

Unfinished Business

A discussion paper on the need for
universal health coverage in Minnesota



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Executive Summary

Universal coverage in Minnesota is within our reach. Health care has been a priority in this state for decades, as witnessed by the many programs Minnesota has developed and supported aimed at expanding access to coverage. In 1976, state policymakers realized that the practice of denying coverage to sick individuals was creating a financial burden on the state and a growing uncompensated care problem. They worked with Blue Cross and Blue Shield of Minnesota and others to create an insurance pool for high-risk individuals called the Minnesota Comprehensive Health Association (MCHA). In 1992, the legislature passed the MinnesotaCare law that created a subsidized insurance product for low-income working Minnesotans who did not have access to employer-sponsored coverage. The new law also required a series of insurance reforms aimed at lowering costs for small employers, to encourage them to offer coverage to their employees.

Employers in Minnesota have long understood the relationship between access to health care coverage, a healthy, well-educated workforce, and business success. There is much data to show a direct relationship between a person's health status and whether or not that person has health care coverage. Data also shows how the uncompensated cost of care that providers deliver to uninsured patients is passed on to those with insurance through higher premiums. A large portion of Minnesota's economy is devoted to businesses that protect, maintain, and advance human health. That commitment to the importance of health care makes leadership to achieve universal coverage both a moral and an economic imperative for our state.

The University of Minnesota and the Minnesota Department of Health recently conducted a health care coverage survey funded by the Blue Cross and Blue Shield of Minnesota Foundation. The survey found that Minnesota's rate of uninsurance has increased from 5.7 percent to 7.4 percent between 2001 and 2004. The highest percentage of Minnesota's uninsured population falls between the federal poverty guideline (FPG) and 300 percent of FPG. The survey found that, with the exception of African-Americans, who have benefited from successful outreach programs, the uninsured level for populations of color grew disproportionately to the rest of the population. The uninsurance rate for adults aged 18 to 24 is a continuous and growing concern. These young people tend to be healthy, and are often uninsured by choice. Geography also is a factor, with rural Minnesota generally seeing higher uninsured rates than urban areas, depending on the job market, average age and median household income in each community.

In the health care coverage survey, those without insurance often cite lack of affordability as the reason they do not have health insurance. Determining what is affordable is an important component of deciding how to assure that all Minnesotans fairly participate in the funding of health care. We need to begin by looking at affordability based not only on income, but also on other factors that affect a person's use of the health care system. With public agreement on these questions, health plans can develop products that meet the needs of the various types of consumers, and will stand more chance of success in achieving the participation of all Minnesotans in financing health care.

Most would agree that Minnesota has done a good job of putting an effective "safety net" in place that assures access to care for all Minnesotans. But Minnesota's safety-net providers are being stretched thin as uninsured rates rise, and some parts of the net are coming unraveled, creating serious access issues in our state. Community clinics specifically chartered to serve low-income Minnesotans are seeing longer wait times for patients to receive vital services, and some clinics are closing for lack of revenue. Hospitals are seeing an increase in the number of poor people using their emergency rooms for primary care visits with no compensation. In addition, MCHA, the largest high-risk pool in the country, runs a deficit of more than \$120 million per year that is not only climbing, but is funded through an unevenly distributed assessment on only half the insurance market. The safety net that is currently in place has large gaps that need to be covered.

Blue Cross' Minnesota *Decides*SM forums held across Minnesota five years ago identified key values that Minnesotans expect from their health care system: fairness, cost control and affordability; market-based but with a clear role for government; and preservation and enhancement of choice. In 2003, Governor Tim Pawlenty formed a task force to explore how Minnesotans control health care costs, with discussions led by former Senator Dave Durenberger. The task force developed a list of recommendations that were very similar to what was heard in the Minnesota *Decides* forums.

When Massachusetts passed a mandate for all to have health care coverage, it renewed debate across the country about how to solve the problem of the uninsured in America. Because Minnesota's state policymakers were careful over the years in crafting reform, Minnesota's market is currently functioning well. Minnesotans will want to build on our success with the same care we have taken in the past. This discussion paper gives a summary of several insurance market reform ideas that Blue Cross has modeled, which are aimed at keeping what works and fixing what's broken. The model includes an individual mandate to purchase, an increase in the current MinnesotaCare subsidy to reach more low-income Minnesotans so they can comply with the mandate, guaranteed issue of individual products to all Minnesotans with subsidy for insurers who take on high-risk people, creation of a mechanism to facilitate outreach to those who qualify for subsidies and to help others to purchase products, and new ideas to explore, such as federal funding to help lower-income people pay for premiums for their dependents.

Visionary health policy leadership has brought Minnesota closer than any other state in the country to achieving universal coverage. Even though Minnesota has the highest insured rate and is ranked as one of the healthiest states in the nation, we are not resting on our laurels. A great deal of work is being done in Minnesota to make systems more efficient, improve health status, and give people more information and power in their own health care experience. Most policymakers recognize that the work being done by all segments of the health care system to make people healthier is undermined by a lack of coverage for all Minnesotans. This discussion paper ends with a series of recommendations for public policy action aimed at making sure remaining coverage gaps are filled.

Introduction

Surveys and forums conducted by the Minnesota Citizen's Forum on Health Care, and by Blue Cross and Blue Shield of Minnesota (Blue Cross) through our Minnesota *Decides* forums, found that Minnesotans overwhelmingly believe everyone should have health care coverage, and they are willing to make certain sacrifices to achieve that goal. Minnesota has acted on this sentiment over the years by enacting aggressive health care system reforms aimed at guaranteeing access to coverage for all.

In 1992 the state legislature enacted the MinnesotaCare Law that created a first-of-its-kind subsidy for low-income working people and their families, and adopted a series of insurance reforms that allowed employers greater access to affordable coverage for their workers. MinnesotaCare was very successful. Minnesota has the lowest uninsured rate in the nation at 7.4 percent. Yet over 383,000 Minnesotans are uninsured. Nearly 80,000 of them are children, many of whom are eligible for subsidized programs. And the number of uninsured is increasing as health care costs grow and the population ages into more costly health conditions. Our modeling shows that if no changes in policy occur, the uninsurance rate in Minnesota will reach 9 percent by 2008 and continue climbing.

Lack of health insurance in Minnesota translates into unnecessary physical suffering, unnecessary financial worry, and an unnecessary drag on the state's economy. Unnecessary because Minnesota has already come closer than any other state to achieving universal coverage. The remaining changes required to finish the job might be controversial to some, but they are do-able. If not done soon, the gap will grow larger and be more difficult to close. It is time to finish the job.

