Universal Coverage Report

Minnesota
Health Care
Commission

February 1, 1994

Pursuant to 1993 Minn. Laws Chap. 345
Art. 6 Sec. 25

Minnesota Health Care Commission

DATE: February 23, 1994

TO: Legislative Reference Library

FROM: Tom Swain
Chairman

SUBJECT: Universal Coverage Report Modification

I am writing to inform you of a modification to one of the recommendations the Minnesota Health Care Commission included in its Universal Coverage Report which was recently submitted to you.

The Universal Coverage Report contains a comprehensive plan for achieving universal coverage for all Minnesotans by July 1, 1997. In the report, the commission recommends changing the insurance laws effective July 1, 1997, to require all carriers to issue coverage to anyone willing to pay the premium, regardless of their health status or risk of requiring health care services. This is known as "guaranteed issuance." The imposition of the guaranteed issuance requirement is timed to coincide with universal coverage and a fully funded subsidy program, to protect health carriers from adverse selection. Without universal coverage, primarily high-risk individuals will take advantage of the guaranteed issuance requirement. Healthy, low-risk individuals will tend to choose not to purchase coverage until they need it, then drop coverage after the need passes. If only the high-risk individuals are covered and paying into the system, the cost of insurance will rise significantly.

In the Universal Coverage Report, the commission included a preliminary recommendation for "conditional guaranteed issuance" in the individual health insurance market effective July 1, 1995. This recommendation was an attempt to implement a modified form of guaranteed issuance before universal coverage is achieved, by allowing health carriers to attempt to protect themselves against adverse selection through pre-existing condition restrictions, waiting periods for coverage, and requiring enrollees to commit to a longer, fixed period of coverage. In the report, the commission indicated that the conditional guaranteed issuance recommendation was a preliminary recommendation that might be modified subsequently based on further actuarial analysis.

After reviewing the results of an actuarial analysis of the commission's recommendations, the commission unanimously decided to eliminate the conditional guaranteed issuance recommendation. Our actuaries concluded that, even with the adverse selection safeguards, conditional guaranteed issuance would result in an average premium increase of 28 percent initially, increasing to 55 percent as the market matures. Actuarial work that has been done by other groups roughly

corroborates these findings. A premium increase of this magnitude will prompt some currently insured persons to drop coverage. The commission concluded that the adverse impact of this requirement is too great a price to pay for any potential benefit that may be realized. Therefore, the commission is no longer recommending the conditional guaranteed issuance requirement that appears on pages 5 and 27-28 of the Universal Coverage Report.

The commission's experience attempting to devise insurance reforms that will increase opportunities for uninsured Minnesotans to obtain private coverage has strengthened the commission's conviction that universal coverage is crucial to achieving the state's access, cost containment, and quality goals. In order for health coverage to be affordable for all, everyone must pay into the system according to their ability--including the many young, healthy, low-risk individuals who would rather spend their money on other things. In return for their investment in health coverage when they are healthy, these individuals can rest assured that affordable coverage will be available when they grow old or become injured or ill. Universal coverage will also eliminate the black hole in the current system that promotes cost shifting, places bad debt and charity care burdens on providers, results in lost opportunities to reduce health care costs through prevention and early intervention, and hinders efforts to monitor and evaluate quality and costs.

Universal Coverage Report

Minnesota
Health Care
Commission

February 1, 1994

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Summary

Minnesota is making good progress toward improving the quality, accessibility, and affordability of health care for its citizens. As a result of the 1992 HealthRight Act (now known as "MinnesotaCare"), many programs addressing each of these three major goals of health care reform are currently being implemented. While all of the state's health care reforms are interrelated, the primary focus of this report is access.

According to research conducted by the Minnesota Health Care Access Commission in 1990, about 280,000 Minnesotans (6.5%) are uninsured at any given point in time. Approximately 370,000 Minnesotans (8.6%) are uninsured at some time each year. Long-term uninsured Minnesotans live both in metropolitan areas and in greater Minnesota. They tend to be lower-income working people. Many reported that they had delayed health care, including care for serious health problems, because of the cost. In addition to those who are uninsured, many Minnesotans are underinsured, which means that they have very high deductibles or limited coverage, or that they are paying a premium that is very high in relation to their income.

Every Minnesotan is entitled to access to quality health care. However, universal access is not just a matter of fairness and equity; universal access is critical to the success of Minnesota's cost containment efforts. Cost containment programs cannot be fully effective until all Minnesotans are in the system, have health coverage, and pay a fair share of the costs of coverage. It is also necessary to address nonfinancial barriers to access to health care, such as limited access to providers due to geography; cultural, language and racial barriers; or a shortage of providers in the community; so that all Minnesotans can obtain the services they need, including primary and preventive services which will lower overall costs.

Minnesota took an important step toward universal access when the MinnesotaCare Program was created in the 1992 HealthRight Act to provide subsidized health coverage to Minnesotans who cannot afford the entire cost of coverage. Other health care reform initiatives, such as insurance reform, cost containment strategies, and rural health programs, are also designed to improve access. However, even when all of these existing programs are fully implemented, Minnesota will fall short of universal access. This report presents a comprehensive plan to take Minnesota the remaining distance to the goal. Under the plan presented here, by July 1997, every Minnesotan will have health coverage and access to quality health care services.

A Vision for the Future

The plan presented here is based on the Minnesota Health Care Commission's vision for universal coverage. Our vision is that, by 1997, the following goals will have been achieved:

- **Universal coverage.** Every Minnesotan has health coverage and contributes to the costs of coverage based on ability to pay.
- **Availability of coverage.** No one is denied coverage or forced to pay more because of their health status.
- **Universal access to services.** Quality health care services are accessible to all Minnesotans.
- **Equal purchasing power.** All health care purchasers are placed on an equal footing in the health care marketplace.
- **Comprehensive, affordable benefits.** A comprehensive yet affordable health benefit plan is available to all Minnesotans.

An integrated package of recommendations

This report is an integrated package of specific strategies that cannot be implemented effectively unless all of the strategies are implemented as a package. Piecemeal implementation of some, but not all the components of the plan, will not take us to the goal of universal coverage and may make the goal harder to obtain.

Universal Coverage Plan Components

The following are the components of the Minnesota Health Care Commission's implementation plan for achieving universal coverage for all Minnesotans by July 1, 1997:

Universal Coverage Goal

- The goal of the state is to reduce the number of uninsured Minnesotans each year according to the following schedule until universal coverage is achieved by July 1, 1997:

July 1, 1994	--	300,000 persons
July 1, 1995	--	250,000 persons
July 1, 1996	--	150,000 persons
July 1, 1997	--	-0- persons

- A process will be established for annually evaluating the state's progress toward achieving the annual access goals.

- State agencies will be charged with the responsibility of recommending, to the Legislature and the Governor, corrective action if it is determined that the state has fallen short of an annual access goal.

General strategy and timing

- We recommend that the 1994 Legislature enact all components of a universal coverage strategy that will lead to universal coverage by 1997.

- The Minnesota Health Care Commission will coordinate research which will be conducted during 1994 to update and improve our knowledge of Minnesota's uninsured population, to determine who has been helped by existing reforms and who remains uninsured, and to evaluate whether the MinnesotaCare Program and other reforms have reduced the number of uninsured and underinsured Minnesotans.

- The Minnesota Health Care Commission and appropriate state agencies will conduct a major study of government health care financing during 1994 and submit to the 1995 Legislature a plan for reforming the system.

- National reform activities will be monitored and analyzed throughout 1994 and beyond.

- The Minnesota Health Care Commission, in consultation with appropriate state agencies, will develop and submit to the 1995 Legislature recommendations for modifying and refining the 1994 legislation and reforming the health care financing system, based on new information about the uninsured, evaluation of the MinnesotaCare program and other reforms, and national reform developments.

Universal Enrollment

The guiding principle of universal coverage involves much more than universal access. Currently, Minnesota has a rough and imperfect form of universal access, particularly for acute and emergency health care services. When health care needs reach the point where treatment is essential, Minnesotans generally receive treatment whether or not they are enrolled in a health plan. To the extent an uninsured person is unable to pay for their care themselves, the costs are paid by others.

The 1993 legislation that required the Minnesota Health Care Commission to develop a plan for universal coverage makes it clear that the goal of the state is to achieve not simply universal access to health coverage, but a system of universal coverage under which every Minnesotan is enrolled in a health plan that is responsible for providing their health care. To ensure that the costs of health care are shared more equitably, every Minnesotan should be required to contribute to the costs of that coverage based on their ability to pay.

- Beginning July 1, 1997, all Minnesotans will be required by law to enroll in a health plan and to contribute to the cost of coverage based on their ability to pay.

- The mandatory coverage requirement will become effective after the full implementation of insurance reforms, market reforms, and government subsidies that will ensure that health coverage is available and affordable for every Minnesotan.

- Mechanisms will be developed to identify those individuals who do not enroll in a health plan and to enforce the state's mandate.

Availability of coverage

To ensure that affordable health coverage is available to every Minnesotan by July 1, 1997, the requirements listed below will apply to all types of health plan companies who enroll Minnesotans. However, these reforms cannot be fully implemented simultaneously without causing premium increases for many Minnesotans, as costs are evened out between low and high-risk Minnesotans and as high-risk uninsured persons enter the insurance market. Therefore, we recommend that the changes be phased-in gradually until all of the requirements are fully implemented by July 1, 1997.

Some of the recommendations below are *preliminary.* Actuarial work will be completed to determine the impact of the changes. The Minnesota Health Care Commission may modify these recommendations based on the results of the actuarial analysis.

