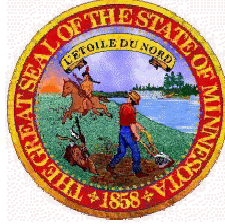


SENATOR LINDA BERGLIN, 61
Senator Paul E. Koering, 12
Senator Tony Lourey, 08
Senator John Marty, 54
Senator Julie Rosen, 24

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



85TH LEGISLATIVE SESSION

THE LEGISLATIVE COMMISSION ON HEALTH CARE ACCESS

SINGLE PAYER WORKING GROUP

REPORT TO THE HEALTH CARE ACCESS COMMISSION

REPRESENTATIVE KEN TSCHUMPER, HOUSE CO-CHAIR
SENATOR SHARON ERICKSON ROPES, SENATE CO-CHAIR

NOVEMBER 5, 2007

EXECUTIVE SUMMARY

Minnesota's health-care system has evolved in a haphazard way – leaving us with a fragmented non-system for health-care financing and delivery (as exists in the rest of the U.S.). The Single Payer Working Group concludes that this situation cannot be remedied by continuing to tinker with this broken system. Instead, it is time to build a health-care system that has the ability to deliver high quality, affordable care to all Minnesotans.

The Working Group recommends that Minnesota move to a health-care system featuring automatic enrollment and financing by a single insurer, either a state agency or commission. The insuring organization would be governed by a citizen board and include regional boards that can oversee defined parts of the state. Ownership and control of the delivery system (i.e. health care providers) would remain private, as it is currently. This model has been proven to work in many other Western countries and is similar in structure to the federal Medicare program.

The Single Payer Working Group estimates that this model would reduce health-care spending in Minnesota by 10-20% over the next several years, as compared to current

law (assuming no new categories of benefits are added in that time period). These dramatic savings come from greatly reduced insurance transaction costs, better management of delivery system capacity, better matching of payments to real costs, budgeting of hospitals, and the ability to negotiate fair and appropriate fees, prices, and reimbursement rates with providers.

The state's economy would benefit greatly from lower health care spending. Most Minnesotans would benefit directly from the elimination of current out-of-pocket health care spending and its replacement with a progressive premium system under which the vast majority of individuals and families would pay less than they pay now. For people with employment-based coverage, wages would increase, premiums would drop, or some combination of the two would occur. In addition, companies would be more likely to relocate to Minnesota in order to reduce the burden of employees' health insurance costs.

This system would provide real universal coverage for all Minnesotans. Residents would have better health-care security. Providers would be able to concentrate more on patient care and be relieved of much of their current administrative burden. Minnesota businesses would no longer have to manage health-care coverage for their workers and would be more competitive in national and global markets. The Single Payer Working Group strongly recommends that the Health Care Access Commission adopt a single payer health plan as the best option for meeting its statutory mandate and that the Commission pursue its implementation in the next legislative session.

I. INTRODUCTION

The Health Care Access Commission is charged with making recommendations to the Legislature on how to achieve the goal of universal health coverage for all Minnesotans by 2011.¹ This goal includes three components: (1) every Minnesotan will have access to a full range of quality health care services; (2) every Minnesotan will be able to afford coverage for a full range of services; and (3) every Minnesotan will pay into the system according to that person's ability.² Anything less than this makes the promise of "universal" an empty promise at best and, at worst, a government-sponsored mandate to increase private health plans' stranglehold on our health care system. In other words, "universal" would not be universal.

Our economy is a balance of the free-market and public control. The market works well for many services and commodities. In the ideal market, consumers are well informed about their choices and are able to purchase goods and services at market prices that cannot be manipulated by sellers. The special features of health care are not compatible with the requirements of an ideal market and hence have led to a market failure in this sector of our economy.

For several decades in Minnesota, our health care system has increasingly treated health care as a commodity – a bundle of services to be bought, sold, and traded on the private market and, like all commodities, subject to the whims of Wall Street. Attempts to reduce cost and expand coverage have not deviated from the "commodity" approach. This has fueled breathtaking corporate profit margins, has led to massive shortages of providers in rural areas, and has contributed to exorbitant costs for even basic health care services. More importantly, this philosophy has created a maze of bureaucracies, public and private, with numerous parties, payers, and a grid of ever increasing complexity. Many patients in today's system can receive immediate access to health care only when they have a life threatening or potentially disabling health condition.

The Single Payer Working Group recommends statewide health care policy and administrative choices be based on an evidence-based system, similar to that adopted by numerous countries and embraced by hundreds of millions of people worldwide. Accordingly, the Single-Payer Working Group proposes a unified and universal health care system; progressively funded, and with comprehensive benefits administered by one public organization. Previous health care "experiments" have caused spiraling costs, frustration, inadequate coverage, and gross inequities. A single payer system would

¹ MINN. STAT. § 62J.07, subd. 1 (2007).

