Citizens League

STATEMENT

Health Care Access for All Minnesotans

February 1992

Public affairs
research and education
in the Twin Cities
metropolitan area

CITIZENS LEAGUE STATEMENT

Health Care Access for All Minnesotans

Prepared by the:

Health Care Access Subcommittee,
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of the

Community Information Committee,
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Approved by the Board of Directors
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HEALTH CARE ACCESS FOR ALL MINNESOTANS

BACKGROUND

During its 1992 session, the Minnesota Legislature will consider a series of proposals intended to address the problem of an estimated eight percent of Minnesotans who have no health care insurance. A special subcommittee of the Citizens League's Community Information Committee was convened to review past League positions on these issues and to update them for use during the 1992 session.

To meet this goal, the scope of our inquiry was narrow. The subcommittee's work and this paper focus on the challenge of providing access to health care coverage. Yet, for many years we have understood that *access* is only one aspect of the complex issue of health care. The *cost* and *quality* of health care are equally important and deserve the continued attention of the Legislature and all Minnesota citizens.

The Citizens League has long been involved in research and initiatives in Minnesota's dynamic health care marketplace. In 1977, we recommended that the Twin Cities area address rising medical care costs by reducing its excessive number of hospitals and hospital beds through both regulatory and voluntary efforts. Subsequently, as proponents and opponents of regulation fought over how best to contain costs, the League came to understand that excess capacity was merely a symptom of the more fundamental problem of market failure.

This conclusion was expressed in a 1981 report arguing that the health care industry did not operate as a rational market. The report recommended that we control health care costs by reforming that market -- focusing on the demand side, rather than trying to regulate the supply side. It advocated encouraging true competition with steps such as making provider prices readily available to the public and revising the system's incentives in order to reward efficiency rather than consumption.

The League in a 1987 report recognized the lack of health care coverage for Minnesotans who (1) have incomes that are low, but too high to qualify for public assistance and (2) work for employers who do not offer health insurance. This report recommended that the state create a voluntary health insurance plan for the uninsured up to 200 percent of the federal poverty level, subsidized according to ability to pay, with phased-in eligibility and benefits starting with children, pregnant women and persons leaving AFDC. Subsequently, the Minnesota Legislature enacted the Children's Health Plan.

The League in 1989 questioned the value and equity of Minnesota's large number of mandated insurance benefits. We said that the state's health care priority should be universal access to a basic level of care and recommended (1) a moratorium on new mandates pending a legislative review and (2) critical evaluation of all existing mandates.

Over the last few years, proponents of increased availability of health care in Minnesota have failed in several legislative attempts to expand access, mainly because of the difficulty of funding such a program in an already strained state budget. That problem grows increasingly difficult as the cost of health services continues to rise far faster than general inflation.

PRINCIPLES

The Citizens League believes that:

- Universal coverage of basic health care benefits at a reasonable price for all Minnesotans should be an important state policy goal. All residents have not only a right to basic coverage, but a responsibility to obtain it if that is within their financial capability.

Imposing such a duty is not something we take lightly. This country, after all, is built on rights more than duties. Yet, we feel strongly that a mutual obligation exists: society will ensure access to health care for all citizens, but all must, within their means, participate in the insurance system for financing health care.

- At the same time that we extend access to health care, it is equally critical that we begin to hold down the soaring increases in the cost of medical services. Affordability is a significant and growing barrier to access. Universal access to meaningful benefits will be little more than an empty promise until the state changes a system that allows physician and hospital costs to rise unchecked, mainly because it provides few incentives for quality care at affordable prices.

- As Minnesota seeks to improve access, we must *at the same time* enact effective cost-containment and quality provisions. If costs continue to rise at past rates, we will find it increasingly difficult to afford adequate care for a much higher proportion of the population.