- **Guaranteed issuance and renewability.** All health plans, including Integrated Service Networks (ISNs) and all-payer insurers, must provide health coverage to anyone willing to pay the premiums, without conditions or restrictions (guaranteed issue is currently required only in the small employer market). (Effective 7/1/97)

    - **Conditional guaranteed issuance.** Effective July 1, 1995, all health plans will be subject to a conditional guaranteed issuance requirement. Plans will be required to guarantee issuance and guarantee renewability in the individual market, but they will have the option of imposing a waiting period, preexisting condition exclusion, quarterly premium payment requirement, and 12-month coverage obligation. (This recommendation may be modified after actuarial analysis.)

- **Underwriting eliminated.** Underwriting based on the health status, risk, or characteristics of individuals seeking coverage will be prohibited, except to the extent the Legislature authorizes discounts for healthy lifestyle factors. (Effective 7/1/97)

- **No preexisting condition restrictions.** Carriers will not be able to impose preexisting condition limitations and exclusions with the exception of persons who previously chose not to obtain group or individual coverage when it was available and affordable. (Effective 7/1/97)

- **Community rating.** The amount of variation that is allowed between the premiums charged to different individuals or groups will be reduced annually until July 1, 1997, when everyone must be charged the same premium amount for a particular health coverage product.

- **Portability of coverage.** Effective July 1, 1994, insured individuals may move from public programs to private health plans, and from one product to another within a health carrier's business, without restrictions or exclusions. Effective 7/1/97, individuals will also be able to move between carriers, without restrictions or exclusions. (This recommendation may be modified after actuarial analysis.)

- **Individual coverage required.** All carriers will be required to offer health plan products to those who purchase coverage individually, rather than as a member of a group. (Effective 7/1/95) (This recommendation will be analyzed further before it is implemented to determine whether it should be modified and whether waivers should be allowed.)

- **Uniformity of products.** The number of health coverage products offered by carriers will be limited and all carriers will offer products from a standardized array of options. (Details and implementation dates will be determined in the ISN and the Regulated All-Payer Option (RAPO) implementation plan.)

- **Reinsurance.** Reinsurance mechanisms will be established in all markets.

- **Minimum loss ratios.** In the year 2000, loss ratios will increase to 72% for the individual market and 82% for the small group market, and a loss ratio floor will be established for non-ISN health plans.

- **MCHA.** The Minnesota Comprehensive Health Association (MCHA) will be closed to new enrollees (Effective 7/1/97).

Access to health care services

- The Department of Health, in consultation with the Minnesota Health Care Commission and appropriate agencies and organizations, will develop a permanent process to examine nonfinancial barriers to access to health care services, such as rural provider shortages and social and cultural barriers, and take action to overcome these barriers.

Market reform

- Short-term strategy. Existing laws governing private purchasing pools will be modified to make it easier for private pools to form in the existing health care market.

- Permanent strategy. By July 1, 1997, large purchasing pools will be available to all purchasers, regardless of employment status or group membership, thereby eliminating cost shifting in the marketplace.

- The Minnesota Health Care Commission will submit recommendations prior to the 1995 legislative session on whether some or all purchasers should be *required* to obtain coverage through purchasing pools and whether a state-administered purchasing pool should be established to serve all Minnesotans who do not have access to other purchasing pools (either by expanding the existing purchasing pool operated by the Department of Employee Relations or by establishing a different pooling mechanism).

- The Minnesota Health Care Commission will submit to the 1995 Legislature detailed recommendations for permanent market reform strategies based on evaluations of existing reforms and responding to national reform initiatives.

Affordability: subsidized health care programs

- The current MinnesotaCare program will continue its phase-in according to the schedule in current law.

- In 1994, the Minnesota Health Care Commission will coordinate a new survey of the uninsured and the Department of Human Services will survey the MinnesotaCare population.

- The Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare programs will be consolidated into a single health care program for low-income Minnesotans, which will be mainstreamed into the reformed health care system to prevent the development of a two-tiered health care system and to prevent erosion from private sector programs to government programs. The Department of Human Services will request authorization from the 1994 Legislature to seek federal waivers to accomplish the consolidation.

- Supplemental or wraparound benefit packages and services will be developed

to meet the unique needs of populations served by government programs.

- The subsidy program will be financed by stable, equitable, long-term funding sources as part of an overhaul of the government health care financing system to be enacted during the 1995 legislative session based upon recommendations to be developed during 1994.

Financing

- The Minnesota Health Care Commission and appropriate state agencies will conduct an inventory and analysis of the existing system of government financing of health care in 1994 and submit specific recommendations for overhauling the system to the 1995 Legislature.

- The recommendations for financing reform will be based on specific goals and guiding principles for health care financing to be enacted by the 1994 Legislature.

- The cigarette excise tax should be increased by 40 cents per year over the next 5 years to reduce the health costs associated with tobacco use and to provide supplemental financing for the MinnesotaCare Program for uninsured Minnesotans until the entire system of government financing of health care can be reformed.

- Any temporary shortfall that may occur in the funding for the MinnesotaCare program should be covered by revenues from the cigarette tax increase and by using the anticipated state revenue surplus.

Benefit set

- By January 1, 1997, a universal, comprehensive benefit set will be the minimum standard of coverage for all Minnesotans.

- The universal benefit set will be the basis for coverage under state health care programs, with additional wraparound programs to meet the special needs of populations served by government programs.

Education and Outreach

- Both public and private education and outreach programs will be established and maintained to educate individuals regarding their need for health care and to assist them in obtaining health coverage.

Universal Coverage Plan

Introduction

Minnesota has been working to achieve meaningful health system reform for more than a decade. The creation of the Health Care Access Commission in 1989 and the subsequent work of the Access Commission represented a major step in the state's progress. The Access Commission's work in 1989 and 1990 laid the foundation for House File No. 2, which was passed by the Minnesota Legislature during the 1991 session but vetoed by the Governor primarily because it lacked comprehensive cost containment provisions and did not specify an adequate long-term funding source for the subsidized health care program it created. In January 1992, the Governor and legislative leaders of both parties agreed to appoint a bipartisan negotiating team to draft a health care reform bill that both parties and the Governor could support. The seven-member negotiating team reached agreement on a package of reforms which was ultimately enacted by the Legislature and signed by the Governor. The 1992 MinnesotaCare Act (formerly known as "HealthRight") contained major health system reform strategies relating to the three goals of access, quality, and cost containment. It also created a new commission, the Minnesota Health Care Commission, to plan for and monitor the implementation of health system reforms.

Minnesota's reforms represent an ongoing effort to strike a balance between the goals of universal access and cost containment. House File 2 was vetoed in part because its programs to provide government-subsidized health coverage for the uninsured were not counterbalanced by cost containment and funding provisions to ensure that the programs were affordable and adequately funded. The 1992 HealthRight Act also contained a government-subsidized program for the uninsured (the MinnesotaCare Program), but it also created a stable, long-term funding source (the 2% provider tax) and placed a major emphasis on cost containment. Responding to the directives of the Legislature, the Minnesota Health Care Commission devoted most of its time between the 1992 and 1993 legislative sessions to developing and implementing a cost containment plan. As the cost containment program made progress through the legislative process during the 1993 session, the Legislature once again turned its attention to access issues. Recognizing that the MinnesotaCare subsidy program and other reforms designed to improve access for uninsured and underinsured Minnesotans were important first steps but were not sufficient to achieve true universal coverage, the Legislature looked to the Minnesota Health Care Commission to develop a plan that would move Minnesota the remaining distance to universal access.

The 1993 MinnesotaCare Act (Laws of Minnesota 1993, Chapter 345, Article 6, Section 25) directed the Minnesota Health Care Commission to

develop and submit to the Legislature a comprehensive plan to lead to universal health care coverage for all Minnesotans by January 1, 1997. The Legislature requested an implementation plan and time schedule for the coordinated phasing-in of health insurance reforms, including the expansion of community rating and the phasing-out of underwriting restrictions; changes or expansions in government programs; annual targets for expanding coverage to uninsured persons; and periodic evaluations of the progress being made toward achieving universal coverage.

In order to achieve these goals, the Health Care Commission established the Universal Coverage Committee. This document was generated by Commission staff based on the discussions, assumptions, and "seeds of consensus" of the Universal Coverage Committee and has been approved by the Minnesota Health Care Commission.

Uninsured Minnesotans

In 1990, the Health Care Access Commission authorized a survey to determine the insurance status of Minnesotans, and sociodemographic characteristics of the uninsured and individually insured populations. The study found that:

- At any given point in time, 6.5% of all Minnesota residents are uninsured (279,925 persons).
- 8.6% of the population was uninsured at some point in the previous year (370,363 persons).
- The uninsured are poorer than previously estimated. Seventy percent of those who are uninsured all year have incomes below 200% of the federal poverty limit.
- Although most of the long-term uninsured are located in the metropolitan areas where the state's population is most heavily concentrated, several regions in greater Minnesota have a disproportionate share of uninsured individuals.
- Lack of health insurance is associated with significant barriers in access to care. Some 28.3% of uninsured persons reported that they delayed care, and of those, 70% reported that they delayed

care for a very serious or somewhat serious problem. Some 83.6% reported that cost was the main reason for the delay.

- Some 48.2% of uninsured adults are employed by someone else; 13.2% are unemployed; 32.8% are self-employed; and 5.8% are retired.

- Many people with individually purchased insurance policies have less health care coverage than people with group insurance policies.

- The uninsured and individually insured have significant out-of-pocket expenditures for care, ranging from a mean of $135 to $183 per quarter (3 months), with a high of $17,000.

- The uninsured and individually insured have significant amounts of unpaid medical bills.

- Many of the individually insured population are "underinsured".

- The health status of the uninsured is similar to that of the individually insured, and is probably similar to that of the general population. However, health status accounts for no more than 10% of the variance in health care utilization.