² MINN. STAT. § 62Q.165 (2007).

provide the financial stability and universal access that similar systems have achieved in other industrialized nations.

II. THE PROBLEM

THE INJUSTICE IN OUR CURRENT SYSTEM

Elected officials often proclaim that the U.S. has the best health care system in the world even as millions of people are denied the care they need. The U.S. has the best health care in the world for those who can afford it.³ According to a recent survey, 37 percent of all adults and 42 percent of chronically ill adults said they had skipped medications, not seen a doctor, or foregone recommended care because of costs – a rate two to eight times higher than in single payer countries.⁴

Health care rationing exists in America due to the lack of affordability of coverage and the price of care. Inequality in access to health care has profound ramifications for our society. For example, the U.S. has fallen behind other high-income countries in areas such as deaths due to HIV infection, diabetes, and ischemic heart disease.⁵ Within the U.S., disparities are increasing for poor people in terms of quality of care and access to care.⁶ Such inequality, especially among children, creates health disparities that have later ripple effects in education, the criminal justice system, and on the economy as a whole.

Health care premiums are now often unaffordable for the middle class. Affordable policies are obtainable through the purchase of limited benefits policies involving complex contracts with extensive limits on access to care. Most people simply do not know what or who will be covered until they try to use services and receive a bill. Furthermore, chronic medical problems can easily exceed insurance benefits, putting middle class families into severe financial distress and even bankruptcy.

³ While state health insurance rankings often put Minnesota near the top, more comprehensive rankings reveal that Minnesota ranks just 11th overall, 12th in quality, and an abysmal 38th in equity. J.C. Cantor, et al., *Aiming Higher: Results from a State Scorecard on Health System Performance*, THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM, (June 2007), at http://www.commonwealthfund.org/usr_doc/StateScorecard.pdf?section=4039.

⁴ Schoen et al., *Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007*, 26 HEALTH AFFAIRS 6, w717-734 (2007).

⁵ Gerard F. Anderson, et al., *Health Spending in OECD Countries in 2004: An Update*, 26 HEALTH AFFAIRS 5, 1481-1489 (2007).

⁶ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *National Healthcare Disparities Report, 2006*, iv, available at <http://www.ahrq.gov/qual/nhdr06/nhdr06high.pdf>.

Most health care and health insurance markets are highly consolidated. In Minnesota, for example, three insurance companies have controlled three-fourths of the insurance market for the last 15 years. Similarly, the hospital market and many markets for specialty services, drugs, and equipment constitute either monopolies (one seller) or oligopolies (few sellers).

For these reasons, among many, the Single-Payer Working Group believes that most medical services should be treated as a public good or essential service, not as a commodity allocated via the marketplace. If society is to eliminate health disparities, health care must be a fundamental *right*. If health care is a right, it must be provided through a system that affords equal access for all, and delivers care as an obligation of our common society.

III. HEALTH CARE IN OTHER INDUSTRIALIZED NATIONS

A. THE BRITISH MODEL: ENGLAND, SWEDEN, NORWAY

British model systems have a publicly funded single-payer economic model, universal coverage, and public sector care delivery. Patients receive medical care at government facilities by providers working as contractors for the government, with government paying for the care. Like all Western single-payer nations, these nations have a public-private partnership for financing medical care, with very small patient cost sharing, and a small private insurance sector. Patient care is funded with both private spending (14-15 percent) and public spending (85 percent). The British model is a truly socialist system because nearly all means of medical care production—facilities, physicians—are owned and operated by the government.⁷ Norway also exemplifies public sector care delivery dominance. In 2004, it had 13,000 public hospital beds and only 284 private beds.

B. THE CONTINENTAL MODEL: FRANCE AND GERMANY

The Continental Model is a mix of private and public sector involvement at all levels: financing, access, regulation, and care-delivery. European nations have social structures that differ significantly from the U.S. Some aspects of the health systems in these

⁷ More recently, England has moved away from the 'socialist' system of care, allowing providers to be privately employed even though they are still paid through the National Health Service.

nations cannot be easily replicated in the U.S. due to differences in social, economic, and governance structures.

Employers play a role in Continental systems. However these nations do not typically have employment-based health systems. Some nations finance their systems through employer/employee-paid taxes, while others finance their health care through general revenue. Enrollees are sometimes grouped into a sickness fund. The funds serve as organizing vehicles to create pools of people to be covered, and operate merely as payers, not insurers. Continental systems require employers to help organize the sickness funds. Employers have no policy-setting role. Moreover, employers' health care costs are not dependent on the health, age, or disability status of their employees.