Today, some 370,000 Minnesotans -- 8.6 percent of the population -- are without health insurance for at least one month a year. About 190,000 of them are uninsured for the entire year. That is the lowest proportion of any state except Hawaii.[1]

Universal coverage is sound public policy. Each individual, as a basic entitlement, deserves access to adequate health care. In an overall sense, a healthy citizenry benefits society at large. Universal coverage, however, need not and should not mean a single-payer, government-dominated system, such as Canada's. Such a system would be impractical, if not impossible, for a single state to operate. The shortest route to extended access is to build on and improve the current system, in which a majority of Minnesotans receive health care coverage through employers, rather than dismantle and replace it. Equally important, we opt fundamentally for choice: Variety and true competition -- a mixed system with multiple payers and providers -- is the most promising path to quality medical care at reasonable prices.

Since universal coverage is not achievable in the near future without an increase in state spending, practical budgetary concerns will limit benefits in any package the Legislature enacts. Consequently, in the following recommendations we suggest expanded access with benefits that are not ideal but, based on our rough estimates, should be achievable with the revenue sources we propose.

PROVIDING -- AND REQUIRING -- COVERAGE

The 1992 Minnesota Legislature should institute universal coverage. It should retain -- and, if possible, strengthen -- the current practice of employer-provided coverage, but extend access directly to uninsured *individuals*.

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1 Minnesota Health Care Access Commission, August, 1990.

We recommend that Minnesota require, as basic public policy, that every resident have a specified minimum amount of health insurance protection. How would this be achieved?

- First, we assume that most Minnesotans would continue to be covered, as they are now, through employers, the Minnesota Comprehensive Health Association (MCHA), Medicare/Medicaid, private affinity groups or individual plans. MCHA and the Children's Health Plan would be continued, at least initially.

- Second, the Legislature should create a state-sponsored "Minnesota Basic Care" benefit plan, described below. The plan would be subsidized on a sliding scale based on income, up to 200 to 300 percent of the federal poverty level, for persons under 65 years of age whose incomes disqualify them for Medicaid.[2] The Legislature should determine the cutoff, based on the benefits and amount of funding it chooses to provide.

- Third, those people not otherwise covered and not eligible for the state subsidized plan would be required to secure health care coverage by (1) purchasing a plan such as the Major Medical Care Plan described below; (2) purchasing the Minnesota Basic Care plan without subsidy; or (3) purchasing other basic coverage that the Legislature would deem to meet this requirement.

- Finally, every Minnesota resident would be required to supply "proof of coverage," perhaps by annually filing a form provided by the insurer with the state income-tax return. This requirement would be extended to persons not now filing tax returns. People who do not comply (and are without coverage) would not be denied care. But if and when they sought health care, they would be required to buy the minimum plan or enroll in the state-subsidized plan. We recognize that this provision presents the same unresolved enforcement difficulties that are present in other proposals for universal coverage.

The Minnesota Basic Care Plan

The League *estimates* that a reasonable level of coverage, similar to that recommended by the Minnesota Health Care Access Commission, could be provided in the Minnesota Basic Care plan within the practical limits of available revenue based on our recommendations for financing. Certain existing mandates would be waived to make this proposal more affordable.

Coverage would include inpatient and outpatient hospital care; physician care for diagnosis and treatment, X-ray and laboratory work; maternity and pre- and post-natal care; drugs; preventive matters such as immunizations and eye, ear and speech exams and allergy testing for children; and a specified, limited number of visits to both primary and non-primary care physicians annually. We would include modest co-payments (up to perhaps $5 each) for medical services (excepting preventive care) and on prescription drugs.

If individuals in this category have coverage available through an employer, and drop that coverage, they could not qualify for the Minnesota Basic Care plan until after a six-month waiting period. Residents who qualify for the Minnesota Basic Care plan but prefer only the Major Medical Care plan coverage would be able to purchase that plan instead.

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2 As of October 1991, the federal poverty guidelines (annual income) are as follows:

Family Size	100%	200%	300%
1	$ 6,624	$13,248	$19,872
4	13,404	26,808	40,212

The Major Medical Care Plan

For affordability, the minimum required protection -- the Major Medical Care plan -- necessarily would be slimmer and involve deductibles. We suggest a deductible of $2,500 per individual and $5,000 per family, with 80 percent coverage. Annual out-of-pocket costs would be limited to $3,000 for individuals and $6,000 for family.