To discuss the concept of "universal coverage" it is first important to agree on what we mean. First, it is important to note that "universal coverage" does not necessarily mean "single payer." Although many people believe that universal coverage can only be achieved through a government-run system, we disagree. Minnesota is very close to achieving coverage for all through a unique blend of low-income subsidies and progressive policies to encourage private sector innovation that have made ours one of the most stable health insurance markets in the country. Several public policy groups in the state have tried to define "universal coverage." Here is an attempt to synthesize what these groups have identified as important attributes of universal coverage:

"Universal coverage in Minnesota" means a health care system in which all Minnesotans have health coverage and contribute to the costs of coverage based on ability to pay. In addition to payment for services, a universal coverage system addresses barriers to access such as affordability; geographic availability of providers; cultural, racial and linguistic barriers; lack of transportation; age-related needs; member mobility; and the need for knowledge about how the system works.

This paper is meant not only to outline the reasons to adopt universal coverage reforms, but also to remind ourselves of what has already been done. Blue Cross believes that the change necessary to achieve universal coverage will be better accepted by the community if we build on past successes — recognize what is working and improve upon it. At the end of this paper, we will lay out options for how to reform the insurance market and assure that all Minnesotans have adequate health care coverage. We realize that our suggestions for achieving universal coverage are just one piece of the health care reform puzzle, and they fit into the larger work we must all do with health care choice and access, quality assurance, systems and efficiency, cost containment, prevention and public health. Blue Cross is committed to working with all stakeholders to assure that these pieces are put into place.

Why is Universal Coverage Important to Minnesotans?

Much Progress Has Been Made in Minnesota

The basic premise of health insurance is that healthy people with their low risk of incurring health care expenses are combined, or pooled, with sicker people and their higher health care risk. This assures that those with a lot of health care needs have help in paying their costs, while healthy people can be assured that if they do become sick or injured, they too will be able to afford their care. For insurance to work, healthy people must have an incentive to join the insurance pool before they actually have need of expensive medical care. People in Minnesota can choose to have insurance or not. So insurers cannot guarantee that they will issue their products to individuals, if people know they can get coverage whenever they need and they are more likely to wait until they are sick or injured to purchase coverage. This leaves only sick people in the health insurance pool. With no healthy members' premiums helping to offset the costs for the sick, insurance quickly becomes completely unaffordable. Other states such as Massachusetts have tried requiring insurers to guarantee issue in the individual market without requiring that all people, both sick and healthy, have health coverage. They have found that under this voluntary scenario, healthy people tend to stay out of the insurance risk pools of insurers until they need health care services. As predicted, individual premiums in Massachusetts became quite expensive, causing many people to drop their coverage.

Because insurers were able to deny coverage to sick people, before 1976 Minnesotans who were sick had no place to get health coverage. This was creating a large financial burden on those people and a growing uncompensated care problem for providers. Recognizing that change was needed, state policymakers worked with Blue Cross and others to create the Minnesota Comprehensive Health Association (MCHA).

MCHA offers a set of guaranteed issue products to these people. Legislators limited the rate that can be charged to MCHA members to slightly over the average rate in the marketplace. Because this premium limit does not allow MCHA to charge what it needs to cover expenses, the program runs a deficit every year that is made up through assessment of a surcharge on all insurers in the state based on their market size. Many other states have emulated the MCHA "high-risk pool" model. Minnesota continues to have the largest high-risk pool in the country at over 30,000 members, and has been able to preserve a well-functioning individual market.

In the late 1980s, the state was facing a coverage crisis as health care premiums were quickly rising and employers and individuals found it difficult to afford insurance products. A national survey showed that Minnesota had an uninsurance rate of nearly 10 percent. The state convened a group of citizens who created a universal coverage plan that included sweeping small group insurance reform developed by Blue Cross. The bill was passed by the legislature and vetoed by Governor Arne Carlson in 1991. The following year, the plan was revamped, and the MinnesotaCare law was signed in 1992.

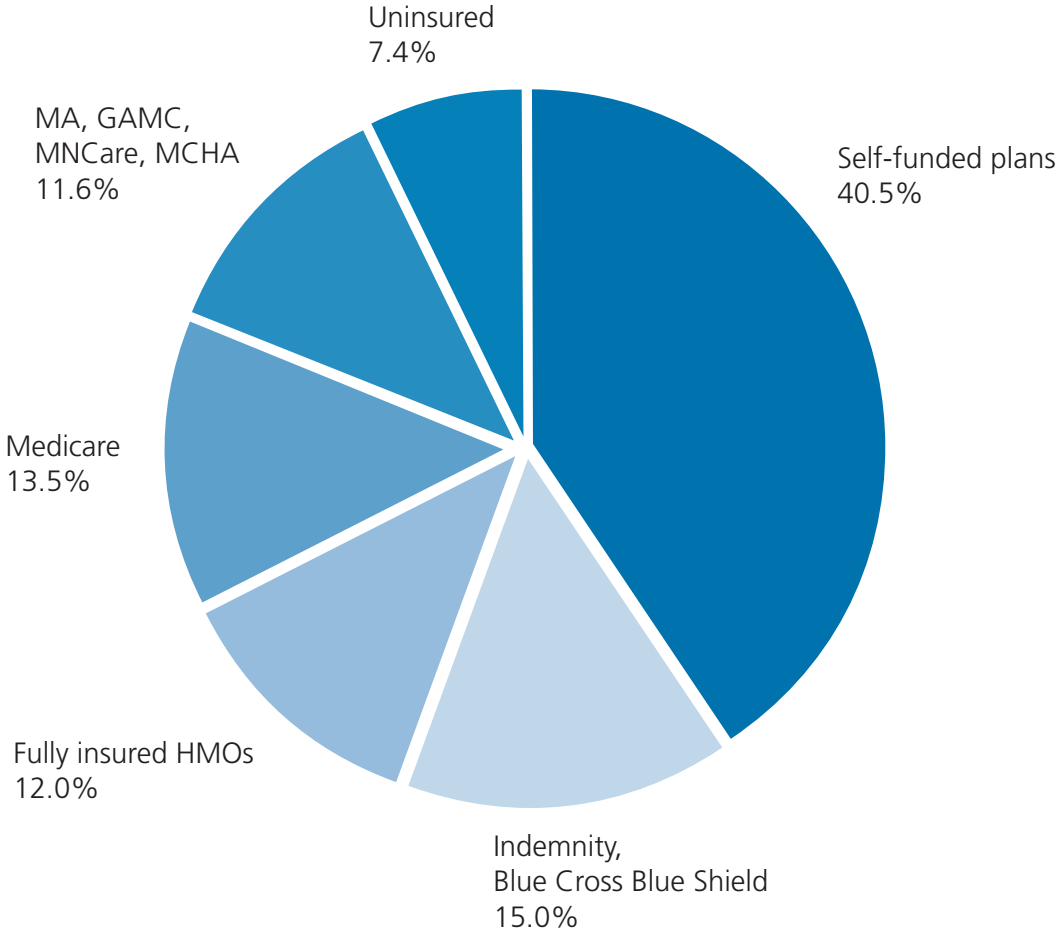
The MinnesotaCare law did two things. First, it created a subsidy for low-income working Minnesotans who did not have access to employer-sponsored coverage, and second, it required a series of insurance reforms aimed at expanding access to coverage.