No studies have been conducted to update the information from the 1990 survey. However, data collected from the March 1993 Current Population Survey (CPS) files found the following proportion of uninsured individuals in Minnesota:

- 1991: 9.3% of the population was uninsured at some point in the year (406,000 persons)

- 1992: 8.1% of the population was uninsured at some point in the year (350,000 persons)

(Woolhandler and Himmelstein, Unpublished Tabulations from March 1993 Current Population Survey)

Several related studies were recently completed by Nicole Lurie, M.D., M.S.P.H. (Associate Professor of Public Health at the Center for Health Services Research,

University of Minnesota) and colleagues. One evaluated the enrollees of several pilot programs which have formed over the past three years to provide coverage to the uninsured. A second examined differences between urban and rural Minnesotans with regard to access and insurance. A third examined barriers to enrollment in Medicaid for Medicaid eligible MinnesotaCare applicants. These studies found that:

- Enrollees in all of the plans were more likely to have delayed seeking care than the uninsured population in general.
- Women enrolled in these programs in a higher proportion than their representation in the uninsured population.
- Many of the program enrollees had attained a higher educational level than the uninsured population.
- Some plans' enrollees' unpaid medical bills were higher than the uninsured population.
- At least one plan attracted enrollees that were sicker than the general uninsured population (this plan did not deny or limit coverage because of preexisting conditions or health status).
- There is tremendous unevenness of coverage and access. Rural residents pay a higher proportion of premiums out-of-pocket and have fewer benefits. Yet, they are more likely to have a usual source of care. Urban residents pay less and have better coverage, but the uninsured report more refusals of care.
- Of the MinnesotaCare applicants who were referred to MA and did not apply, shame and stigma were major reasons for not applying.

Based on the findings of the study, Dr. Lurie concluded that:

- Planning for universal coverage must consider the different issues in urban and rural areas.
- Specific plans to overcome the stigma of Medicaid coverage will be necessary if Medicaid expansion is part of the strategy to achieve universal coverage.

- Standardization of health policies may help address the geographic irregularities and those related to underwriting and may enhance competition on the basis of price and quality.

Another study by Lurie examined sociodemographic data on individuals who were excluded from health coverage due to preexisting conditions. This study found that approximately one year after being excluded from coverage, 61% were able to obtain health insurance in the private market, 22% were insured through MCHA, and 17% remained uninsured (an uninsurance rate nearly three times that of the general state population). The study also found that:

- Compared to the general state population with individual insurance coverage, the individuals surveyed who were able to obtain coverage were more likely to report good or excellent health.

- Approximately one-third of respondents (37%) reported that the cost of MCHA enrollment was prohibitive.

- Twenty-eight percent of the total group reported that they delayed getting medical care over the previous year because of lack of coverage or high cost, while 55% of the uninsured group delayed care. This is in contrast to 18% of individually insured residents who reported delaying care in the 1990 survey.

- The individuals surveyed were found to have a lower unemployment rate and to be as well educated as the insured population. With regard to employment, those with private insurance were more likely to be employed than either the uninsured or risk pool enrollees. Of the employed, uninsured individuals and those enrolled in MCHA were more likely to work in the smallest businesses compared to the privately insured. Nonetheless, a sizable proportion of MCHA enrollees and uninsured individuals worked in businesses having over 250 employees (21% for both).

- The study found that the uninsured have significantly lower age, income, and mental health status compared to the insured and MCHA groups.

A study is currently being conducted by the state through a Robert Wood

Johnson Foundation grant to evaluate the implementation of the MinnesotaCare program and related health insurance reforms in order to understand the interface between these two efforts and their effect on health care reform. The study is described in more detail in Appendix A. As part of this effort, the Rand Corporation surveyed a sample of 2000 households in Minnesota to establish baseline data on whether Minnesotans can afford the health care they need. This project will provide specific estimates of the uninsured population and their characteristics as well as gaps in health care use and health status. The data is scheduled to be available in April 1994.

The Relationship Between Access and Cost Containment

Every Minnesotan is entitled to access to quality health care. Lack of health insurance is related to an individual's health. The 1990 study of uninsured individuals found that 28.3% of uninsured persons reported that they delayed care, and of those, 70% reported that they delayed care for a very serious or somewhat serious problem. Some 83.6% reported that cost was the main reason for the delay. However, universal access is not just a matter of fairness and equity; universal access is critical to the success of Minnesota's cost containment efforts. Individuals who currently do not have access to health care because it is unaffordable will end up utilizing the health care system at some time. The costs of this care are shifted to others in the form of taxes or higher health insurance premiums, and these costs can neither be controlled nor contained. In addition, uninsured individuals who are young and healthy are not paying into the system, even though they will eventually require health care services as they grow old or become sick or injured.

It is also necessary to address nonfinancial barriers to access to health care, such as: limited access to providers due to geography; cultural, language and racial barriers; age-related needs; and a shortage of providers in the community, so that all Minnesotans can obtain the services they need. If access to primary and preventive care is insufficient due to these barriers, medical care costs are likely to increase through higher use of more costly emergency room visits, delays in receiving needed care which results in higher overall costs to treat advanced conditions, and the use of more costly specialists to provide routine primary care.

Cost containment programs cannot be fully effective until:

(1) all Minnesotans are in the health care system, have health coverage, and pay a fair share of the costs of coverage; and

(2) all Minnesotans have access to, and receive, the health care services they need.

Progress toward universal coverage

A variety of reforms are currently being implemented in Minnesota to improve coverage for the uninsured:

- A cost containment plan to improve the affordability of health care
- Insurance reform to make coverage available to more people, including high-risk persons and persons with existing health conditions
- The MinnesotaCare Program to provide subsidies to uninsured persons who cannot afford to pay the entire cost of health coverage
- Rural health initiatives to improve the availability of health care in rural communities
- Data programs to collect and distribute information about quality and cost.

In order to achieve universal coverage by 1997, additional steps must be taken. A number of strategies to achieve this goal are outlined in this paper. In addition, to the greatest possible extent, current reforms should be monitored and evaluated on a periodic basis and future recommendations should be based upon those evaluations.

An integrated package of recommendations

This report is an integrated package of recommendations. The specific strategies recommended here cannot be implemented effectively unless all of the major strategies are implemented as a package. For example, this report recommends a legal requirement that all Minnesotans obtain health coverage. This requirement cannot and should not be implemented unless affordable health coverage is *available* to all, including small businesses, individuals, persons with preexisting health conditions, high-risk persons, and low-income persons who cannot afford to pay the cost of purchasing coverage.

National Reform

The plan presented in this report is an attempt to balance the state's need to continue to move forward to achieve universal coverage with the possibility that national reform will be achieved in the near future. In some areas, the plan has been designed ***around*** existing federal laws, such as the ERISA law. Unquestionably, this plan would look very different if certain ERISA and Medicaid laws did not exist.

For example, the federal Employee Retirement Income Security Act (ERISA) limits the ability of states to regulate the health benefit plans of employers who choose to self-insure (as opposed to purchasing insurance coverage). Most large employers are self-insured, as well as many medium-sized and some smaller employers. The ERISA law exempts these employers from state regulation of their employee health benefit plans, and preempts state laws requiring insurers to pay a premium tax and contribute to MCHA, the state's high risk pool. The ERISA law prohibits states from implementing an employer mandate to provide health coverage to employees. ERISA also limits states' ability to apply health reform requirements to self-insured employers. While the full reach of ERISA is unclear, states face the risk that courts will strike down state requirements relating to cost containment, quality, data collection, rural health initiatives, minimum benefits, and prohibitions on "carving out" high-risk employees (and potentially purchasing less expensive MCHA coverage for them), as applied to self-insured employers. ERISA also may limit a state's ability to tax all health care purchasers to pay for health-related activities that benefit all residents of that state.

For many employers who wish to provide health coverage for employees, self-insurance is the most cost efficient way to do so, and is a sound business decision. Self-insurance is not generally used by Minnesota businesses as a means of avoiding state mandates or gaming the system to shift costs and responsibilities upon the state, MCHA, or the insured market. Most large Minnesota corporations and many medium-sized and small employers provide good health coverage for their employees, do not carve out high-cost employees, and are supportive of Minnesota's cost containment initiatives. However, ERISA creates the opportunity for employers to avoid some of the costs and burdens of health reform requirements, when this is to their benefit, while enjoying the benefits of reform when the regulated insurance market proves a more attractive option for them. ERISA allows an employer with a healthy, low-risk work force to self-insure, thereby paying only the low costs of the existing employees and avoiding the taxes and assessments that the state uses to provide coverage to uninsured and

uninsurable individuals. However, when employees get sick or the work force becomes higher risk, the employer can choose to return to a reformed insurance market where health plan companies are obligated to provide coverage and must spread the costs to other purchasers. Self-insured employers also can "carve out" or shift the sick employees to state-funded programs or MCHA (which is subsidized only by purchasers in the "insured market").

We do not intend to suggest that these business decisions are illegal or even inappropriate. We expect businesses to compare their options and choose the option that makes the most financial sense. However, the self-insurance option means that the state has no control over a substantial portion of the health care marketplace. It also means that every state requirement that increases costs or regulatory burdens will tend to drive insured businesses toward the self-insurance option. Finally, it means that the insured market over which the state has some control is likely to retain the highest risk, and therefore highest cost, enrollees since the healthy, low-risk companies will often find the self-insured market more attractive.

Current federal laws and requirements pertaining to Medicaid also limit the state's ability to achieve its cost containment and access goals. These laws and rules dictate with great specificity the benefit set, the eligibility requirements, and the administration of Minnesota's Medical Assistance (MA) program. As a result, these requirements inhibit efforts to consolidate the current MA program, which covers over 400,000 Minnesotans, with a universal plan for all Minnesotans. The Department of Human Services is seeking approval from the Legislature to apply for a package of waivers from the federal government. These waivers would excuse the state from many of the problematic Medicaid requirements, and allow the department to simplify the Medical Assistance program and consolidate it with other public programs, such as General Assistance Medical Care and MinnesotaCare.