Coverage would include both inpatient and outpatient hospital care; physician care for diagnosis, treatment, X-ray and lab tests; ambulance and home health service; and maternity and pre-natal care. All entities offering individual and small group coverage in Minnesota would be required to make this plan available.[3] Anyone would be free, of course, to buy or provide additional benefits.

These proposals are a function of the dollars available, the level of subsidy and benefits provided and the number of persons afforded access. We make no attempt to detail the proposals further, since we would expect the Legislature to decide the specifics of such trade-offs.

FINANCING

The League is aware that, while expanded access to health care is popular, the Legislature will find raising the money for this difficult, at best, particularly in an election year and at a time when balancing the budget will require cutting existing programs. However, it seems indisputable that any meaningful expansion of access will require significant funding.

If Minnesota and the Legislature are unwilling to provide such funding, then universal health care access will be unattainable, in our judgment. Further discussion of this goal would represent little more than empty rhetoric.

In creating a state-subsidized plan, the Legislature needs to deal with four variables and bring them in to balance:

- The amount of revenue appropriated;
- The number of recipients, based on the income standards;
- The benefits included and the amount of cost-sharing required; and
- The amount of subsidy available to individuals and families.

We believe it is both logical and appropriate that a fundamental service such as health care be financed from the state-wide income tax, so that all citizens share in the responsibility of providing it, based on ability to pay. Thus, our first choice to finance universal access is to eliminate the state individual income-tax exclusion from income for (1) employer-provided health insurance benefits and (2) any employee contributions for health premiums to so-called salary reduction plans. We recommend this as sound public policy because it:

- Improves basic fairness by eliminating a perverse subsidy that (1) encourages *increased* health care costs, (2) goes to relatively well-off citizens but not lower-income persons (3) provides the greatest subsidy to those in a position to receive the richest medical care benefits from their employers and (4) eliminates current discriminatory treatment of individuals who must buy insurance with dollars left after they pay their state tax.
- Taxes hidden income and plugs a tax loophole.

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[3] A change in state law would be needed to permit health maintenance organizations to sell such a policy.

- Helps to make the true cost of health care more visible to employees and to provide them with a motivation to consume wisely.

Removing this exclusion from taxable income would raise more than $180 million/year.[4] Depending upon legislative decisions on subsidy levels and on the number of persons enrolled, additional support would be necessary. We recommend the following funding sources in this order: (1) a tax on all non-federal hospital bills raises more than $160 million/year at six percent and/or a tax on physician bills, which raises $93 million/year at six percent; and (2) increasing the state cigarette tax, with each cent per pack raising about $4 million/year.

As Minnesota moves to increase access, providers presumably will be reimbursed for all the patients they treat, causing an initial, one-time reallocation of resources from the taxpaying public to providers and insurers. We would expect a decrease (or smaller rate of increase) in provider and insurer charges to balance this reallocation.

MANAGEMENT STRUCTURE

The subsidized Minnesota Basic Care program for otherwise uninsured persons would be managed by a new, non-profit corporation, established by statute and governed by a seven-member board, appointed by the governor, with Senate consent, to staggered three-year terms. Five members should represent the general public, one should represent providers and one the plan members.

The corporation should directly employ a small, core staff (up to say 10 professionals) with the expertise necessary to negotiate with competing health plans. It would provide the Minnesota Basic Care plan through contract(s) with managed care health plan(s), selected via bidding, based on cost and quality. In geographic areas without such plans, it would first try to contract with a managed care plan to extend its operations into the uncovered area. If unsuccessful, it would either negotiate rates directly with fee-for-service providers or contract with a third party, such as Blue Cross and Blue Shield, to provide coverage.

The new corporation could spend only as much money as is appropriated to it by the Legislature each biennium. It thus would necessarily need authority to reduce or increase benefits and/or premium charges, based on the level of appropriation. Initial enrollment in the plan would, of course, be difficult to project. We would expect the introduction of this plan would result in expanded Medicaid enrollment.

SMALL GROUP MARKET REFORM

Minnesota employers play an important role in providing health care coverage -- more than 90 percent of companies with more than 30 employees offer coverage, as do a meaningful proportion (30 percent) of even the smallest (those with four or fewer employees). It will be to Minnesota's advantage to build on that foundation.