The MinnesotaCare subsidy program allowed families with incomes below 275 percent of the federal poverty guideline (FPG) and individuals below 175 percent FPG to purchase a state-sponsored MinnesotaCare product with a sliding fee scale subsidy based on income. The MinnesotaCare product includes comprehensive outpatient benefits with a \$10,000 capped hospital benefit. Although eligibility and benefits were cut recently due to a state budget deficit, the program continues to function well. It continues to be funded by a combination of member premiums, federal matching funds for certain members, a provider tax of 2 percent on all medical services in the state, and a 1 percent premium tax on all HMO and Blue Cross products.

The MinnesotaCare small group insurance reforms, proposed by Blue Cross and enhanced by legislators, health plans and the Minnesota Department of Commerce, ended certain practices in the insurance market that had allowed insurers to “cherry pick” healthy employer groups while denying coverage to sicker groups. The MinnesotaCare reforms require all insurers offering small group products in the state to guarantee issue their products to any group sized 2 to 50 that requests them. It also requires the insurers to limit the variation in the premiums they can charge between sicker and healthier groups in order to spread the risk more fairly across the population.

Since the passage of the MinnesotaCare subsidy program and insurance reforms, Minnesota saw its uninsured rate fall to a low of 5.4 percent in 1999. The MinnesotaCare program was also included in a state waiver to allow for federal Medicaid matching funds that help pay for the care of some people in the program. Minnesota’s success has been a model for other states, but we are losing ground. Health care costs are climbing at a rate much higher than the cost of living, changes in state policy have decreased eligibility for the program, and employers find it more difficult to continue to extend coverage to their employees.

Where Minnesotans Get Their Health Insurance (2005)
Total Population 5.1 Million



Source: MN Department of Health

The Effects of Lack of Insurance on Health Status and the Economy

Employers in Minnesota have long understood the relationship between a healthy and productive, well-educated workforce and profitability. Since the core of our state's economy relies on a healthy population, we believe that finding a way to cover all Minnesotans is not only a moral imperative, but an economic imperative for Minnesota.

Correlation between insurance and health status

- 49 percent of uninsured adults with chronic conditions forgo needed medical care or prescription drugs due to cost
- Uninsured adults with chronic conditions are 4.5 times more likely than insured people to report an unmet need for medical care or prescription drugs
- Uninsured adults are 3 to 4 times more likely than insured adults to go without preventive services such as screening for cancer or hypertension
- Uninsured children are nearly 8 times less likely to have a regular source of care than insured children, and are twice as likely not to have had a well-child checkup within the past year
- Uninsured children are also four times more likely to go to an emergency room than insured children
- 27 percent of uninsured adults with chronic conditions reported no visits to a health professional in the past year
- Uninsured adults have a greater chance of experiencing a major health decline than insured adults
- When hospitalized, uninsured patients are likely to be in worse condition than insured patients and are 3 times more likely to die in the hospital than are insured patients

Costs passed on to the community

People without insurance often seek care later in the course of an illness when it is more costly to treat the illness. They also tend to seek more care in hospital emergency rooms, even when a primary care setting would have been adequate for their condition. The care they receive is mostly uncompensated to the provider, which means that these costs are passed on to the rest of the community through the payments made by health plans and through local taxes that fund certain hospitals that have higher uncompensated care.

- 65 percent of the total cost of health care services provided to the uninsured is not paid by the uninsured themselves
- In 2006, the cost of uncompensated health care in Minnesota is expected to approach \$250 million. A significant portion of the uncompensated care providers deliver will be because of uninsured patients
- Nationally, average health insurance premiums for families who have employer-sponsored coverage currently include \$922 per year to pay for uncompensated care costs passed through to insurers by providers. This figure is expected to climb to \$1,050 by 2010.
- For individuals, this national average portion of the premium attributable to uncompensated care was \$341 in 2005, and is expected to be \$532 by 2010

Other effects

The effects of uninsurance on businesses are harder to quantify, but easy to describe. Because people without insurance either seek care less often, or seek it later in their illness, it means more time lost on the job either due to absence or inability to function at full capacity.

- Economists estimate that between \$65 billion and \$130 billion of productivity is lost each year in the United States due to the absences or diminished ability to function, related to the effects their uninsured status has on people's ability or willingness to seek necessary care
- Research also shows that children who are insured have better attendance in school and perform better academically, which can eventually translate into a well-educated workforce

Minnesota saw interesting proof of the positive economic effects of insuring its people when it successfully cut its rate of uninsurance through the MinnesotaCare reforms. Minnesota saw a \$2.19 per capita decrease in uncompensated care costs for each 1 percent increase in MinnesotaCare enrollment between 1992 and 1996. The data suggests that during that time, there was a \$58.6 million reduction in uncompensated care spending in the state.

In addition to the benefits that universal coverage can bring to business productivity and global competitiveness, Minnesota has another specific interest in assuring that all of its residents have health care coverage. A significant portion of Minnesota's thriving economy is based upon the health care industry.

Minnesota employs nearly 350,000 people who provide health care, and another 22,000 in the medical technology and biotechnology industry. In fact, Minnesota is home to some of the leading medical technology and pharmaceutical manufacturers in the world, and the number of medical technology jobs in Minnesota has increased by over 30 percent in the last ten years. A large portion of Minnesota's economy is devoted to businesses that protect, maintain, and advance human health. That commitment to the importance of health care makes leadership to achieve universal coverage both a moral and an economic imperative for our state.

Who Are the Uninsured in Minnesota?

The University of Minnesota and Minnesota Health Department health care coverage survey found that Minnesota's rate of uninsurance has increased (from 5.7 percent to 7.4 percent) between 2001 and 2004. The survey gives valuable detailed demographic information that can be used to identify specific populations with higher uninsured rates.