If a national reform program is enacted, adjustments will be needed in Minnesota's plan. Minnesota has watched closely developments on the national scene. It is hoped that national reform will make it easier, not harder, for Minnesota to achieve its goal. In addition to recommendations for reforms which will lead to universal coverage, this report also contains recommendations for a process of monitoring national reform and making adjustments to Minnesota's plan as needed. The timing of the plan is also designed to take advantage of national reform, if it occurs in the near future. However, Minnesota cannot afford to suspend its progress toward universal coverage and wait and hope for national reform. The costs to uninsured and underinsured Minnesotans

are too great. In addition, Minnesota's cost containment and quality programs will not be fully effective unless and until universal coverage is achieved. Therefore, this plan will move Minnesota forward to the goal of universal coverage by 1997 with or without national reform.

A Vision for Universal Coverage

The Minnesota Health Care Commission believes Minnesota's strategies for achieving universal coverage must be based on a clear vision of the state's ultimate future goal. The Minnesota Health Care Commission's vision for the future is that, by 1997, the following goals will have been achieved:

- **Universal coverage.** Every Minnesotan has health coverage and contributes to the costs of coverage based on ability to pay.
- **Availability of coverage.** No one is denied coverage or forced to pay more than others because of their health status.
- **Universal access to services.** Quality health care services are accessible to all Minnesotans.
- **Equal purchasing power.** All health care purchasers are placed on an equal footing in the health care marketplace.
- **Comprehensive, affordable benefits.** A comprehensive yet affordable health benefit plan is available to all Minnesotans.

We recommend that the 1994 Legislature enact a statement of Minnesota's commitment to universal coverage and vision for universal coverage that incorporates these elements, and enact the reforms necessary to achieve this vision.

Universal Coverage Goal

The universal coverage plan presented in this report is designed to achieve universal coverage by 1997. The 1993 MinnesotaCare Act required a plan which would lead to universal coverage by January 1, 1997. However, the Legislature also expressed its desire to phase out rate bands and move to community rating

by July 1, 1997. The reforms in this document were planned around the July 1, 1997, date and complete universal coverage will be achieved by this date.

The 1993 Legislature also required us to include in the plan interim goals that will ensure that we remain on target toward our final goal. We recommend the following annual targets for reducing the number of uninsured Minnesotans.[1]

- The number of uninsured Minnesotans will be reduced each year according to the following schedule:

July 1, 1994	--	300,000 persons
July 1, 1995	--	250,000 persons
July 1, 1996	--	150,000 persons
July 1, 1997	--	-0- persons

- Household surveys and other research will be conducted annually to determine the number of uninsured Minnesotans and to assess the impact of existing reforms that are intended to improve access and coverage.

- If the state is not meeting annual targeted goals, the appropriate state agencies will be given the responsibility to recommend changes or new strategies to ensure that the state remains on schedule toward achieving universal coverage by 1997.

- Underinsured Minnesotans. The annual goals set forth above apply both to persons with no insurance and persons whose insurance plan provides inadequate benefits or coverage, or the premium costs are excessive. The definition of "underinsured" will become more precise when a universal minimum benefit set has been established and the affordability study described in a later section of this report is completed.

[1]The annual targets are based on the following assumptions: (1) During 1990, about 380,000 persons were uninsured at some time during the year; (2) MinnesotaCare insurance reform and the partial phase-in of the MinnesotaCare program have produced a moderate decrease in the number of uninsured persons; (3) progress toward universal coverage will be moderate in 1994 and 1995, and more rapid in 1996 as more insurance reform is implemented and the MinnesotaCare Program phase-in continues; and (4) a final, substantial decrease in the number of uninsured persons will occur when guaranteed issuance, full community rating, and the elimination of underwriting are mandated (July 1997).

General Strategy and Timing

Minnesota is undergoing major changes in its health care financing and delivery systems. The insurance reforms that were enacted in the original HealthRight Act only recently went into effect. The MinnesotaCare program is still being phased in. A Commerce Department study of the impact of insurance reform, including community rating, will not be completed until December 1994. The state's cost containment plan is in the process of being implemented and its full impact will not be realized for several years. A major project is still underway to develop a plan for consolidating state health care purchasing programs. The findings of a project, funded by the Robert Wood Johnson Foundation, to evaluate our first steps toward reform will not be known until the spring of 1994 at the earliest.

On top of all of this activity in Minnesota, the prospects for national reform are improving. Some federal action is possible by the end of 1994. Even if comprehensive reform is not enacted by the end of the year, it appears increasingly likely that some steps will be taken that will improve our ability and flexibility to enact and implement effective health care reform (such as ERISA reform and increased Medicaid flexibility). It is possible that by the end of 1994 federal legislation will have been enacted that will allow Minnesota to proceed directly ***ahead*** with the most effective reform strategies instead of being forced to design ***around*** federal barriers.

The timing of implementation of state and national reform is such that *every* detail of the universal coverage plan cannot and should not be ***finalized*** during the 1994 legislative session. Our first steps are being taken and we are moving in the right direction. We should complete our first steps before taking our next ones, and we should remain flexible regarding the next steps so that we can take advantage of national reform, if and when it becomes a reality, and so we can evaluate the impact of our first steps and tailor our next steps to complement, enhance, and if necessary redirect, our progress.

In addition, major restructuring of government health care funding is needed before Minnesota takes its final steps toward universal coverage and full implementation of cost containment and quality programs. The state funds dozens of different health care related programs. Existing funding streams encourage fragmented and duplicative services, create perverse incentives, and encourage turf battles. A major project must be undertaken to identify existing funding streams and recommend reforms that will make the system more rational and efficient. The final steps toward universal coverage and full implementation

of Minnesota's health system reforms should occur in coordination with government financing reform.

Because of the timing of implementation of existing reforms and the need to continue to develop the details of some parts of the universal coverage strategy, the plan presented here must be considered a "work in progress." Additional legislation will be needed in the future to improve and refine the state's universal coverage strategy and to add details in some areas. Therefore, the plan presented here has two components:

(1) a comprehensive strategy for taking the final steps toward universal coverage;

(2) a process for continuous improvement and refinement of the strategy during the next three years based on additional research and evaluation of existing state and national reform efforts.

We believe the strategies that must be implemented to achieve universal coverage are clear. These strategies are described in this report. Many strategies, including the insurance reform and short-term market reform strategies, are described in detail. Even though some details regarding future actions are not yet ironed out, it is important for the state to express a commitment to universal coverage by enacting, in some form, all of the strategies in this report so that both public and private stakeholder groups can plan and prepare accordingly. Enactment of the remaining details and financing of the state's strategy can occur during the 1995 session and subsequent sessions based on an evaluation of the impact of existing reforms such as cost containment, insurance reform, and the MinnesotaCare program; a plan for restructuring government health care financing; and any national reform legislation that may be enacted during 1994.

For those strategies (such as financing reform and long-term market reform) which require further development, we recommend that the Legislature follow the same process that was used for the ISN and all-payer option portions of the state's cost containment plan: enact in legislation the goals, guiding principles, and major provisions of the strategy, then require the Minnesota Health Care Commission and appropriate state agencies to develop and submit to the 1995 Legislature detailed recommendations including proposed legislation and rules.

Universal Coverage Plan: General Strategy and Timing

- We recommend that the 1994 Legislature enact all components of a universal coverage strategy that will lead to universal coverage by 1997.

- The Minnesota Health Care Commission will coordinate household and employer surveys and other types of research during 1994 to update and improve our knowledge of Minnesota's uninsured population.

- The Minnesota Health Care Commission will evaluate existing reforms that are intended to improve access and affordability to determine their effectiveness and impact on Minnesota's uninsured population in terms of the accessibility, quality, and affordability of health coverage and health services.

- The Minnesota Health Care Commission will conduct a major study of government health care financing and submit recommendations for reforming the system to the 1995 Legislature.

- National reform activities will be monitored and analyzed throughout 1994 and later.

- The Minnesota Health Care Commission, in consultation with appropriate state agencies, will develop and submit to the 1995 Legislature recommendations for modifying and refining the 1994 legislation and reforming the health care financing system, based on new information about the uninsured, the MinnesotaCare program, and national reform.

- The final steps needed to achieve universal coverage will be taken in coordination with the implementation of ISNs and the all-payer option, insurance reform, government financing reform, consolidation and restructuring of government health care programs, and national reform.

Universal Enrollment in Health Coverage

The guiding principle of universal *coverage* involves much more than universal *access.* Currently, Minnesota has a rough and imperfect form of universal access, particularly for acute and emergency health care services. When health care needs reach the point where treatment is essential, Minnesotans generally receive treatment whether or not they are enrolled in a health plan. To the extent an uninsured person is unable to pay for their care themselves, the costs are paid by others. The cost of their treatment is ultimately paid for by the government (and therefore taxpayers) when a person becomes eligible for Medical Assistance or other publicly funded programs, or by other purchasers when they end up having to make up for providers' losses when they are not paid for services provided.

It should be noted that some advocate for a Canadian-style single-payer system as the ***simplest*** way to achieve universal coverage because it eliminates the complications of private sector insurance--all citizens are automatically covered and do not have to enroll in a health plan, pay premiums, or comply with health plan requirements for billing and access to providers and services. However, a single-payer system is not an option that is available to Minnesota under existing federal law. (The ERISA law prohibits the state from requiring self-insured employers to participate in a single-payer health care system, and federal law changes would be necessary to require Medicare, Medicaid, and federal employees to participate.) In addition, even if national reform eventually provides Minnesota the option of a single-payer system, this approach is not consistent with the Minnesota Health Care Commission's overall approach of encouraging competition in the marketplace, minimizing government regulations, and building on the current privately financed medical system. However, some of the characteristics and goals of the single-payer system are compatible with the state's health reform strategy and have been incorporated into the universal coverage proposal:

- Every citizen has equal access to health care (universal access)
- The government has a role in controlling costs
- Quality care including preventive services is provided to all citizens
- Financial barriers to access to health care are eliminated
- Administrative costs are reduced by eliminating insurance rating and underwriting, by establishing uniform billing and electronic data interchange systems, and by integrating care and financing.

