscal year 2009, \$45.3 million in fiscal year 2010 and \$69 million in fiscal year 2010.

While the growth limit proposal was not successful last session, DHS could be required to aggressively negotiate the PMAP contracts within the same perimeters.

9. Create a penalty on employers who do not provide health coverage for their employees. This approach has been implemented in at least two states and has been proposed in several states. Both Massachusetts and Vermont passed an employer penalty as part of their comprehensive health care reform. In Massachusetts, employers with more than ten employees who do not make a "fair and reasonable" contribution toward providing health coverage for their employees are required to make a per employee contribution that is capped at \$295 per full-time equivalent employee per year. In Vermont, employers who do not offer coverage, only offer coverage to some employees, or have uninsured employees, are required to make a quarterly health care premium contribution of \$1 per day per total full-time employees. Finally, the Governor of California, as part of his comprehensive health care reform, is proposing an employer assessment on employers with more than ten employees who do not offer health coverage to employees and dependents based on a sliding scale from 0 to four percent of the employer's total payroll. This assessment would be used to cover the cost of health care coverage provided through a purchasing pool.

10. Reevaluate the health care provider tax. Currently, the health care provider tax is imposed on hospitals, health care providers, and wholesale drug distributors and assessed at two percent of the gross revenues received from patient services of hospitals and health care providers, and two percent of gross revenues from sales or distribution of prescription drugs

delivered in Minnesota. In fiscal year 2007, the provider tax generated \$408 million in revenue. This revenue is deposited into the health care access fund.

As part of this reevaluation, this recommendation includes a reexamination of the current assessments and taxes imposed on the regulated health plans recognizing that the burden of these assessments and taxes are borne disproportionately by the small employer and individual regulated markets. These assessments and taxes include:

- 2% - health care provider tax (health care access fund);
- 2% - gross premium tax on indemnity insurance carriers (general fund);
- 1% - gross premium tax on HMOs and nonprofit health service plan corporations (health care access fund);
- 0.6% - Medicaid surcharge on HMOs (general fund);
- 1.56% - Medicaid surcharge on hospitals (general fund); and
- 1.97% - Minnesota Comprehensive Health Association (MCHA) premium assessment on certain insurance carriers (subsidizes MCHA).

11. Increase the MinnesotaCare health care tax. Currently, the MinnesotaCare health care tax is imposed on hospitals, surgical centers, health care providers, and wholesale drug distributors and assessed at two percent of the gross revenues received from patient services of hospitals, surgical centers and health care providers, and two percent of gross revenues from sales or distribution of prescription drugs delivered in Minnesota. In fiscal year 2007, the MinnesotaCare tax generated \$408 million in revenue. In fiscal year 2008 the tax is forecasted to generate \$434 million and in fiscal year 2009 \$462 million. The revenue from the MinnesotaCare tax is deposited into the health care access fund.

12. Eliminate current health care taxes and assessments that are imposed on a small portion of the health care market and replace with a tax such as the MinnesotaCare tax that is assessed through a more equitable distribution. The current assessments and taxes imposed on the health care market include the following:

- 2% - MinnesotaCare health care tax (health care access fund);
- 2% - insurance gross premium tax on indemnity insurance carriers (general fund);
- 1% - insurance gross premium tax on HMOs and nonprofit health service plan corporations (health care access fund);
- 0.6% - health care provider surcharge on HMOs (general fund);
- 1.56% - health care provider surcharge on hospitals (general fund);
- \$2,815 – health care provider surcharge on licensed nursing homes per licensed bed (general fund);
- \$1,040 - health care provider surcharge on intermediate care facilities per licensed bed (general fund); and
- 1.97% - Minnesota Comprehensive Health Association (MCHA) premium assessment on certain insurance carriers (subsidizes MCHA).

There is no argument that the burden of these assessments and taxes is borne disproportionately by the small employer and individual regulated markets. The working group recommends that there is a need to reevaluate these taxes and assessments and replace them with a tax that is more

equitably distributed throughout the health care system. An example of such a tax is the MinnesotaCare health care tax that is based on gross revenue received from patient services. Another benefit of replacing these other taxes and assessments with a tax such as the MinnesotaCare health care tax is that since this tax is based on gross revenue received the revenue generated from the tax should increase with the increase in medical inflation.

Additional Comments: Recommendations to be passed on to the Health Care Access Commission for further research and discussion.

A number of additional proposals and ideas were discussed in the working group. As the group evaluated these proposals, it became apparent that though they are relevant to the overall health care reform discussion, these proposals were not within the purview of this working group's charge. Therefore, the working group is forwarding the following proposals on to the Health Care Access Commission for further research and discussion.

1. Pay health plans an enrollment "fee" for each new enrollee. These payments would not begin until an enrollee has completed a health assessment, chosen a medical home, and showed up for a specified number of appointments depending on the assessment.
2. Create a reward system for health plans with enrollees who stay enrolled in the same health plan for more than 18 months; penalize health plans when enrollees drop out.
3. Implement continuous 12-month eligibility for the Medical Assistance program.
4. Limit networks in certain areas where value and cost effectiveness is demonstrated.
5. Create programs to reduce supply-sensitive care (services where evidence regarding efficacy is either lacking or not conclusive). The state could encourage and facilitate collaboration among providers to address these issues.
6. Examine the development of incentives to enrollees to complete a health assessment and participate in care management programs if recommended.
7. Ensure that the health care access fund is dedicated to health care.