C. THE CANADIAN MODEL

The Canadian system involves a public-private financing mix for patient care, a public sector single-payer social insurance model, universal coverage, and a mix of public sector and private sector care delivery. The system is roughly akin to the U.S. Medicaid program. A comprehensive minimum benefit set is established by the national government and each province must offer coverage including those benefits, with funding divided between the national government and the provinces. In some instances, provinces have flexibility to establish their own regulations, but the main framework is federally determined.

The single-payer system pays for a comprehensive set of benefits. Selling private insurance products that duplicate the publicly funded benefit set is prohibited. However, a system of private supplemental insurance can be purchased to cover any benefits not covered under the public plan-- akin to Medicare's Medigap plans. Hence, insurance coverage is available in Canada for any treatment covered by insurance in the U.S. Another option is a small cash market system in which benefits that would typically be covered under the public plan are paid for by a patient through an out-of-pocket cash payment directly to the provider.

The care delivery system is also a mix of public and private facilities and providers. Approximately 70% of Canadian doctors are privately employed. Facilities are publicly owned to a higher degree than in the U.S.

IV. PRINCIPLES OF A SINGLE PAYER SYSTEM

A. UNIVERSAL ACCESS THROUGH AUTOMATIC COVERAGE

There are three main types of access to health insurance coverage: voluntary, mandated, and automatic.

Voluntary coverage is a system through which people obtain insurance by an individual's or an employer's decision to purchase health insurance. This is the approach for the 68 percent of Minnesotans who have private health insurance (an additional 14 percent have Medicare and 11 percent receive health care through a state funded program).⁸

Alternatively, mandates to buy private insurance coverage (now in place in Massachusetts and under consideration in other states) is typically implemented in two forms. Individual mandates require individuals to have insurance coverage from some source. Employer mandates require employers to offer some form of health insurance, but are generally nullified at the state level due to preemption by a federal law – the Employee Retirement Income Security Act (ERISA).⁹

In a single payer system, health care coverage is automatic. Automatic coverage is used for public health insurance programs, either on a system-wide basis (all persons), or for particular demographic categories, e.g. Medicare and seniors. Automatic systems result in universal coverage by removing financial barriers to receiving medical care. When people are automatically able to access and receive medical care, regardless of personal finances, universal coverage exists. Health care is treated as a right, rather than a commodity. Single payer systems use automatic coverage to solve many of the market failures that are inherent in the private insurance system. Additionally, automatic enrollment encourages even those employers with ERISA plans to voluntarily join the single payer system, thereby avoiding federal preemption.

B. COMPREHENSIVE BENEFITS

A single payer system should cover all medically necessary health care provided by a licensed provider, including necessary medical equipment, in a timely manner for every

⁸ MINNESOTA DEPARTMENT OF HEALTH, *Health Economics Program, Section 2: Trends and Variation in Health Insurance Coverage* 7 (July 2007).

⁹ Title 29, United States Code, section 1001 et seq. provides for federal preemption of any state law "insofar as they may now or hereafter relate to an employee benefit plan." 29 U.S.C. § 1144(a) (2007).

patient, as well as covering long-term care and providing "first dollar" coverage instead of requiring co-pays and deductibles. Appendix 3 offers an example of one such list of benefits, but is not intended to be conclusive.

C. AFFORDABLE COSTS

The "single-payer" model utilizes public financing and is established as the single payer for all medically necessary health care goods and services. Single payer is fundamentally an efficiency-maximizing economic model for financing patient care via one payer. Using the bulk purchasing power of the population covered (e.g. all Minnesotans), one policy instead of hundreds of variations of insurance policies, and the authority to set limits on cost, a single payer system is able to lower costs and improve services for enrollees.

Single payer systems around the world are clearly more affordable than our current system. Minnesotans and Americans currently pay more while receiving less for their health care dollars than any other people in the world. Industrialized nations spend just 8.8 percent of Gross Domestic Product (GDP) on health care costs, while the U.S. spends 15.3 percent of GDP on health care.¹⁰ Minnesotans spend \$5,765 per capita on health care (lower than the U.S. national average), as compared to \$2,552 per capita among other industrialized nations.¹¹

Differences in spending are not due to rationed care – on the contrary, people in the United States have lower utilization rates for physician visits, acute care bed days, and average length of inpatient stay than these other countries.¹² Instead, higher spending in the U.S. goes to administrative costs – money spent figuring out who is responsible for paying the costs of care.¹³ In short, Minnesota would go from a huge multiple payer system (HMOs, indemnity insurers, employers, unions, various levels of government, and individual Minnesotans paying cash out-of-pocket) to a single payer system.