Low-income Minnesotans — The highest percentage of those lacking insurance in Minnesota fall between the federal poverty level and 300 percent of FPG. The number of low-income workers with employer-sponsored coverage decreased measurably, from 19.7 percent in 2001 to 15.2 percent in 2004.

The study found that, like the previous survey in 2001, a large number of those who are eligible for public programs are not enrolled. Nearly 9.5 percent of the uninsured are below 100 percent of FPG and many of them would be eligible for Medicaid. In fact, the survey found that nearly 3 out of 4 uninsured children in Minnesota are likely to be eligible for a public program. On the other end of the spectrum, nearly 10 percent of those without insurance are at or above 400 percent of FPG.

Ethnicity — The survey found that with the exception of African-Americans, who have benefited from successful outreach programs, the uninsured trend for populations of color grew disproportionately to the rest of the population. American Indians are seeing a 3 percent increase in their uninsured rate and Latinos in Minnesota are seeing a 16.6 percent increase in the numbers of those without health care coverage. Recent public policy decisions at the state and federal level have favored not extending government-funded health care services to immigrants without documentation, which has in turn increased the level of uncompensated care delivered by providers both in the Twin Cities and in certain areas of rural Minnesota. These policies also discourage some families from seeking coverage for family members who are actually eligible for coverage. The national debate over immigration policy is not likely to conclude any time soon. However, states such as Massachusetts have made their own decision to offer coverage to undocumented people with the understanding that the public policy implications are the same as for other people without insurance — delayed diagnosis and treatment for conditions, which lead to higher uncompensated care costs for the entire community.

Young Adults — The uninsurance rate for young adults (aged 18 to 24) continues to be an issue, with an 18.9 percent uninsured rate, up a full 5 percent for that age group from 2001. The young adult age group has long been identified as a difficult population to insure as they reach an age where they are no longer eligible to remain as dependents on their parent's plan. These young adults tend to fall into the lower income levels as they begin their careers, and they tend to be less risk-averse, preferring to "take their chances" because they are healthy and believe they won't need health care services.

Rural Populations — The survey found that as in past years, geography plays a part in uninsured status, with rural Minnesota generally seeing higher uninsured rates than urban areas, depending on the job market, average age and median household income in each community.

Reasons People Don't Have Health Care Coverage

The health coverage survey asked a series of health status questions of those who were identified as uninsured. Their results confirmed that in Minnesota, people without insurance face the same access and health status issues as those identified by the national statistics.

The survey tried to quantify reasons for uninsured status. The following were identified as some of the likely reasons why a growing number of people are without insurance in the state:

- Lack of affordable premium level for their income

- Young and healthy without access to employer coverage tend not to participate
- Public policies lead to access gaps for specific populations (for example, immigration status)
- Changing employer participation (dropping coverage, shifting to jobs that do not offer coverage such as part-time or contracted work)
- Employee job mobility and widely varying employer subsidization (for example, some employers help pay for dependent premiums; some contribute more than others to employee premiums)
- Complexity of numerous programs and access mechanisms leading to gaps
- Lack of adequate outreach to get eligible people enrolled into coverage (language barriers, cultural understanding of insurance concept, funding cuts for outreach workers)

Again, Minnesota has proven that when it gives priority to a problem, it can be solved. In 2001, the health coverage survey identified the disparity in coverage between white children and children of color. Many organizations undertook concerted outreach efforts, which the 2004 survey showed essentially eliminated the coverage disparity between white and black children. However, the survey also shows that children of other races are falling even further behind, and more successful outreach is needed.

What is Affordable?

Under Minnesota's current health care system, most people have access to some form of coverage. Depending upon one's income level, there are programs and subsidies for everyone, regardless of health condition. The issue is no longer one of access to coverage, but rather of ability to afford coverage and responsibility to purchase it. If we assume that a universal coverage environment requires that all participate in the health care funding system, how does one define what is affordable for them? And for those who cannot afford the coverage that is available to them, how do you help them meet their responsibility to participate?

In 1992, in determining who would be able to participate in the state's MinnesotaCare health coverage program, the Minnesota legislature decided that for individuals, 175 percent of the federal poverty guideline or higher was the income level at which a person should be able to find an affordable health insurance product. For families with children, that level was determined to be 275 percent of FPG. By today's standards, that means that a family of 4 making less than \$55,000 per year should expect some kind of help in affording insurance, and an individual making \$17,500 per year would also qualify for a subsidy. The national average premium for individual coverage is \$2,070 per year and \$4,000 for families, which represent 12 percent and 7 percent of annual income respectively.

But determining affordability must include factors in addition to percentage of income. A person's age and health status, for example will affect how much health care they use, and therefore the cost effectiveness for them of buying insurance at different deductible levels. A very ill person with a \$5,000 deductible will end up spending that \$5,000 in addition to the premium they pay each year. While this is appropriate at certain income levels, it may defeat the purpose of a comprehensive universal coverage proposal if people at lower income levels are purchasing high-deductible products and then not getting needed care due to lack of affordability. On the other hand, there is some evidence that first-dollar coverage for certain preventive services doesn't necessarily encourage appropriate use of those services and may draw funds away from more cost-effective products for some low-income individuals. An effective universal coverage strategy requires a more thorough consideration than previously undertaken in Minnesota to decide what are appropriate cost sharing and subsidy levels, to maximize people's use of the system and, ultimately, their health status.

2006 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$9,800	\$12,250	\$11,270
2	13,200	16,500	15,180
3	16,600	20,750	19,090
4	20,000	25,000	23,000
5	23,400	29,250	26,910
6	26,800	33,500	30,820
7	30,200	37,750	34,730
8	33,600	42,000	38,640
For each additional person, add	3,400	4,250	3,910

Source: *Federal Register*, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849

What Difficulties Does the Safety Net Face?

Through the years, Minnesota has pieced together an effective “safety net” that was built to fill coverage gaps and assure adequate access to care for all Minnesotans. But if we recognize the need for reform to create a functioning health care system, we must also recognize that the safety net performs functions that will need to be preserved and supported in that reformed system. Even in a functioning universal coverage model, there will always be a need for the “safety net” and so safety net providers must be supported in evolving to meet the reformed structure. They are currently being stretched very thin, and their survival through the current reform debate is not assured.