The Commission believes that a system which achieves the goals of a single-payer system while taking advantage of the strengths and advantages of an effective competitive marketplace is the most effective approach.

The 1993 legislation that required the Minnesota Health Care Commission to develop a plan for universal coverage makes it clear that the goal of the state is to achieve not simply universal ***access*** to health coverage, but a system of universal ***coverage*** under which every Minnesotan is enrolled in a health plan that is responsible for providing their health care. The Minnesota Health Care Commission believes that, in order to ensure that the costs of health care are shared more equitably, every Minnesotan should be required to contribute to the

costs of that coverage based on their ability to pay. This coverage should be required as of July 1, 1997.

We recognize that a state mandate on individuals to purchase health coverage is an imperfect method of achieving universal coverage. However, a mandate represents a strong expression of the policy of the state regarding the importance of universal coverage. In addition, the individual mandate is only one of many complementary strategies for achieving universal coverage and ensuring that every Minnesotan contributes to the cost of coverage according to his or her ability to pay.

By recommending the individual mandate, we do not intend to minimize the importance of the employer's role in providing health coverage for employees. The employer's role should be encouraged and supported. While federal law limits the options that are available to a state to enhance and expand employer-based coverage, we intend to continue working on state strategies in this area.

Universal Coverage Plan: Universal Enrollment

- Beginning July 1, 1997, all Minnesotans will be required by law to enroll in a health plan and to contribute to the cost of coverage based on their ability to pay. The individual mandate should be enacted in 1994 with a delayed effective date (July 1, 1997) to allow time for citizens to prepare to meet their obligations.

- The mandatory coverage requirement will become effective *after* the full implementation of insurance reforms, market reforms, and government subsidies that will ensure that health coverage is *available* and *affordable* for every Minnesotan.

- Before the individual mandate becomes effective, mechanisms will be developed to identify those individuals who do not enroll in a health plan (either public or private) and to enforce the state's mandate. These individuals will be required to pay a premium (including, at a minimum, back premiums for the period during which the individual did not have coverage).

- Individuals who do not obtain coverage but require health care at some point will be identified at this time ("point of entry") and a mechanism to obtain reimbursement for care provided and premiums owed will be established.

- Incentives will be established that will encourage individuals to purchase coverage prior to implementation of the mandate and not avoid purchasing coverage.

- The Minnesota Health Care Commission will develop and submit details regarding enforcement to the 1995 Legislature.

Enforcement. The Commission recommends that a variety of options for enforcing the individual mandate be considered and implemented. In particular, the Commission suggests the following options be examined further:

- Replicate the process used to enforce child support payments, which utilizes a collection process, payment plans, levy against savings accounts, wage garnishment, and prevention of reissue of state licenses.

- Require verification of health coverage before dispensing drivers licenses or completing school registrations. Add a question confirming health coverage status to income tax filings.

- Institute mandatory tax filings so that the state could verify coverage and, if necessary, obtain health insurance premiums through this mechanism.

- Require each health carrier to submit the name and social security number of each enrollee to the Minnesota Department of Revenue. The Department would then check this list against the Social Security Administration listing to identify individuals without health coverage.

These are just some of the possibilities for enforcement mechanisms; the Commission recommends that other options be identified and explored before an enforcement strategy is finalized.

Availability of Health Coverage

If all Minnesotans are required to maintain health coverage, every Minnesotan must be able to obtain coverage. In the current private insurance market, many individuals and families are unable to obtain coverage because insurance companies consider them a bad risk due to health history, age, occupation, or other factors. Coverage is unavailable for these Minnesotans because they are denied coverage outright, because the plan they are offered will not cover existing

health conditions for which health care services will be needed, or because the premium is so high that it is unaffordable.

Minnesota has adopted a health care reform strategy that is built upon a private sector delivery and financing system that preserves a role for competing private health plans and insurance companies. To achieve the goal of universal coverage, private health plans and insurance companies must operate within a legal framework that ensures that every Minnesotan is eligible to enroll and maintain coverage. The system must also ensure that persons who have the means to pay a reasonable premium but who have preexisting health conditions or are at-risk of requiring health care are not forced into government programs because of underwriting restrictions and rating practices.

Some steps have already been taken to increase the availability of private insurance through changes in insurance laws. However, additional insurance reforms will be necessary to ensure that Minnesotans are not denied coverage and that legal methods of determining the amount of the premium do not make coverage unavailable to some persons (with or without subsidies) because of cost. In addition, these reforms are intended to change the nature of competition so that health plans compete based on cost and quality and not through attempts to attract individuals at lowest risk.

The insurance reform strategy that was begun in the 1992 HealthRight Act, and that we believe should be continued, contains two major components: (1) guaranteed issuance of coverage regardless of health status or risk; and (2) community rating of premiums so that all enrollees pay the same premium regardless of health status or risk. However, these reforms cannot be fully implemented simultaneously without causing premium increases for many Minnesotans, as costs are evened out between low and high-risk Minnesotans, and as high-risk uninsured persons who have not had access because of costs and underwriting requirements, or who are currently enrolled in the MCHA high risk pool, enter the private insurance market. The price of making coverage affordable for older, higher risk persons with existing health problems is higher premiums for young, healthy persons. We believe this redistribution of the costs of coverage is appropriate because the young will eventually grow old and the healthy can at any time become sick or injured. To minimize the burden of the increases, we recommend that the changes be phased in gradually until all of the requirements are fully implemented by July 1, 1997. Implementing the requirements too quickly, or implementing too many different requirements at the same time, could actually ***increase*** the number of uninsured Minnesotans if premium increases prompt currently insured persons to drop their coverage.

As the Minnesota Health Care Commission developed its recommendations on access and insurance reform, the Commissioner of Health was concurrently developing the rules for ISNs and the Regulated All-Payer Option (RAPO). We have attempted to coordinate our efforts to ensure that the Commissioner's ISN/RAPO Implementation Plan is consistent with the Commission's universal coverage plan. To ensure that affordable health coverage is available to every Minnesotan by July 1, 1997, the requirements listed in this section will apply to all types of health plan companies who enroll Minnesotans -- not only to existing types of health coverage operating in the traditional health care market, but also new types of health plans such as Integrated Service Networks and those health plans that will operate under the regulated all-payer option. The timing of these reforms will facilitate individuals purchasing insurance coverage in the private market to the greatest possible extent. In addition, reforms will be implemented in a time frame such that ISNs will operate primarily under new insurance law, as opposed to current laws which are being phased out.

Some of the recommendations below are preliminary. Actuarial work will be completed to determine the impact of the changes. The Minnesota Health Care Commission may modify these recommendations based on the results of the actuarial analysis.

Universal Coverage Plan: Availability of coverage.

- Guaranteed issuance. All health plans, including ISNs and all-payer insurers, must guarantee issue (provide coverage to anyone willing to pay the premiums) and guarantee renewability in all markets in which they offer products. The unconditional guaranteed issuance requirement will take effect July 1, 1997, the same date as the implementation of mandatory coverage. Implementing these two requirements simultaneously will prevent adverse selection which would otherwise occur if healthy individuals were not required to obtain coverage, while health plans were required to cover individuals with health care problems.

- Conditional guaranteed issuance. Prior to full implementation of unconditional guaranteed issuance and renewal in July 1997, health plans will be subject to a conditional guaranteed issuance and renewal requirement. Effective July 1, 1995, health plans must guarantee issue and guarantee renewability in the individual insurance market, but the following conditions may be imposed:

(1) A waiting period of up to 60 days before coverage goes into effect;

(2) Preexisting condition limitations or exclusions of up to 12 months from the date coverage begins (the preexisting condition limitations or exclusions apply only once if continuous coverage is maintained, even if the individual changes health products or switches to a different carrier);

(3) Enrollees may be required to pay their premiums on a quarterly basis; and

(4) Enrollees may be required, as a matter of contract law, to retain coverage for at least 12 months from the time the coverage initially goes into effect. (This would not apply to enrollees who change employment or family status or move out of a health carrier's service area.)

This recommendation may be modified after actuarial analysis.

- **Underwriting eliminated.** By 1997, all forms of underwriting will be prohibited, except to the extent the Legislature authorizes discounts for healthy lifestyle factors.

- Effective July 1, 1997, carriers will not be able to impose preexisting condition limitations and exclusions, with the exception of persons who previously chose not to obtain group or individual coverage when it was available and affordable.

- Limitations and exclusions may not be applied to individuals who have previously experienced preexisting condition limitations as long as they have maintained continuous health coverage, nor to individuals moving from public to private coverage.

- During the summer and fall of 1994, the Minnesota Health Care Commission will study the impact of eliminating preexisting conditions and limitations in steps. The study will also examine the option of standardizing the limitations and exclusions utilized by health carriers.[2] The effect of narrowing the exclusion/limitation time to 6 months instead of 12, and providing a limited amount of coverage for services related to the preexisting condition, will also be studied.

[2]A study completed by Nicole Lurie, M.D., et al. of individuals who were excluded from insurance because of their medical history found that approximately one year later, 61% were able to obtain health insurance in the private market while an additional 22% obtained coverage through MCHA. This suggests that inconsistent standards are being applied.

- **Community rating.**[3] The rate bands enacted in the individual and small employer markets as part of the 1992 insurance reforms will be narrowed, with a ban imposed in 1997.