¹⁰ *Supra* n.5, Anderson (2007).

¹¹ See MINNESOTA DEPARTMENT OF HEALTH, HEALTH ECONOMICS PROGRAM, *Minnesota Health Care Spending and Cost Drivers* (Oct. 2007), at <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/section1.pdf>. See also *supra* n.5, Anderson (2007).

¹² *Id.*

¹³ J.G. Kahn, et al., *The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals*, 24 HEALTH AFFAIRS 8, 1629-39 (2005).

D. EXAMPLES OF EXISTING SINGLE PAYER SYSTEMS IN THE UNITED STATES

Medicare is an American example of a single-payer system with automatic enrollment for seniors. The original Medicare program allowed patients to choose providers and facilities, with the federal government paying providers on a fee-for-service basis. In the past 15 years, private insurers and HMOs have been allowed to provide services and managed care functions for Medicare enrollees, greatly increasing costs.¹⁴ Thus, Medicare's original single-payer approach has been eroded to some degree. Nevertheless, Medicare still outperforms the private multiple-payer system on both administrative costs¹⁵ and quality measures.¹⁶ Medicare can be counted on to control health care spending growth more than private insurers (9.6 percent annual growth versus 11.1 percent for the private sector – a significant savings).¹⁷

The Veteran's Administration is an example of both a single-payer system and a public provider system. Eligible veterans' receive comprehensive health care services through the system of VA employed providers and VA owned facilities with the federal government paying for their care. Recent studies show that the VA Health System provides care for about two-thirds of the cost of the private system. Overall VA health care is better than private insurance, notwithstanding isolated incidents of mismanagement, as seen at places like Walter Reed and the Minnesota Veterans Home.

V. A MINNESOTA SINGLE PAYER SYSTEM

A Minnesota single payer system would focus on universal health coverage that is both comprehensive and affordable. It would be founded on the present public-private partnership. Just as we have today, providers and facilities would be private businesses; they would not work for the government, nor be government-owned. The current

¹⁴ Medicare lacks several features typically associated with single-payer systems, notably the ability to set budgets for hospitals and to negotiate for reduced drug prices.

¹⁵ In 2006, Medicare administrative expenses were just 1.5 percent of total spending (in Part A, Part B, and Part D). Medicare Trustees 2007 Annual Report, *Table II.B.1. Medicare Data for Calendar Year 2006*, (April 2007) at <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2007.pdf>.

¹⁶ Karen Davis et al., *Medicare Versus Private Insurance: Rhetoric and Reality*, HEALTH AFFAIRS, WEB EXCLUSIVE, W311-324, Exhibits 3-5 (2002) (Medicare vastly outperformed the private sector insurers on all statistically significant measures).

¹⁷ Cristina Boccuti and Marilyn Moon, *Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades*, 22 HEALTH AFFAIRS 2, 230 (2003) (finding that Medicare outperformed the private sector even after controlling for comparable services covered).

private-sector care delivery system would continue to co-exist in the same proportion to our current public-sector care system.

A. GOVERNANCE OF A SINGLE PAYER SYSTEM

A single payer system could be governed in a number of ways, including a new state agency, a public utility board, or through regional governance. We discuss the third option in more detail here, without recommending any specific governance structure.

A set of six to nine regional governing boards would offer a federalism-style framework with governance at a State level via a State Health Board (SHB). Counties' current health care administrative functions would be integrated into the regional organization structure. The regional boards would govern different geographic regions, to ensure equal representation and also to account for localized differences. Regional Boards would include representation from residents of that region. Each region would choose a representative to serve on the State Board.

The State Board would be populated with a mix of Regional Board representatives and statewide representatives. These statewide representatives can be selected using a variety of methods, possibly involving either legislative or gubernatorial appointments. The State Board would govern the State Health Plan (SHP) that is created. The State Health Plan can operate as a traditional state agency, on a quasi-government basis akin to the Federal Reserve or public utilities, or as a private sector non-profit functioning under heavy regulation by the state, akin to the Minnesota Comprehensive Health Association (MCHA), regulated by the Department of Commerce. The leadership of the SHP entity can be filled through an elected Commissioner, an appointed Commissioner, or an Executive Director.

The State Board would develop the overall structure of the system, establish the mechanisms used to finance the SHP, establish coverage benefits, and develop other general structures and policies. The SHB would also, in partnership with the regions, develop projections of the costs for the SHP in given regions, set budgets for each, and then allocate those funds to each region.