Small firms employ a meaningful proportion of the working population but often are least able to afford health insurance for their employees.[5] State policy should be to encourage as many small employers as possible to provide health care coverage for their employees. Our recommendations are intended to keep insurance as affordable as possible for small employers and to increase the stability of coverage by restricting several common insurance industry practices.

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4 Minnesota Tax Expenditure Budget, Commissioner of Revenue, January, 1989.

5 According to one 1988 source, 91.7 percent of all firms in the state employed 19 or fewer employees. About 23 percent of all employees worked in those small firms.

Minnesota should:

- Allow small employers (those with two to 29 employees), when first applying for coverage, to "carve out" high-risk or "uninsurable" employee(s) and purchase MCHA coverage for them. This should keep rates as low as possible for the remaining employees and allow small employers who would otherwise be refused insurance or priced out of it to provide coverage for those remaining employees. This approach has many of the benefits of creating a public reinsurance arrangement for high-risk individuals, but with less of the administrative burden and cost associated with such arrangements.

- To improve portability of coverage for people switching jobs, limit insurers to a one-time, 12-month individual exclusion of coverage for conditions existing up to six months before enrollment, so long as any coverage gap does not exceed 60 days. In the small group and individual markets, insurers consistently exclude pre-existing conditions on initial coverage.

- Enact re-rating reform, which is applicable to the individual market, as well. Prohibit insurers from either cancelling or increasing the cost of insurance to a particular small group or individual due to higher claims experience or a health-status change. Increasing all rates within an entire class would not be prohibited.

- Allow insurers to sell to small employers the Major Medical Care package we have recommended, waiving current mandated benefits, in order to encourage small employers to provide coverage by making it more affordable to them.

We choose to bypass some of the so-called reform steps typically proposed for this market. We do not, for example, propose complete, extensive community rating, since we believe that it would be counter-productive. It would significantly raise the insurance costs of many small employers and encourage them to drop coverage for their employees. Requiring insurance companies to guarantee that they would provide insurance to all who apply would present the same difficulty.

While we seek to encourage employers to offer coverage by making it more affordable, we do not propose mandating that employers provide coverage, since that is not allowed under federal law. Finally, we do not propose any additional tax incentives to encourage small employers or self-employed people to buy insurance.

COST AND QUALITY CONTROL

Legislative progress on the cost and quality control issues is critical. Most discussion of health care "reform" over the last few years has focused on *extending access* to the small minority of Minnesotans who are without health insurance. That is an important question of policy and social equity. But at least as important are cost and quality control in the *entire system affecting persons already insured.*

The system's structure in this country does not encourage quality care at affordable prices. It has been aptly described as one in which reimbursement is guaranteed for charges that are neither controlled by competition nor regulated by public authority, and in which no motive for economy can be discerned.

In Minnesota, the relatively early development of managed care organizations and competitive strategies have produced health care costs which, although rising rapidly, are nevertheless well below the national average. The average premium for a Minnesota employee in 1990 was 23 percent less than the national average, and for state health-maintenance organization enrollees it was 31 percent under the national average, according to a national health care consulting firm. A different study showed that Twin Cities medical costs were 18 percent below the national average in 1990. Minnesota providers and plans deserve credit for such results.

Still, basic structural reform is essential to achieve cost control, for in most cases neither consumers nor providers have incentives to hold down costs and provide quality care. The system in fact contains many features that serve to push up costs. For example:

- Employers don't necessarily offer their employees true managed care programs, which have demonstrably proved more efficient. When they do, they all too frequently pay all or most of the premiums of whatever plan the employee chooses, whether it is an efficient plan or not. This not only destroys any incentive for the *provider* to reduce costs, it gives the *consumer* -- the employee -- no reason to choose a plan that delivers more for less.

- With third-party insurers paying the bill, most consumers have no motivation to consider costs when they seek care.

- The exclusion of the value of employer-paid and before-tax health benefits from individual income taxation further insulates the consumer from any concern about cost.