Minnesota’s Community Clinics — The most financially vulnerable part of the safety net, these clinics provide free or low-cost care to Minnesotans who do not have coverage. These clinics also serve those enrolled in public programs and commercial insurance that have specific geographic, language or cultural needs. Community clinics deliver high-quality care to their patients, but they report that demand is outstripping their capacity, and patients are subject to increasingly long wait times and even lack of access for vital services in some cases. Some community clinics are reporting that they have to turn patients away, and expressed concerns during the 2006 legislative session that increased federal cuts and increased numbers of uninsured patients are stretching them beyond capacity.

Minnesota’s outpatient clinics are expected to deliver nearly \$100 million in charity care in 2006. Community clinics will see a much higher percentage of the state’s uninsured than will other types of clinics. During a legislative hearing in 2006, the executive director of the Minnesota Association of Community Health Centers reported that the number of people without health care coverage seen by the clinics she represents has increased by 33 percent in the past four years. Simultaneously, these clinics saw a significant drop in the number of patients covered by commercial carriers or Minnesota government-funded programs. In 2006, Minnesota has seen the Family Health Care Center in Moorhead and La Clinica in Minneapolis close their doors because federal and state budget cuts and an increasingly uninsured patient base made it unfeasible for them to continue offering services. These clinic closures may create a problem for nearby hospitals that will pick up the majority of those patients through their emergency rooms.

Minnesota’s community clinic providers are uniquely talented in caring for specific populations and have skills that will always be needed and valued in the system. Achieving coverage for all will assure coverage for their patient base that allows safety net providers to remain financially viable and able to concentrate on delivering excellent care to these unique populations.

Hospitals — Minnesota’s hospitals will deliver approximately \$150 million in uncompensated care in 2006 that is attributable to people who lack insurance. The hospitals that bear the brunt of uncompensated care costs are Hennepin County Medical Center in Minneapolis, Regions in St. Paul, St. Mary’s in Duluth, and certain regional hubs in greater Minnesota. However, any hospital can see an increase in uncompensated care, based on the availability of access to providers and payment sources in their communities. As the number of insured people goes down in an area, local hospitals will see an increase in the number of people coming to their emergency rooms for basic health care services. These costs are normally recouped through increases in rates charged to insurance companies, self-funded employers, and individual patients. Recent regulatory scrutiny of billing practices has made it more difficult for hospitals to try to recoup uncompensated care dollars from patients, which will likely lead to increased fees for commercial payers.

Minnesota Comprehensive Health Association — MCHA is the largest high-risk pool in the country, with over 30,000 members. MCHA currently runs a deficit of more than \$120 million per year that is funded by an assessment on all insurers in the state. This assessment is passed on to all insured people in the state through their premiums. In recent years, the MCHA assessment has averaged over 2 percent of the premium that each insured Minnesotan is paying. Because employers who self-fund their employees’ health care claims are exempt from this assessment, nearly half of the people with health coverage in the state are not helping to fund MCHA, and the burden is being borne only by insured individuals and small employers who purchase insurance for their employees.

Because MCHA is comprised of almost all high-risk people, MCHA members are asked to pay a higher premium than do those in the private-sector insurance market. Minnesota law allows MCHA to charge up to 125 percent of the market average. However the commissioner of commerce has the final say on the rate each year, and typically sets the rate lower than the MCHA board requests.

In addition to the problematic funding for MCHA, there are those who argue that a mandatory, functioning universal coverage system should allow sick people into the general marketplace to pay the same rates as other individuals and to enjoy the same choice of plans. True health care reform that achieves universal coverage should be crafted to allow that type of integration without undermining the choice and access of other market participants.

Employer-based Health Care Funding is Important and Changing

Minnesota employers are known for their commitment to their employees’ well-being, shown, among other ways, by high offer rates in health care coverage. Minnesota spent nearly \$23 billion on health care in 2002 (the last year for which data is available), with 40 percent of that expenditure coming from private health insurance.

Employer-based contribution to cover health care costs is fundamental to America’s health care funding infrastructure. However, employers are finding it increasingly difficult to maintain past contribution percentages, or in some cases, to offer coverage at all. In Minnesota, the 2004 University of Minnesota uninsured survey found that group coverage in Minnesota decreased from 68.4 percent in 2001 to 62.9 percent in 2004. The report found that this shift in employer-based coverage was due to a decline in the percentage of people working for an employer that offered coverage, as well as a decrease in the number of those eligible for coverage through their employers.

The voluntary nature of health care coverage participation has created an unfair economic model in which some employers invest a significant portion of their “bottom line” in health care premiums or expenses, while others contribute nothing to their employees’ health care costs. During a panel discussion in February, 2006, industry experts Paul Ginsburg, Ph.D., Helen Darling, and Peter Kongstvedt, M.D., told Blue Cross that any palatable state or federal solutions to universal coverage and health care cost containment will be built around the current employer-based insurance system and might include:

- Models that allow employers to play new and different roles in their employees' coverage
- An individual mandate for people to have coverage, plus some form of employer participation
- Subsidies for low-wage employers and low-income employees
- Changes to tax incentives for employers

The expert panel also noted, and the University of Minnesota survey has confirmed, that small employers are increasingly being forced to choose between wages and health care coverage, and as a result, small employers are dropping coverage. High-deductible health plans are slowing this erosion somewhat, but employers are seeking other mechanisms that will allow them to continue to offer benefits to their employees. They are seeking educational tools and purchasing mechanisms that engage their employees to actively participate in health care spending decisions and healthy lifestyle choices.

Employers have expressed concerns about health care reform proposals that attempt to mandate their participation in health care funding. However, there is a growing recognition among all employers of the strong role that employers play in assuring the health of their employees, which in turn ensures the health of their communities and, ultimately, of their businesses. What employers should expect in return for responsibly participating in the health care coverage of their employees is fairness in funding and structures that promote efficient use of the hard-earned dollars they are putting into the system.

In Massachusetts, employers recognized the benefits that can be gained from universal coverage in their communities. When the Massachusetts legislature passed a law last April requiring all employers who don't offer coverage to pay a "fair share" assessment to help fund subsidies for lower-income insurance purchasers, employers did not object, and in fact many reacted favorably to the reforms.