  July 1, 1995: Rate bands will narrow to ±12.5 percent for industry of employer, duration of coverage, health status, and claims experience and ± 25 percent for age.

  July 1, 1996: Rate bands will narrow to ± 7.5 percent for industry of employer, duration of coverage, health status, and claims experience and ± 15 percent for age.

  July 1, 1997: **Community rating in effect:** Insurers or health plans charge all members of a group or community the same premium for the same coverage without regard to factors such as age, sex, health status or occupation. Because health costs vary geographically, the rate will continue to vary by geography as specified under current law.

- **Individual coverage required.** Effective July 1, 1995, all carriers will be required to offer health plan products to those who purchase coverage individually rather than as a member of a group. (This recommendation will be analyzed further before it is implemented to determine whether it should be modified and whether waivers should be allowed.)

- **Portability of coverage.**

  - Ultimately, with full implementation of the guaranteed issuance requirement and the elimination of underwriting restrictions and discriminatory rating practices, all individuals will be able to move from one health carrier to another without being denied coverage or subjected to preexisting condition limitations. *Effective July 1, 1997.*

  - Even before full implementation of insurance reforms, individuals will be able to move from public programs to private market coverage, and from one health product to another within the same carrier, with no new underwriting restrictions. *Effective July 1, 1994.* (This recommendation

[3]The Commission has defined "community" as the individuals purchasing an identical product within the same carrier, subject to further insurance reforms which will limit the range of products in the market, and elimination of differentiations between market segments through mechanisms such as pooling. Community rating will apply in all markets.

may be modified after actuarial analysis.)

- **Uniformity of products.** The number of health coverage products offered by carriers will be limited and all carriers will offer products from a standardized array of options.[4] The standardized products and implementation dates are described in detail in the Integrated Service Network/ Regulated All-Payer Option (ISN/RAPO) Implementation Plan developed by the Commissioner of Health in consultation with the Minnesota Health Care Commission.

- **Reinsurance.** Effective reinsurance mechanisms will be established to protect carriers from adverse selection by spreading the risk of high-cost cases across all carriers. Reinsurance mechanisms are described in detail in the ISN/RAPO Implementation Plan.

- **Risk Adjustment.** A risk adjustment mechanism will be established for ISNs to ensure that an ISN is not adversely affected if higher proportions of high-risk persons and persons with existing health conditions enroll in that ISN. Risk adjustment mechanisms are described in detail in the ISN/RAPO Implementation Plan.

- **Minimum loss ratios.** "Minimum loss ratios" are laws that limit the percentage of premiums collected by health plans that may go for profit and administration (the rest is paid out in claims). Minimum loss ratios were established in the individual and small employer market as part of the 1993 insurance reform. As a result of the reform legislation, the loss ratio in the individual market will increase to 72% in the year 2000, and the ratio for the small employer market will increase to 82% in the same year. (These ratios will also apply to ISNs.) The Commission has incorporated the recommendation in the draft ISN/RAPO Implementation Plan, which states that a floor will be established for the loss ratio of lines of business offered by health insurance companies in the non-ISN sector. The floor will be designed to (1) prevent windfall profits to insurers as provider costs become controlled and (2) control the administrative expenses of insurers.

[4] A number of benefits will result from this requirement:
(1) It will ensure that the size of each group purchasing a particular product is significantly large enough to spread risk effectively.
(2) It will also ensure that individuals are not underinsured.
(3) Administrative costs will be decreased by reducing the number of different products that are offered.
(4) A limited number of standardized products will facilitate comparison-shopping by consumers on the basis of cost and quality.

- MCHA. Once the proposed insurance reforms are implemented, the state will no longer need the MCHA high-risk pool. MCHA will be closed to new enrollees *effective 7/1/97.* The guaranteed issue and renewal requirement will allow all individuals to purchase health coverage in the private market, and underwriting will be eliminated. Although it is likely that MCHA membership will decline due to attrition after full implementation of insurance reforms, the major study of existing government health care programs and financing (see page 41) should consider MCHA and how to address the individuals who remain enrolled in this program.

- During the summer and fall of 1994, the Minnesota Health Care Commission will evaluate existing insurance reforms and market reforms to determine their impact and effectiveness.

- The Minnesota Health Care Commission will collect new data on the uninsured to determine who has been helped by existing reforms and who remains uninsured.

- The Department of Human Services will survey the MinnesotaCare population to determine the characteristics of Minnesotans who are enrolling in the program.

- The Minnesota Health Care Commission will monitor the initial implementation of ISNs and the all-payer option for their impact on uninsured Minnesotans.

- The Minnesota Health Care Commission and appropriate state agencies will submit recommendations to the Legislature for any modifications or refinements that may be needed, based on the findings of these evaluations and research.

Accessibility

Health insurance coverage does not necessarily mean that people are receiving quality health care. A number of nonfinancial barriers prevent people from obtaining care even if they are enrolled in a health plan. Examples of nonfinancial barriers which can and do impede access include: limited access to providers due to geography; a shortage of providers in the community; cultural, racial and language barriers; lack of transportation; dependence upon out-of-

state providers; age-related needs; and lack of knowledge regarding how the system works.

Nonfinancial barriers to access will vary in different parts of the state. The Commission consulted the Regional Coordinating Boards as it attempted to identify barriers to access to health care. Regional boards will continue to play an important role in identifying and addressing barriers to access.

Universal Coverage Plan: Accessibility

- The Integrated Service Network and Regulated All-Payer Option (ISN/RAPO) Implementation Plan developed by the Commissioner of Health, in consultation with the Minnesota Health Care Commission, will hold private health plans accountable for maintaining and enhancing the health of all enrollees. Health plans will be responsible for overcoming nonfinancial barriers in order to ensure that all enrollees receive needed and appropriate health care services. The Implementation Plan also recommends creating an Office of Enrollee Ombudsman, which will also provide assistance with access issues.

- A permanent process will be established to examine nonfinancial barriers to access to appropriate and necessary care, evaluate existing programs that are designed to address them, and recommend modifications and new strategies.[5]

- The process for evaluating and addressing nonfinancial barriers will be developed by the Minnesota Department of Health, in consultation with the Minnesota Health Care Commission, the Office of Rural Health, public health agencies, the various councils and agencies for communities of color and disability, and other state agencies with an understanding of nonfinancial barriers to access to health care. Private organizations will also be consulted.

- The Minnesota Department of Health will maintain an inventory and evaluation of existing access programs, including programs designed to improve access in rural communities and for special populations and communities.

[5]For example, in addition to public health agencies, the Regional Coordinating Boards could be authorized to assist Community Health Boards in their responsibility to provide community-wide health assessments including issues of health care access and in the development of programs to address these barriers, or grants could be awarded to establish pilot projects.

Market Reform

In the current market, small employers and individuals generally pay higher prices and are subject to greater underwriting restrictions than large purchasers. Higher marketing and administrative costs result in higher premiums, and the cost of coverage for small employers and individuals can fluctuate significantly from year to year based on the claims experience of the health plan. In addition, the existence of a market of small groups and individual purchasers has historically facilitated approaches that do not spread the risk across large populations in order to level out premiums; instead, many health plans have sought to sell coverage to healthy, low-risk groups and avoid high-risk groups and groups with members who have had health problems. Recent insurance reforms in the state have attempted to eliminate these strategies, particularly in the small employer market.

Most of the focus of Minnesota's cost containment reform so far has been on the health care delivery system (the health care "product"). In contrast, the Clinton health care reform proposal targets the purchasing side of the equation, also referred to as "market reform" (how, where, and by whom the "product" is purchased). The different focus of Minnesota's cost containment strategy is in part the result of existing federal laws such as ERISA which limit Minnesota's ability to enact employer-based, market reform mandates. The Minnesota Health Care Commission, however, made market reform one of the priorities for its 1993-1994 agenda. The Commission established a Market Reform Task Force to work with the Universal Coverage Committee on market reform issues. Because the federal ERISA law narrows the range of options that are available to Minnesota for achieving market reform, this report focuses on both short-term changes that will improve the opportunities for voluntary purchasing pools to form under the current system without ERISA changes, and permanent strategies to be implemented in the future that will ultimately eliminate cost shifting by putting all purchasers on an equal footing but which **may** require changes in federal law. The recommendations in this report are the product of the work of the Market Reform Task Force, which focused on short-term strategies to improve the purchasing power of small group purchasers in the current market, and the Universal Coverage Committee, which focused on future market reform strategies that must be implemented as part of a comprehensive package of reforms.

National reform is likely to have a clear impact on the flexibility of states in this area. The Clinton proposal would result in the establishment of "health alliances" -- either regional or corporate-- which would negotiate and contract

with health plans on behalf of alliance enrollees. Alliances would, among other things, offer enrollees a choice of health plans, make available to enrollees information regarding health plans, and ensure that the plans comply with requirements related to quality of services and privacy. The recommendations of the Commission are not inconsistent with this proposal and could be adapted to this plan if it is enacted. The state must continue to closely monitor the progress made through national reforms and incorporate this into its own plan.

Universal Coverage Plan: Market Reform

Short-term strategy: Market Reform Task Force Recommendations

- Change Minnesota law to allow voluntary purchasing pools to form beginning July 1, 1994, for the purpose of buying health coverage, if the following requirements are satisfied:

  (1) All participants must be linked through a common thread, such as employment or geographic region. The region must be large enough to encompass a significant number of members.

  (2) A pool must have a governing structure which is locally controlled by its members (e.g., employers and employees or individual enrollees). This body will be responsible for overseeing the administration of the pool, such as reviewing and evaluating bids for coverage, determining the criteria for joining and leaving the pool, and any incentives the pool might offer to employers to create health promotion programs for their employees. The governing body should provide consumers as much choice of health plans as possible, while balancing financial realities and cost containment goals.