- Comparative information on results -- on the quality of care -- is not publicly available, so that competition based on quality is impossible. Consequently, providers too often compete by avoiding risk rather than on the basis of cost and quality care.

- The system encourages the use (and over-use) of the latest, expensive technology and drugs. A much-cited recent statistic is only one example among many: The 21 highly expensive (to purchase and operate) magnetic resonance imaging scanners in Minnesota is more than the number of such machines in all of Canada.

Minnesota cannot afford simply to extend access to this system, with the uncontrolled and rapidly rising costs it produces. The state must begin to restructure this system -- to get rid of its automatic, invisible financing features. Minnesota needs to change the incentives that drive up costs, and it needs to insist that providers make quality information available. The idea is simple, but basic: *If the people have a direct economic stake in their decisions, if good choices and good information are available to them, they will choose value for their money.*

We have already suggested several structural improvements -- removing the hidden (and regressive) tax subsidy for employer-provided and before-tax health benefits; requiring universal coverage; mandating that the new, subsidized Minnesota Basic Care plan use exclusively the most efficient managed care organizations.

Another major part of the cost-containment/quality issue will be the systematic measurement of results -- how well health plans and hospitals do, and at what cost -- and making those results publicly available. As providers themselves have expressed it, Minnesota must restructure today's market so that competition is over cost and quality of care (as indicated by specific results) rather than over avoiding poor risks.

It seems clear, based on work already done in the Twin Cities but held confidential by providers, that meaningful cost/quality variations do exist, according to persons who have seen the data. This accords with results made public elsewhere, as in Pennsylvania and New York.[6] The citizens of Minnesota deserve to know about those variations, and the Legislature owes it to the people to see that such information is available.

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6 The Pennsylvania Health Care Cost Containment Council makes public mortality rates for every hospital in the state, arrayed by procedure, so that consumers can make informed choices. The New York State Health Department makes public death rates for each hospital in New York that performs surgery for heart disease, adjusted by 12 variables that could affect the severity of patient illness.

- The Legislature should initiate a process that will provide, as promptly as possible, comparative cost and quality information for the health care consumer. This would produce an effective medical care market by allowing Minnesotans to make wise choices when they select providers, an arrangement that would benefit consumers and reward the physicians, health plans and hospitals that are doing the best jobs.

- The Legislature could structure this process in a number of ways, but one feature is essential. Collection and, ultimately, publication of the information must be mandated. Experience clearly indicates that providers are extremely reluctant (for obvious, understandable reasons of self-interest) to voluntarily make public comparative performance and cost information arrayed by health plan and hospital -- the kind and detail of data on results, in short, that is absolutely critical to creating a true medical care market in Minnesota.

- The state should require such information from all bidders and use it in awarding contracts for the subsidized Minnesota Basic Care plan.

RELATED ISSUES

The subcommittee did not investigate other areas that deserve careful attention as the state moves to slow the rapid escalation of medical-care costs. They are:

- Tort reform that will reduce the pressure on physicians, who fear malpractice suits and react defensively by ordering expensive procedures as much to ameliorate the risk of lawsuits as to improve patient health.

- The trend to consolidation among Twin Cities area hospitals, which already has raised anti-trust concerns. Consolidation has, in the past, removed unused beds and increased efficiency as the area reduced its large number of relatively small hospitals. While some additional consolidation might be appropriate, the closer the hospital market moves to a monopoly the more difficult it will be to control costs through competition.

- The use of technology. The unnecessary duplication and subsequent over-use of highly expensive technology is widely recognized in the Twin Cities.

- Administrative practices. Reform and standardization can save money; it would include steps such as uniform descriptions and documents -- enrollee applications and claim forms, for example.

Finally, it is important to recognize that the bulk of our health care system -- providers and health plans alike -- still deals, essentially, with illness, not wellness. In that sense, the now-familiar term we use to describe the system -- "health care" -- is a decided misnomer. In one sense, it is true that physicians and hospitals produce health when they successfully treat illness. But we all know that "health" should extend far beyond treating illness to embrace a panoply of preventive issues, many relating to life-style. And prevention will not only promote health and wellness; it is also a very real cost-containment tool.