- "There's strong support in the business community for this measure," says Michael Widmer, president of the Massachusetts Taxpayer Foundation. "This equalizes the burden between companies who don't provide health care and those who do." (*Business Week Online*, April 4, 2006).
- "Increasingly, large employers have become more receptive to the concept of an individual mandate. Polls of our [HR Policy Association] members indicate strong support by many and a willingness to consider the concept by most others." (*Massachusetts' Universal Health Insurance Law: Analysis From a Large Employer Perspective*, HR Policy Association, May 12, 2006).
- John G. Macdonald, the executive director of the Massachusetts Business Roundtable, called the Massachusetts reforms a "creative solution to what's fair and reasonable. It's a solution we hadn't thought of and it's a creative approach." (*Boston Globe*, July 1, 2006).
- Richard C. Lord, chief executive of Associated Industries of Massachusetts said that the new regulations "won't penalize employers who are doing the right thing, which is providing health care coverage." (*Boston Globe*, July 1, 2006).
- Reports Paul Guzzi, president of the Greater Boston Chamber of Commerce, "There is buy-in by a significant portion of the employer community" (*Boston Globe*, April 7, 2006).

While the reaction of the Massachusetts business community is encouraging, there were some dissenters who fear this would lead to a government-run single payer system. But the majority of those with concerns worry about product affordability and are interested in how policymakers will design the purchasing pool created by the law to allow greater purchasing power for employers and individuals.

What Do the People Want?

Minnesota *Decides*

Five years ago, Blue Cross leaders embarked on a tour of 20 Minnesota communities and held Minnesota *Decides* forums to better understand what the people of Minnesota want and expect from their health care system. Through a survey and the community forums moderated by former Congressman Tim Penny, Blue Cross worked with Minnesotans to identify key themes and values that Minnesotans believe are essential to their health care system. The key themes and values they identified were:

Fairness — Minnesotans didn't define fairness as a one-size-fits-all health system, but rather wanted equitable treatment for people in comparable situations. For example, a common view was that the link between employment status and health coverage was unfair. The forums also found that Minnesotans believe no one should be denied care, but that people should pay what they can afford for their health care.

Cost control and affordability — Participants felt strongly that costs were growing out of control at both the individual and system-wide levels. While recognizing the role of consumers in cost control, participants thought that health plans, employers, providers and government were all key to controlling costs. Participants said that reducing health costs shouldn't always mean reducing health investments. They saw spending on prevention, early detection and community health initiatives as good investments. Participants also consistently said they wanted to learn more about what's driving health care costs.

Market-based, but with a clear role for government — Most participants felt that a health system that builds on what is working is preferable to a system with more government involvement. Participants felt that although government does have important roles to play, most did not want the government running the overall system. Participants saw government's role in promoting system improvements, protecting consumers' rights or in specific areas like offering incentives for, or even mandating that employers offer group health insurance even if employees were to pay the full cost of insurance.

Preservation and enhancement of choice — Participants wanted to be able to choose their health care provider and wanted their employers to offer more options within their employer-sponsored coverage. At the same time, they expressed that they were overwhelmed by the complexity of the system. They wanted a system that was simpler and they wanted more help in navigating that system.

Minnesota Citizen's Forum on Health Care

A task force was formed in 2003 by the Pawlenty Administration to make recommendations on how Minnesotans can work together to control health care costs. The members of the task force represented business and policy leaders throughout the state, and were led in their discussions by former Senator Dave Durenberger. Based on a series of town hall meetings and an online survey, the Forum developed a list of recommendations very similar to those we heard in the Minnesota *Decides* forums. Some of the specific messages resonated strongly with the Minnesota *Decides* forums and are being used as a foundation for Blue Cross's health care reform work:

- People want a responsive system in which everyone gets the health care they need through universal participation in health care decision making, with a commitment to covering all Minnesotans
- People want a private-based health care system that offers as much choice as possible, while preserving the basic concept of spreading risk across sick and healthy
- People want to reform the insurance market and promote purchasing pools to create better opportunities for individuals and small businesses
- To have lasting success, control of the health care system must be given back to the people who pay for and use it through choice, transparency of price and quality, and new models of health care education

What Can Be Done to Achieve Universal Coverage?

The Massachusetts Example

When Governor Mitt Romney of Massachusetts announced in early April that his state had passed a bipartisan plan to achieve universal coverage, it renewed debate across the country about how to solve the problem of the uninsured in America. Minnesota has been struggling since the late 1980s with how to achieve universal coverage. It has come closer than any other state in the nation to achieving the goal, except for the obstacle of how to assure that everyone in the system participates.

Although there are some similarities to Minnesota's situation, Massachusetts was motivated by some very specific issues that we currently do not face:

- The state's federal Medicaid fund use waiver was about to expire and it needed to submit a new proposal or lose millions of dollars per year in Medicaid matching funds
- Insurers such as Blue Cross Blue Shield of Massachusetts were pushing hard for market reforms because Massachusetts already had guaranteed issue in the individual market with no limits. With healthier people staying out of insurance pools until they needed care, the individual premium level was running more than 40 percent higher than small group rates.
- Massachusetts already had a funding source available. It had created an "uncompensated care fund" several years earlier, paid for by an assessment on hospitals and health insurers. That fund collects \$1 billion per year. This money will be rerouted to fund the subsidy for lower-income people to purchase insurance.

In the end, Massachusetts' version of universal coverage includes:

- Mandating all to buy coverage, except those without access to an "affordable" product. (This may prove to be one of the biggest challenges to the Massachusetts reforms, as there were very few cost containment initiatives nor a definition of "affordable" included in the legislation.)
- Redirecting the existing uncompensated care fund (funded by an MCHA-like assessment on all health plans and hospitals) to be used as a subsidy for low-income residents to purchase coverage
- Increasing eligibility for Medicaid to 300 percent of FPG (this Medicaid waiver is used to draw in federal money)
- Combining the individual and small group markets to decrease individual rates that were very high because they had earlier enacted guaranteed issue in the individual market without a mandate for coverage
- Creating a "Connector" purchasing mechanism that determines and publicizes which products meet the mandate requirements, facilitates combining premium subsidies from multiple employers, and use of pre-tax dollars to pay premiums
- Penalizing employers who don't offer coverage, through a "fair share" fee (\$295 per employee per year) and a "free rider" penalty payment of costs for uninsured employees who get care more than three times per year)

A Universal Coverage Model from Blue Cross and Blue Shield of Minnesota

Simply transplanting the Massachusetts proposal to Minnesota would not work. Because Minnesota's state policy makers were careful over the years in crafting reform, Minnesota's market is currently functioning well. Minnesotans will want to build on our success with the same care we have taken in the past. Here are components that we believe are important to reforming Minnesota's insurance market to assure coverage for all, with some suggested methods to realize each component.