The Regional Boards would address the demographics and health needs for their residents. They would use their expertise in their localized care needs and provider structures to establish policies to help foster the efficient delivery of care—including oversight and coordination of capital spending. They would also develop policies to allocate their funds for care delivery using global budgets for hospitals and methods for paying providers such as budgeted spending and fee-for-service. Data collection for use

in assessing such areas as system performance, cost effectiveness, and medical quality, would be carried out in large part at the regional level.

B. BENEFITS OFFERED

A Minnesota single payer system could offer automatic, universal access to comprehensive benefits for all Minnesota residents without regard to their ability to pay. See Appendix 3 for a suggested benefit set.

C. FINANCING A MINNESOTA SINGLE PAYER SYSTEM

The single payer system makes health care affordable by charging income-earners based on a progressive, ability-to-pay basis. Most residents would pay less under a progressive premium system than they are paying now in out-of-pocket health care spending on premiums, co-pays, and deductibles. That revenue would fund the system, with additional cost savings from administrative efficiencies, making it possible to cover all Minnesotans with true universal coverage.

The research on single payer systems indicates a Minnesota single-payer system could achieve universal coverage for no more, and possibly for much less, than we are spending now on all health care-related costs. The standard reference to \$30 billion in current Minnesota health care spending fails to account for spending on health coverage in auto insurance policies, workers' compensation, and litigation costs related to determining liability for health expenses. A single payer system will achieve savings in four main areas: administrative costs, redundant equipment and facilities, fees and prices, and reduced fraud.

Roughly half to two-thirds of total savings will be attributable to reductions in administrative costs.¹⁸ According to the U.S. Government Accountability Office (GAO), the administrative savings from a single-payer plan are 10 percent of total spending.¹⁹ In other words, a single-payer system that started tomorrow and did nothing to reduce spending by providers, drug companies, and manufacturers of equipment could save Minnesotans \$3 billion in one year. No other proposal can make that claim.

¹⁸ J.G. Kahn, et al., *The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals*, 24 HEALTH AFFAIRS 8, 1629-39 (2005).

¹⁹ GOVERNMENT ACCOUNTABILITY OFFICE, *Canadian Health Insurance: Lessons for the United States*, GAO/T-HRD-91-35, 63, Table 5.1. (1991), available at <http://archive.gao.gov/d38t12/144048.pdf>.

The GAO reported that approximately half the 10 percent savings was attributable to a reduction in administrative costs in the insurance sector, while the other half was due to reduced administrative costs for providers. The insurance sector savings consist of money spent on marketing, underwriting, "management" of doctors, high salaries and lavish non-cash benefits, lobbying, and profit. Providers would have reductions in administrative costs because they will spend less money trying to get paid for their work. It is far less expensive for a clinic to submit a bill once a month to a single payer that does not look for excuses to avoid paying, than it is to submit to numerous payers, all with different forms and all attempting to delay or deny payment.

An additional five to ten percent could be saved through changes in payment methodology. A single-payer system would reduce costs through global budgeting for hospitals, controlling delivery system capacity, and fair negotiating of fees and prices. Consumers' volume of health services used in the U.S. is not much different than other Western countries, but our fees and prices are considerably higher.²⁰

D. DOCUMENTING ACTUAL COSTS

The Health Care Access Commission requested a fiscal note on a single payer plan. It was our conclusion that our short time frame and lack of access to departmental assistance prevented an in-depth analysis of direct and indirect cost savings that would be needed to identify the true savings from a single payer system. A single payer system offers a comprehensive approach to the health care needs of all Minnesotans and thereby affects other sectors of the economy and other aspects of the state budget.²¹ Accordingly, a fiscal note of only the benefit set would not accurately reflect the cost and benefits of such a change.

A number of studies have been performed to estimate savings under various types of single-payer proposals in the U.S., mostly at the state-level. The results of these, however, depend on the particular details of the proposals themselves, and on existing state structures and demographics. In general, these studies show an estimated 10-20% savings within five years of enactment, depending on the benefit set.

²⁰ Gerard F. Anderson, et al., *It's the Prices, Stupid: Why the United States Is So Different From Other Countries*, 22 HEALTH AFFAIRS 3, 89-105 (2003).

²¹ An accurate fiscal note on a single payer system would need to account for reduced education costs, criminal justice costs, and local government expenses. In addition, it would produce greater levels of revenue from citizens who get timely health treatment and can get back to work.

E. PROVIDER REIMBURSEMENT

Capitated payments create an inherent conflict of interest when the entity to whom health care payments are made also has the authority to decide how much of the health care dollar gets spent. Our current system imposes another layer of administrative costs when providers must individually negotiate reimbursement rates. This tends to result in lower reimbursement for smaller, more rural providers.