  (3) A pool must have an open enrollment period during which all participants may enter into the pool without preexisting condition limitations imposed that are more stringent than Minn. Stat., Sec. 62L requirements or other statutes. The governing body for the pool will determine the length of the open enrollment, but it cannot be shorter than 15 days.

  (4) The pool cannot be continued unless an enrolled population of at least 1,000 members is reached within six months. If the pool fails to achieve or remain at the minimum threshold, coverage would

continue under then-existing laws relating to health coverage, rather than through the special laws applicable to purchasing pools.

(5) Members will be required to stay in a pool for a specified period of time, such as two or three years, as determined by the governing body. Subsequent enrollment or renewal after that initial period of time would be for a similar period. (This creates stability in the experience of a pool as well as premium rate stability for the employers and individuals participating in the pool.) The governing body of a pool will be responsible for developing penalties for groups or individuals who leave the pool prior to the completion of the specified time period.

(6) The governing body of a pool will be required to review and evaluate bids for coverage from all ISNs and carriers.

(7) If a pool is employer-based, the underwriting and rating restrictions must meet or exceed those standards under Minn. Stat., Sec. 62L.

- The experience of a pool must be pooled and the rates must be blended across groups.

- The pool may decide to create tiers for the rates based upon each group's experience, but only within parameters set by Minn. Stat., Sec. 62L. These parameters allow a $\pm$25% differential from an index rate for such factors as health status, claims experience, industry of employer and duration of coverage. Further rate bands of $\pm$50% limit the factoring of age.

- In addition, criteria may be established by the governing body of each pool limiting the movement between tiers for employer groups participating in the pool. However, if a pool opts to use tiers, those tiers must be phased out within two years.

(8) If a pool includes individuals, the underwriting and rating restriction must meet or exceed those standards applied to the existing individual market.

(9) Employers with 2 - 29 employees will be guaranteed issuance into a pool, consistent with existing practices in the small group market, including portability of coverage from pool to pool. A pool can

determine uniform entrance requirements for employers other than small employers participating in the pool. Pools including individuals can determine entrance requirements consistent with existing market practices.

(10) Carriers providing coverage to purchasing pools may take advantage of the reinsurance market as is the current market practice. It is not necessary for the pool to purchase reinsurance as the pool is not the risk bearing entity.

(11) The governing body of a pool may charge an administrative fee. This is really an access fee paid to the pool to perform administrative tasks.

(12) In an effort to create a resource for employers wanting information on purchasing pools, each pool must annually file the following information with the Information Clearinghouse in the Department of Health, prior to the effective date of coverage:

- the number of lives in the pool
- the geographic area the pool will cover (to be approved by the Department)
- the number of health plans offered
- a description of the benefits in each plan
- the premium structure for each plan
- evidence of compliance with Minn. Stat., Sec. 62L, including rates
- a sample of the marketing information, including a phone number to call for more information
- administrative fees charged.

(13) The Information Clearinghouse will design a communications plan to promote the use of purchasing pools utilizing this information. This communications plan will also be an appropriate vehicle for use by the Regional Coordinating Boards, which may facilitate the

development of a pool. These reporting requirements will also allow the Department to monitor the effects this statutory revision will have on the market. This information, however, would not contain information necessary to provide consumer protection or regulatory enforcement functions.

Permanent market reform strategy

- In order to place all health care purchasers on a level playing field, the state will strongly encourage the formation of large purchasing pools, which will be available to all individuals and small employers by July 1, 1997.

- The Minnesota Health Care Commission will continue to identify methods of improving the health care coverage market and will submit recommendations to the 1995 Legislature. Among other things, the Commission will study:

  (1) Integrating workers' compensation and the medical component of automobile no-fault coverage with coverage purchased through a purchasing pool;

  (2) The impact of integrating public and private sector financing mechanisms to extend MinnesotaCare subsidies to employees and dependents who are eligible for employer-based coverage without eroding existing coverage;

  (3) The impact of requiring purchasing pools to make available to consumers all plans which submit bids to the pool;

  (4) The issue of whether some (e.g. individual purchasers) or all purchasers should be ***required*** to obtain coverage through a public or private pool;

  (5) The impact and effectiveness of the Minnesota Employers Insurance Program (MEIP), the purchasing pool operated by the Minnesota Department of Employee Relations for private employers;

  (6) How statewide or regional purchasing pools could be developed for all individuals and small groups that do not have access to a private purchasing pool, and perhaps for the MinnesotaCare Program and

other state-subsidized health care programs as well, either by expanding the purchasing pool for employers currently operated by the Department of Employee Relations or in other ways.[6]

Affordability

The state's strategy for making health coverage more affordable has many facets. The cost containment program seeks to control the rate of increase in health care costs and create competitive pressures to reduce costs even further. Insurance reforms are designed to ensure that the costs of coverage are spread equitably so that health coverage is affordable for all persons who have the means to pay a reasonable premium, not just for healthy, low-risk persons. Market reforms are intended to even out the buying power of purchasers so that coverage is more affordable for individuals and small groups. The requirement that all Minnesotans obtain coverage and contribute to the cost of care according to their ability to pay are designed to make coverage more affordable by ensuring that persons pay in to the system when they are young, healthy and low-risk so that coverage will be more affordable when they become old, sick, or higher risk. However, even if all of these strategies are implemented successfully, some low-income Minnesotans will be unable to afford to purchase coverage on their own. For those who cannot afford to pay the full amount themselves, the government must provide assistance through subsidies.

The state must ensure that individuals' and families' share of health care expenditures is affordable. When evaluating the affordability of health care, the Commission recommends that out-of-pocket spending (copayments and deductibles), insurance premiums, and, if feasible, taxes, be included in the overall health care costs to an individual or family. The Commission proposes that an individual's or family's health care costs must not exceed a specified percentage of their income. That amount should be determined through a study which will examine the various factors that affect affordability such as age, income, etc. This study should be completed by October 1994, when the comprehensive universal coverage strategy is in place and the estimated costs of the benefit package are known.

[6]Among the more obvious benefits of this approach is that it reduces the possibility of erosion of the market from the private sector to MinnesotaCare. Right now, the only way a low-income working person can get affordable coverage is to drop any individual policy that is available, go "naked" for four months, and enroll in MinnesotaCare. If MinnesotaCare were folded into a statewide or regional pool, individuals would still choose a health plan from among many private sector choices and would be eligible for a subsidy from the government.

It is important to carefully consider the issue of affordability and how to evaluate this concept. A variety of factors contribute to affordability of health care for different individuals and families. A study by the Economic Policy Institute examined the distribution of health care spending among families by income level and found that health expenditures, including out-of-pocket spending, premium purchases and share of taxes which ultimately purchase health care, are regressively distributed. (Out-of-pocket spending is defined as deductibles, copayments and coinsurance, and expenditures for services not covered by insurance which might include prescription drugs or mental health care.) The study found that:

- Low-income families pay over twice the share of income for health care as high-income families.
- Out-of pocket spending is particularly regressive, with low-income families paying a share of income that is nearly nine times that of high-income families.
- If everyone purchased health insurance, premium costs as a share of income for low-income families would be five times the level for high-income families.

The MinnesotaCare program may provide us with important information regarding affordability. For example, although the program is expanding rapidly, some current enrollees are dropping out of the program. The greatest number of people who are dropping out are individuals or families with incomes greater than 185% of the federal poverty line. At this income level, the MinnesotaCare premium is approximately 5% of income. Disenrollment may be occurring because these enrollees find the premiums unaffordable. However, because the program only became a premium-based program in August 1993, it is impossible to know what patterns or trends might continue to emerge. These trends must be monitored and the information used to improve our understanding of affordability.

The existing system of government-subsidized health care programs is really a nonsystem of fragmented, uncoordinated pieces. Major reform of government programs is needed to produce a rational, efficient system. The 1993 Legislature requested a plan for coordinating the health care programs administered by state agencies and local government in order to improve the efficiency and quality of health care delivery and make the most effective use of the state's market leverage and expertise in contracting and working with health plans and health care providers. This plan should be the foundation for a major restructuring of government programs and financing.

The MinnesotaCare program is an important first step toward the goal of affordability of health coverage, but the MinnesotaCare program is not available to many persons who are uninsured and cannot obtain affordable health coverage. The program must now evolve into a different program that is consistent with the state's other reform strategies and that truly provides adequate assistance to all Minnesotans who cannot afford to purchase health coverage on their own. Because Minnesota has endorsed a reform strategy that preserves a competitive, private-sector delivery system, government programs should be restructured so that enrollees obtain private sector coverage in the same manner as private enrollees.

Universal Coverage Plan: Government Programs.

- The current MinnesotaCare program will continue its phase-in according to the schedule in current law.

- In 1994, the Minnesota Health Care Commission will coordinate a new survey of the uninsured and of the MinnesotaCare population (the Department of Human Services will conduct this portion) and develop updated estimates of the projected costs of the program.

- The Department of Health, in consultation with appropriate agencies, will conduct a study which will examine the various factors which affect affordability of health care. Based on this study, to be completed in October 1994, the Minnesota Health Care Commission will determine a specified percentage of income which health care costs may not exceed. When evaluating affordability, out-of-pocket spending, insurance premiums, and if feasible, taxes, will be included in the overall health care costs to an individual or family.

- The MA, GAMC, and MinnesotaCare programs will be combined so that each will have the same eligibility process and requirements (entry through one door and with one set of rules) and the same standard benefits set (the same as the benefits set offered through ISNs.) The Department of Human Services will request authorization from the 1994 Legislature to seek federal waivers to accomplish the consolidation.

- The new, consolidated health care program will be incorporated into the larger, reformed health care system to prevent the development of a two-tiered health care system and to prevent erosion from private sector programs to government programs.

- The new program will be financed by stable, equitable, long-term funding sources.