WORK OF THE SUBCOMMITTEE

CHARGE TO THE COMMITTEE

The Community Information Committee adopted the following charge to the committee.

Health Care Access

Minnesota has attempted over the years to address the cost of health care and, more recently, has debated several proposals for expanded health-care coverage. Similarly, the Citizens League has concerned itself for more than a decade with questions of cost and access; its last reports on these subjects were made in 1987 and 1989.

Public discussion and debate about these twin dilemmas during the last year or so have focused on the report of the state Health Care Access Commission; the related though dissimilar bill the 1991 Legislature passed and Gov. Carlson vetoed; a Blue Cross-Blue Shield proposal to the 1991 Legislature; and recent proposals by the HMO Council, the Minnesota Insurance Federation and the governor.

The subcommittee should consider existing proposals, and other possible solutions if the subcommittee chooses, for change in health care access, delivery and financing, and whether any expanded access should (or need not) be coupled with structural reform. It should by Feb. 1 propose a League position appropriate for the 1992 Minnesota Legislature.

SUBCOMMITTEE MEMBERSHIP

William Johnstone, who chaired the subcommittee, was nominated for that position by the Community Information Committee and appointed by the Board of Directors, of which he is a member. The following members also participated actively in the subcommittee's work:

John Brandl
John Costello
Carl "Buzz" Cummins
Virginia Greenman
Curt Johnson
Stephen Kelley
Ted Kolderie
A. Scheffer Lang
Tony Morley
Harry Sutton

SUBCOMMITTEE STAFF

Peter Vanderpoel, who prepared this statement, Allan Baumgarten, Donna Daniels and Joann Latulippe provided staff support to the subcommittee.

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New research from the Citizens League

Minnesota Homestead Property Tax Review 1991
Minnesota Managed Care Review 1991

Two new research reports from the Citizens League provide useful objective information about two topics that almost everyone thinks about: property taxes and health care. *Minnesota Homestead Property Tax Review 1991* builds on the annual property tax survey done by the League for the past 25 years. It includes data and trend analysis on residential property taxes in the Twin Cities area and in cities around the state.

Minnesota Managed Care Review 1991 provides valuable information about Minnesota's health coverage marketplace, including health maintenance organizations, preferred provider arrangements, and Blue Cross/Blue Shield. The report also analyzes key trends in enrollment, self-insurance, and management arrangements and costs. *Minnesota Managed Care Review 1991* is a valuable reference for people who need to keep up with Minnesota's dynamic health care marketplace.

League members can buy either report for $10.00; the nonmember price is $15.00. Discounts are available for multiple copy orders. To order your copies, please use the enclosed form or call the League at 612/338-0791.

The computer data sets developed by the League staff in preparing its analyses are also available. The property tax data set includes files of multi-year data on property tax rates, valuations, and calculations of taxes on homes of different values. The managed health care files include data on health plan enrollment, finances, utilization, etc. The sets can be used on your PCs and Macintosh computers. Call the League office for details.

Public Affairs Directory 1991-1992 Now Available

The Citizens League Public Affairs Directory is a handy guide to the people and organizations in the public, private, and nonprofit sectors that influence and implement public policy in the state. The listings include metro area legislators as well as other key elected and appointed officials at many different levels of government. To order your copies, use the attached order form or call the League office.

School Shopper Help for Parents

Minnesota parents who are selecting schools now have a concise source of comparative information. *The School Book, A Comprehensive Guide to Elementary Schools in the Twin Cities,* a new publication from the Citizens League, profiles 449 public and private elementary schools in the metropolitan area.

The book features information about each school's curriculum, foreign languages, building and facilities, extracurricular activities, number of students and teachers, class size, use of technology, grading system, parent organizations and communications, and services such as latchkey and breakfast. Each school profile includes a self-description of the school's teaching philosophy and strengths.

The School Book also includes information about what to consider when choosing a school, an explanation of Minnesota's school choice law, an application for the open enrollment program, and a Metropolitan Council map of public schools and districts in the region. You can get a copy of *The School Book* by calling the Citizens League at 612/338-0791 or by using the enclosed order form. League members can buy the book for $10.00; the nonmember price is $12.95.

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