One way to greatly simplify and bring equity to the rates paid would be to allow the regional boards to negotiate uniform rates for all providers in their geographic region, accounting for local variations in the cost of delivering care. Rates would also be adjusted to encourage a more appropriate mix of physicians in the state (e.g. more primary care doctors). Once the negotiated, uniform rates are established, payments to physicians would be on a fee-for-service basis. Hospital payments will be determined through global annual budgeting, negotiated with the SHB. These budgets will take account for projected increases in volume and prices.

In this manner, the single payer system would improve upon – not eliminate -- the existing Minnesota infrastructure relating to health care. The State would serve as the one payer in the state for patient medical care, collecting funds via taxes or premiums. No payment mechanism will create an incentive to reduce care. Health care decisions would be made by patients and the professionals they know and trust, not by HMOs and insurance companies.

VI. FEDERAL PROGRAM INTEGRATION

FEDERAL FUNDING STREAMS IN A SINGLE PAYER SYSTEM

Developing a statewide single payer health care system in the context of existing federal programs and funding is likely to pose unique challenges for policymakers. These challenges could be addressed if Minnesota were to start out with a smaller program of universal single-payer coverage for children or single-payer coverage at the local or county level. Ultimately, we envision Medicare, Medicaid and other federal health care program funding as a component of the single payer financing system. Federal program eligibility determinations, benefits limitations, and cost sharing would have to be continued in a state level single payer health care system, to the extent required by

federal law.²² This is to ensure that federal matching dollars are not used for anyone other than traditional eligibility categories, even while the state uses its own dollars to create the single payer system, providing coverage for all residents.

VII. INTEGRATION WITH EXISTING INFRASTRUCTURE

The existing state structure would be adapted to the new single payer system. The current infrastructure could be used to better coordinate inter-agency operations. In a single payer system, existing infrastructure could be streamlined as a result of the reduction or elimination of a number of payers and health plans of different types, all of which are currently regulated and administered according to numerous laws, rules, and agency policies. The existing state agency infrastructure would also function in an expanded role to institute a series of checks and balances between the new health plan agency and existing departments.

The Department of Health would continue to perform many of its current duties regarding licensing regulation, oversight of medical professionals, monitoring health condition issues, public health issues, overall demographic studies, and research. Many of the new ongoing monitoring functions established by the new State Health Board (SHB) can be housed in MDH, which would work in collaboration with the State and Regional Boards.

The Department of Commerce would continue to provide oversight of commercial entities. This prevents too much oversight of the functions of providers coming under one entity. **The State Auditor** would audit the SHP and Boards regarding finance issues. **The Office of the Legislative Auditor** would continue its function of focused program evaluations to address policies and practices in the new system, and some aspects of financial auditing. **The Attorney General** would serve as inspector general and compliance officer of the new health plan and Boards to ensure the public interest is being served, to eliminate conflicts of interest, and to assure that compliance with law is maintained. **The Department of Human Services** can possibly serve a role to help people navigate the SHP, possibly as ombudsman, drawing on its mission of working with the public for other public services. **The Department of Revenue** would collect the funds to be spent by the SHP, so the standard control features of a financial system

²² Certain federal programs explicitly envision and authorize state innovation in the realm of health care. Medicaid section 1115 waivers and S-CHIP flexibility allow the possibility that Minnesota could apply for waiver authority to expand coverage in a single payer system using its own dollars, while maintaining budget neutrality for the federal government. 42 U.S.C. § 1315 (2007).

would be in place. **The Secretary of State** can play a role in overseeing the selection of Board representatives to insure the integrity of the system.

The division of the duties called for in the SHP is obviously contingent on many factors, but the general concept is that not all of the duties involved in the new system are new to the state's infrastructure. Hence, wherever those duties rest currently, those assets and personnel can be shifted to the new SHP, or elsewhere, or remain where they are to help operate the new system. While critics of a single-payer approach express concerns that it would result in one overwhelmingly large new agency and attendant bureaucracy, we do not propose creating a new agency. The duties performed by a variety of state agencies would create a solid system of checks and balances to monitor the new single-payer system.

VIII. RECOMMENDATIONS

Adopting a single payer health care system in Minnesota would ensure that:

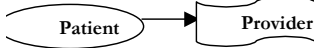
- Every Minnesota resident would be covered;
- Residents would have health care security—knowing they could get necessary care without worries about co-pays, deductibles, or losing coverage when they change jobs or get sick;
- Providers could spend more time working with patients instead of dealing with insurers. Monetary savings to providers would be substantial.
- Social services involving health care, such as long-term-care, would be less expensive with service providers only needing to coordinate their efforts with one health payer.
- Employers would be relieved of the costs and administrative burden of offering health plans, making them more competitive internationally and nationally.
- Self-employed individuals and small business employers would be able to maintain economic viability, relieved of health care's costly burden.