Underlying Assumptions of this Model

- Universal coverage should be achieved through a public/private partnership that builds upon Minnesota's success to date
- The proposal should recognize the strong individual and group markets, create smooth transitions for a mobile population, educate and assist people to enter appropriate systems, and fill gaps between government programs and the private sector
- The MinnesotaCare program remains in place
- The provider tax remains as a prominent funding source for a subsidy for low-income people to afford their health care premium
- Minnesota maintains the waiver it has received from the federal government that allows it to use managed care plans to deliver Medicaid, MinnesotaCare and General Assistance Medical Care (perhaps with eligibility and subsidy use modifications)
- The Minnesota community must deal with the issue of essential benefits. This proposal assumes a set of benefits for modeling purposes, but the ethical discussion of how a coverage mandate can be made affordable must be undertaken by all Minnesotans, to have a chance of successfully achieving universal coverage.

Model Components

A mandate for all Minnesotans to have coverage

- People who do not comply with the mandate to have coverage are subject to a "fair share" penalty based on income and related to what they would pay for coverage. As an added incentive to comply when the mandate takes effect, people who are noncompliant could be subject to a pre-existing condition limitation for a specified time period when they do apply for coverage.
- Enforcement through employers and the tax reporting system, with a mechanism created to which employers can refer their uninsured employees to assess subsidy eligibility or what their fair-share penalty is. Employers could then deduct this amount from payroll.
- People at up to 300 percent of poverty level who are not eligible for MinnesotaCare could be eligible for a sliding-scale premium subsidy to purchase in the private market (may require federal waiver change)
- Unmarried children are allowed to remain on their parent's policy up to age 25 regardless of student status

New and existing subsidy mechanisms for lower-income families and individuals

- Redirect current MCHA funding to subsidize guaranteed losses for insurers covering high-risk individuals who have specific conditions
- Identify other funding sources as needed
- Work with Minnesota Department of Human Services (DHS) to consider allowing MinnesotaCare subsidy to flow to the private-sector dependent coverage

Guaranteed issue in the individual market

- All carriers in the state must offer all of their individual products on a guaranteed issue basis to Minnesotans
- All insurers doing business in the small and large group markets must participate in the individual market by offering at least three pre-defined products
- Individuals' risk is assessed and those at high risk are placed into a "tracking" pool by each insurer.
- Losses for insurer's high-risk pool are subsidized through a fund that is subsidized by the state and run by MCHA
- MCHA members are moved into the private market with choice among all carriers
- Portability requirements are eliminated (not necessary as people on portability products can be moved into the individual market in a guaranteed issue environment)

Employer participation

- Employers help monitor insurance status and payroll deductions
- Outreach assistance (tools for employers to help their employees take advantage of new opportunities created by the reforms proposed)
- Barriers to dropping coverage and new incentives for employers to maintain coverage
- Employers offer Section 125 (flexible spending) accounts to employees to give people a tax benefit for money spent on health services and premiums

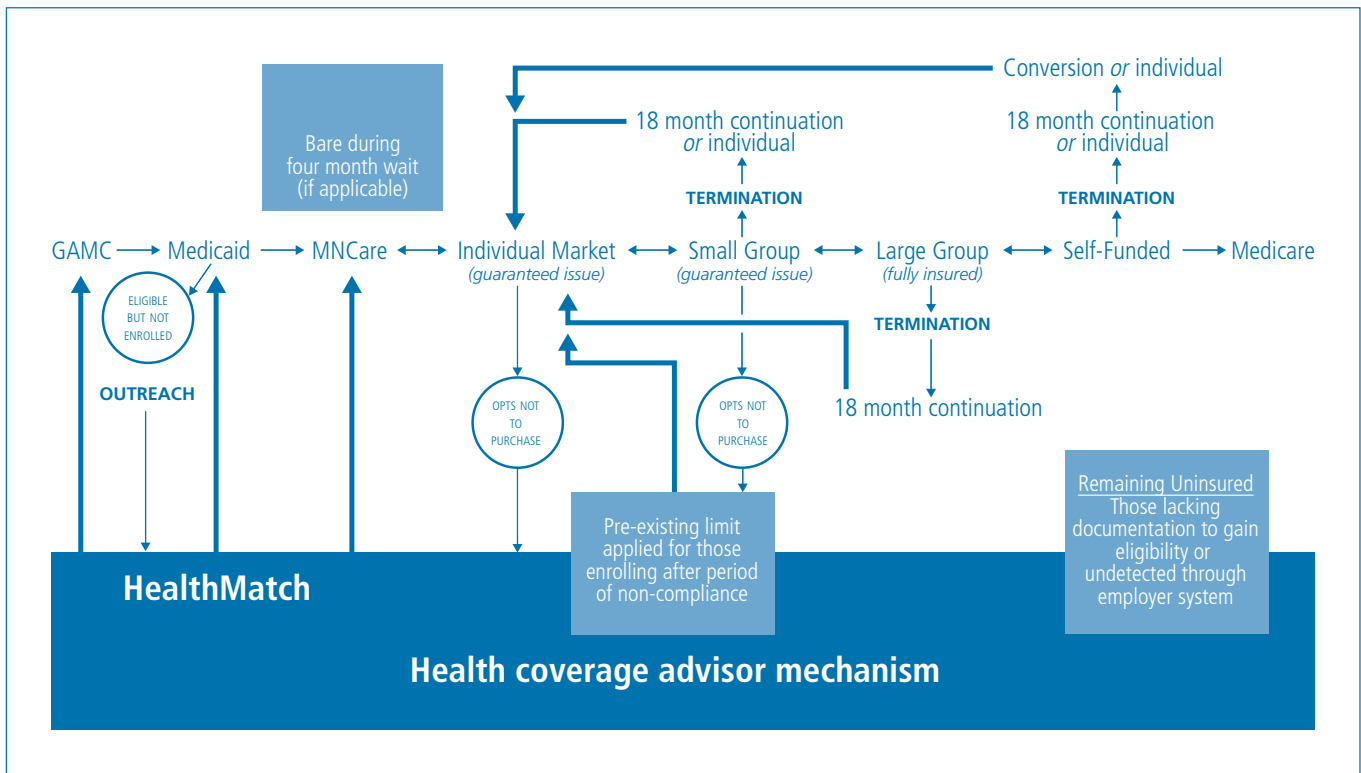
Affordability initiatives

- A community-supported essential benefit set to serve as a minimum required coverage benchmark
- Regulatory flexibility to allow for new benefit structures and cost-sharing models
- Continued support for disease management programs, quality of care improvement programs and a stronger public health infrastructure

Access mechanisms

Create an entity that will:

- Automatically enroll those eligible for public programs (through the state's HealthMatch system)
- Simplify the process for individuals and their agents to search for insurance
- Allow people to combine premium sources and tax deductibility to maximize their coverage
- Assist employers to determine if their employees qualify for subsidies, and if they are required to pay noncompliance fees, and calculate those fees
- Allow employers to refer their employees who do not qualify for employer coverage to find suitable coverage
- Outreach for diverse and hard-to-reach populations (using information from uninsured survey, in consultation with DHS, county and social service agencies, The Minnesota Council of Health Plans, the Children's Defense Fund and Cover All Kids Coalition)



How It Fits Together

Minnesota’s health care community is leading the nation in many areas of health care reform. One reason for Minnesota’s success is a recognition of how the different pieces of the health care system fit together. The more effective the health care, the more cost efficient is the system, and the more cost efficiency, the more people have access to effective health care. An upward spiral of good health is possible if all Minnesotans are included and actively participate in meeting health improvement goals.