There is a concern that the adoption of a single-payer system would result in temporary worker displacement. As with any major restructuring or modernization, some positions – such as those that now deal with billing complexities – would certainly become obsolete. Retraining and other assistance for displaced workers over a 3-5 year period could be included in a single payer proposal. The cost savings from using a single-payer system leaves additional money in the economy, money that can create new jobs in the health care sector and in other economic sectors.

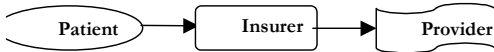
The Single Payer Working Group strongly recommends that the Health Care Access Commission adopt a single payer health plan as the best option for meeting its statutory mandate and that the Commission pursue its implementation in the next legislative session. In the end, any health care system is only as good as the care that is actually utilized by Minnesotans. Our Single Payer Working Group believes there is an urgent need for a real, stable, affordable, and geographically accessible solution. A single payer system can meet that need.

APPENDIX 1: EVOLUTION OF THE HEALTH CARE MAZE

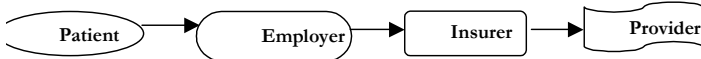
1. The Direct-Pay, Non-Insurance Mode



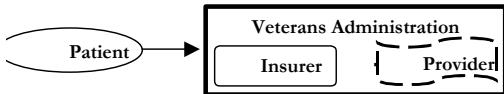
2. The Indemnity Insurance Model



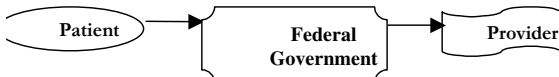
3. The Employment-Based Health Insurance Model.



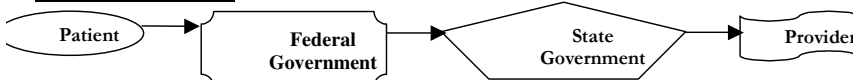
4. Veterans Administration



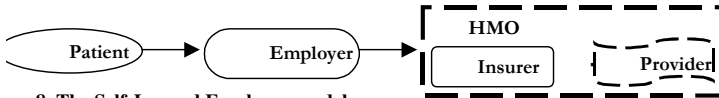
5. The Medicare Model



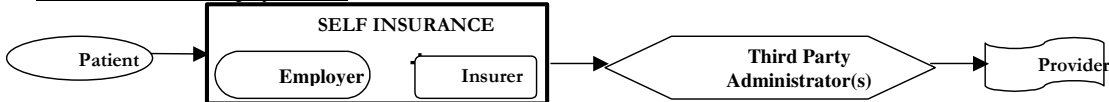
6. The Medicaid Model



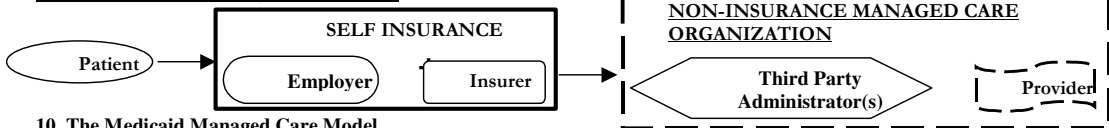
7. The Managed Care Model Dashed lines denote the provider-managed care organization (MCO), e.g. HMO, PPO, relationship as permeable in degree of provider freedom from MCO: staff model, exclusive or preferred network, etc.