Many exciting initiatives are underway in Minnesota’s health care community to improve the health care system and ensure that Minnesota maintains its position as the healthiest state in the nation. Here are just a few examples of the various pieces of the universal coverage puzzle that Minnesotans are working together to solve.

The Minnesota Medical Association — The MMA has initiated the Healthy Minnesota Project, which is convening four work groups of health care leaders to craft solutions to assure high-quality health care for all Minnesotans. This project has given Blue Cross a forum to discuss the insurance market reform modeling that we are doing. Minnesota’s physicians are also working with Minnesota’s health plans in unprecedented ways to measure quality of care and improve their patients’ health care knowledge and participation in decision making. Initiatives such as the Institute for Clinical Systems Integration (ICSI), which develops practice guidelines using the best scientific evidence of what works, and the Community Measurement Project, which measures provider systems’ adoption of best practice standards and reports quality levels to consumers, are just two examples of this nation-leading collaboration.

Minnesota's Health Plans — In addition to the leadership they have shown over the years in insurance reform, Minnesota Council of Health Plan members are participating in the MMA work groups. Minnesota's nonprofit health plans are actively engaged in all aspects of health care reform. They are developing new products and services every day that share cost and quality information with their members, as well as collaborating with providers separately and as an industry to increase administrative efficiency. The Minnesota Council of Health Plans created the Community Measurement Project, which uses groundbreaking methods to measure health care service quality across populations, and leads the work of the HIPAA collaborative, a unique provider/plan partnership that adopts standards for transactions and data sharing. Minnesota health plans are heavily involved in developing electronic medical records and data exchange mechanisms. And the executive director of the Minnesota Council of Health Plans is a co-founder of the Cover All Kids Coalition, which works with the Children's Defense Fund and advocacy groups toward universal coverage for children in Minnesota and conducts outreach programs to get people enrolled in appropriate programs.

Minnesota's Hospitals — The Minnesota Hospital Association is actively working on initiatives aimed at more effectively engaging communities in facilities planning and decision making. The MHA has also shown national leadership on patient safety, creating a medical errors public reporting system that has become a national model. And MHA members are working with Minnesota's health plans on a major initiative to identify administrative inefficiencies and uniformity opportunities that have the potential to significantly decrease administrative costs in the state.

Minnesota's Business Community — As discussed above, Minnesota's business community is very aware of the benefits of healthier communities on their bottom line. The employers in the state have worked with their insurance companies, health care third-party administrators and provider partners to improve health care cost and quality, patient safety assurance, innovations in product service delivery, and consumer engagement and educational tools. Minnesota's businesses joined forces with state government purchasing officials to form the "Smart Buy Alliance" to share what they are learning about measuring quality, and to adopt common standards to gauge provider and insurance plan quality and efficiency.

How Minnesota is Working Together to Make the Health Care Puzzle Pieces Fit

Health Plans

- Access to coverage
 - Risk pooling and product innovation
 - Universal coverage and outreach proposals
- Quality and consumer experience
 - Community Measurement
 - ICSI and evidence-based medicine
 - Consumer education
 - Cost and quality transparency
 - E-Health
 - Network structures
- Cost containment
 - Administrative streamlining
 - Product innovations and cost sharing
- MN Mental Health Action Group
- MMA Healthy Minnesota project
- Prevention public policy
- Cover All Kids

Providers

- Front line of care delivery
- MMA Healthy Minnesota initiative
 - Insurance reform
 - Blue Cross universal coverage modeling
 - Essential benefit set discussion
 - Public health Infrastructure
 - Delivery systems
 - Quality assurance
 - ICSI and evidence-based medicine
- MHA's system improvement initiatives
 - Administrative streamlining
 - Patient safety
 - Facilities planning
- MN Mental Health Action Group
- Prevention public policy and practice
- Cover All Kids

Minnesota Residents

- Health literacy
- Engagement in decision making
- Prevention and healthy lifestyles
- Sharing in rights and responsibilities of health care

Business Leaders

- Smart Buy Alliance
- E-Health initiatives
- Product innovations
- Employee education and engagement
- Community Measurement
- MMA Healthy Minnesota project
- Administrative streamlining
- Regulatory flexibility
- Prevention and wellness
- Cover All Kids

Government and Policy Leaders

- State operative services
- Prevention public policy
- Public health planning and infrastructure
- State E-Health initiatives
- Administrative streamlining
- Regulatory flexibility
- Coordination of social and medical services
- Cover All Kids
- CDF outreach initiatives
- Long-term care payment and coordination
- MN Mental Health Action Group
- MMA Healthy Minnesota project
- Smart Buy Alliance

Suggested Public Policy Action

- Act in a nonpartisan manner to adopt and fund a proposal for reform of the insurance market. Ideally, the proposal should require that all people have some form of adequate coverage, assure financial assistance for those who need help to afford their coverage, require insurers to guarantee participation in their products so that sick people are no longer segregated from the rest of the insurance market, and fund the losses of those high-risk individuals.
- Support the work of the MMA's Healthy Minnesota project to recommend changes in the public health infrastructure, care delivery and quality assurance, and development of insurance reform, and an essential benefit set to allow the state to afford a basic level of health care for all
- Encourage the state of Minnesota to present a proposal to the federal government that would encourage flexibility, allowing lower-income workers to use federal health care dollars to subsidize their share of employer-based coverage for their dependents
- Intensify outreach efforts to enroll those eligible for public programs but not yet enrolled
- Improve the current enrollment system for public programs so they do not create unintended barriers due to complicated forms and processes
- Allow regulatory flexibility to continue development of products and tools to empower consumers to choose plans, providers, care options, and lifestyle modifications
- Consider innovative approaches to getting coverage for populations that are not eligible for state or federally funded health care programs

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