8. The Self-Insured Employer model.



9. The Self-Insured Managed Care Model.



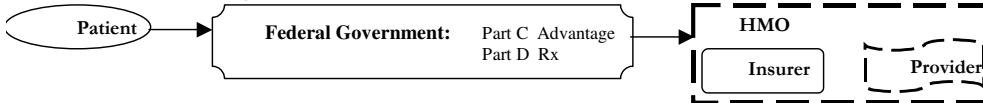
10. The Medicaid Managed Care Model



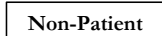
11. The MinnesotaCare Model



12. The Medicare Managed Care Model



13. The No Care Model Person needs care but can't afford, neither via insurance nor out of pocket.

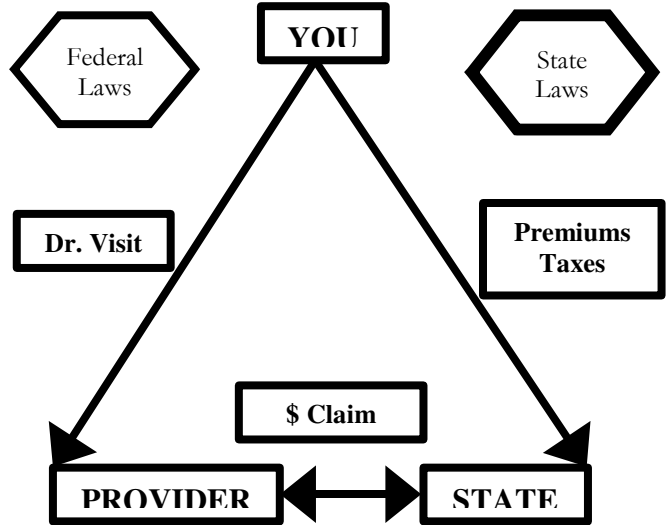


APPENDIX 2: SINGLE PAYER STRUCTURE

The Triangle: *Minnesota's proposed single-payer*

You. All residents are automatically enrolled in State Health Plan. Taxes and/or premiums based on ability to pay are paid to the state. Residents see providers. **State.** The State serves as the one payer in the state for patient medical care, collecting funds via taxes/premiums. The State reimburses providers. **Providers.** Providers see patients regardless of patient's financial situation. The State pays providers. Providers work in both the private and public sector as currently. Likewise, facilities are still privately and publicly owned as currently

SIMPLIFIED: The Triangle depicted does not include private, supplemental health insurance plans nor any, if any, outside contracted entities. The presence and extent of the role those parties play varies by system.



APPENDIX 3: PROPOSED BENEFIT SET

1. Inpatient/outpatient health facility services;
2. Inpatient/outpatient professional health care provider services by licensed health care professionals;
3. Diagnostic imaging, laboratory, and other diagnostic and evaluative services;
4. Medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids and their repair;
5. Inpatient/outpatient rehabilitative care;
6. Emergency transportation and necessary transportation for health care services for disabled and indigent persons;
7. Language interpretation and translation for health care services, including sign language and Braille translation;
8. Child and adult immunizations and preventive care;
9. Health education;
10. Hospice care;
11. Home health care;
12. Prescription drugs (formulary); non-formulary prescription drugs (to be determined);
13. Mental/behavioral health care;
14. Dental care;
15. Podiatric care;
16. Chiropractic care;
17. Acupuncture;
18. Blood and blood products;
19. Emergency care services;
20. Vision care;
21. Adult day care;
22. Case management and coordination to enable a person to remain safely in the least restrictive setting;
23. Substance abuse treatment;
24. Care in a skilled nursing facility; and
25. Dialysis.

APPENDIX 4: PRINCIPLES FOR HEALTH CARE REFORM

Senator John Marty/Representative Ken Tschumper

Senate File 2324/House File 2522

25 Senate co-sponsors

32 House co-authors

In order to develop a plan that keeps Minnesotans healthy and provides the best quality of health care, health care reform must:

- (1) ensure all Minnesotans receive high quality care, regardless of their income;
- (2) not restrict, delay, or deny care or reduce the quality of care to hold down costs, but instead reduce costs through prevention, efficiency, and reduction of bureaucracy;
- (3) cover all necessary care, including all coverage currently required by law, complete mental health services, chemical dependency treatment, prescription drugs, medical equipment and supplies, dental care, long-term care, and home care services;
- (4) allow patients to choose their own providers;
- (5) be funded through premiums and other payments based on the person's ability to pay, so as not to deny full access to all Minnesotans;
- (6) focus on preventive care and early intervention to improve the health of all Minnesotans and reduce costs from untreated illnesses and diseases;
- (7) ensure an adequate number of qualified health care professionals and facilities to guarantee availability of, and timely access to quality care throughout the state;
- (8) continue Minnesota's leadership in medical education, training, research, and technology; and
- (9) provide adequate and timely payments to providers.

We, the undersigned respectfully ask the Health Care Access Commission to adopt recommendations that reflect the contents and conclusions of this report:

Rep. Ken Tschumper, co-chair

Senator Sharon Erickson Ropes, co-chair

Senator John Doll

Senator Mary Olson

Dr. Jim Hart

Senator Yvonne Prettner Solon

Barb Hollenbeck

John M. Schwarz

Rep Carolyn Laine

Eileen Weber, RN, JD

Rep. Tina Liebling

We, the undersigned, respectfully dissent from this report:

Senator Ray Vandever

Rep. Matt Dean

Dr. Robert W. Geist