- A separate wraparound benefit package will be developed to help low-income persons pay their copayments and purchase needed, uncovered services. Wraparound benefit packages will also be developed to cover the needs of special populations such as people who are elderly or have disabilities. Services such as case management, personal care assistants, intense habilitative services, day treatment and 24-hour private duty nursing may be included in supplemental packages for special populations. (These wraparound packages are a different concept than the supplemental benefit packages which ISNs and health carriers may offer enrollees who wish to supplement the standardized benefit packages, as described in the ISN/RAPO Implementation Plan.)

- The Department of Human Services, in consultation with other appropriate agencies and upon review and comment of the Minnesota Health Care Commission, will submit recommendations to the 1995 Legislature for further changes to the MinnesotaCare program and other state health care programs, based on the findings and recommendations of the study of consolidation of state programs and responding to any national initiatives that are enacted in 1994.

Government Financing

Universal coverage cannot be achieved without adequate, stable, long-term financing for government programs. Financing will be necessary to provide government subsidies to low-income persons who cannot afford to pay the entire cost of coverage themselves, and for government evaluation and monitoring activities. We believe that the amount of private and public money currently being spent on health care services in Minnesota is sufficient, or nearly sufficient, to meet the health care needs of all Minnesotans, including those who are currently uninsured. The uninsured currently receive health care services in Minnesota. The cost of their health care is borne by health care providers and shifted to others in the form of higher fees or health care premiums, or through state or local taxes for government health care programs. However, these costs are not spread equitably and are shifted from those who cannot or will not pay for coverage to others. In addition, in many cases the costs of health care for the uninsured is higher than it should be, because the uninsured are more likely to forego preventive care or to put off needed treatment until their condition becomes more costly to treat.

We recommend that the final steps toward universal coverage be timed to coincide with a major restructuring of the government health care financing system. There are many advantages to such a restructuring. First, we believe some of the savings that will accrue in some sectors of the system as a result of universal coverage can be captured and reallocated to reduce the cost of achieving universal coverage. For example, the "bad debt" and "charity care" burdens of providers will be significantly reduced if all patients have health coverage. Second, the inequities that currently exist in the system can be corrected. For example, the Minnesota Comprehensive Health Association subsidy could be eliminated or funded through a more equitable mechanism. Another benefit of restructuring would be to consolidate the existing, fragmented nonsystem of government health care programs into a more efficient system that would work in partnership with the private sector and with health-related components of other government systems such as the education and transportation systems. Similarly, funding reform would enable Minnesota to provide a more stable funding stream for the core public health functions such as disease prevention and control, instead of forcing public health agencies to subsidize these activities through revenues generated by providing personal services to uninsured persons or persons who are not served effectively in the existing system. Finally, funding reform would provide an opportunity to reverse cost shifting that has occurred both from government (because of inadequate payments to providers) and to government (because of underwriting and rating requirements and coverage limitations that force persons onto government programs).

We believe that, by combining our last steps toward universal coverage with government health financing reform, it may be possible to reform the health care financing system in a way that allows us to achieve universal coverage and a more efficient, equitable, and rational financing system **without increasing total public and private health care spending.** In addition, even though providing government-subsidized coverage for all Minnesotans who cannot afford to purchase coverage on their own is likely to require additional revenues beyond those currently provided for government health care programs, the amount of the increase can be reduced through financing reform. We believe Minnesotans expect and are prepared to pay more to ensure that everyone has health coverage. However, we also believe it is our responsibility to make sure the amount of any increase is minimized. This should be the goal assigned to those who would be responsible for developing recommendations. While there will certainly be winners and losers under financing reform, as windfalls and savings are recaptured and cost shifting is reversed, we believe the system <u>must</u> be reformed and reform will enhance the quality, affordability and accessibility of health care in Minnesota. The pain of restructuring the financing system can be minimized

by phasing in the changes over time.

It is important to clearly state, up front, that in order to achieve universal access and coverage, the state of Minnesota and Minnesota health care consumers may experience a short-term increase in costs. Additional state spending will be necessary to provide subsidized health coverage for those remaining Minnesotans who are currently uninsured. Utilization may increase as uninsured persons who have delayed or foregone needed health care are finally able to obtain coverage and services. However, we believe that over time, overall costs will be lower as cost-shifting is eliminated, uncompensated care costs go down significantly, increased use of primary and preventive care begins to pay off, and cost containment strategies are fully implemented.

Financing study

Financing reform of this magnitude cannot be accomplished before the end of the 1994 legislative session. Existing financing systems are complex and interrelated. The mechanics of capturing savings and reallocating them in the health care system have not yet been developed and will undoubtedly be difficult. A major study must be undertaken during 1994 to document and analyze the existing funding system and develop recommendations for financing reform. The financing study should be undertaken jointly by the Minnesota Health Care Commission and affected state agencies, with the assistance of a technical consultant with actuarial, finance, and taxation expertise. We recommend that, during the 1994 session, the Legislature authorize the financing study, provide the necessary resources, and enact guiding principles upon which financing reform recommendations should be based.

Universal Coverage Plan: Government Financing

- During 1994, the Minnesota Health Care Commission and appropriate state agencies will conduct an inventory and analysis of the existing system of government financing of health care, and submit to the 1995 Legislature recommendations for overhauling the system.

- The recommendations for financing reform will be based on the following goals and guiding principles, which should be enacted in the 1994 enabling legislation to guide the Commission and state agencies as they design a financing reform strategy:

(1) To the extent possible, universal coverage should be achieved without a net increase in total health spending, taxes, or government spending, by recapturing savings and reallocating resources within the system.

(2) To the extent that universal coverage will require additional financing mechanisms, revenues should be raised by taxing items that are considered to be health risks and contribute to preventable illness and injury. If additional revenues are needed, revenues should be raised by implementing broad-based taxes with appropriate offsets for low-income individuals.

(3) Financing reform should ensure adequate and equitable financing of all necessary components of the health system.

(4) Activities that benefit the entire community, such as core public health activities (i.e., collection of data on health status and community health needs) should be financed by broad-based funding sources. Funding mechanisms should promote collaboration between the public and private sectors.

(5) Personal health care services for individuals who are enrolled in a health plan should be provided or paid for by the health plan.

(6) Government subsidy programs for low-income Minnesotans should be financed by broad-based funding sources.

(7) Funding mechanisms which are inequitable or create undesirable incentives should be restructured (e.g., the Minnesota Comprehensive Health Association assessment).

Short-term financing

The long-term revenue and funding structure for health-related government activities and programs should be developed as part of an overhaul of government financing and must be coordinated with national reform. However, existing revenue sources may not be sufficient to ensure that Minnesota's progress toward universal coverage continues until financing reform has been enacted. It is critical that the state continue its existing programs for covering the uninsured. We cannot falter and even step backward by allowing enrollment in the MinnesotaCare program to stop.

To provide short-term funding for the MinnesotaCare program, we recommend an increase in cigarette and tobacco taxes. Because of the clear and serious health risks created by tobacco, we strongly believe a tobacco tax increase is worth enacting as a public health and prevention measure even without considering its value as a source of revenue. The need for additional revenues to finance the state's program to provide coverage to the uninsured makes the case for a cigarette tax increase all the more compelling. A cigarette tax increase would make it possible to simultaneously improve the health of Minnesotans and expand access to uninsured Minnesotans. The Commission also recommends that a portion of the state's anticipated revenue surplus be used to finance coverage for the uninsured. As funding is currently available for the MinnesotaCare Program through July 1995, surplus revenues would not be needed until that time.

Universal Coverage Plan: short-term financing

- The cigarette excise tax should be increased by 40 cents each year over the next five years. The revenue generated from the additional excise tax will be used for universal coverage and specific prevention initiatives.
  The Minnesota Health Care Commission's recommendations regarding cigarette and tobacco taxes are described in more detail in a separate report.

- Any remaining shortfalls in the MinnesotaCare Program for 1994 and 1995 should be covered through anticipated surplus revenues.

Comprehensive Benefit Set

It is critical that a comprehensive yet affordable benefit set be available to and utilized by all Minnesotans. The goal of universality will be measured by evaluating not only the number of persons who are covered by some kind of health plan, but also the type and level of coverage provided by the health plan. A single, comprehensive yet affordable benefits set should be uniformly applied to all private and public health plans and programs in Minnesota. This set will function as a floor for coverage for all Minnesotans, with additional coverage options available on the market for those who wish to purchase them.

This report recommends a comprehensive benefit set that some have argued may prove unaffordable. We believe affordability must be considered in terms of the goals of broader reform of health care financing and delivery systems. Just because a particular necessary service is not covered in a benefit set does not mean

there is no cost associated with that service. The need still exists, the cost is just shifted to someone else. While the up-front cost of the premium may be reduced by a more limited benefit set, the overall long-term cost to the purchaser, the consumer, government programs, and the entire community may actually increase. This is particular true when a benefit set does not cover primary and preventive care, or care that has been proven to be cost-effective.

For example, when mental health benefits are severely limited under an individual's health insurance policy, an individual who needs mental health treatment is more likely to forego needed treatment and let the condition deteriorate until a major crisis occurs, at which time services are provided by community hospitals, crisis centers, schools, law enforcement personnel, and other public and private agencies. As a result of the mental health crisis, the patient may lose his job and his employer-subsidized coverage and apply for Medical Assistance or state mental health programs. The costs are borne by taxpayers and by other health care purchasers who must absorb the unreimbursed costs incurred by those health care providers who provide the needed treatment and services. A comprehensive benefit set will benefit not only the patient but society as well.

The issue of a comprehensive benefit set is not just a cost issue. Even those who can afford to pay for uncovered services themselves have difficulty making sure these services are coordinated with other health care services. A comprehensive benefit set ensures that all needed services are coordinated and provided in the most efficient manner. In addition, limited benefit packages facilitate "cherry picking" and "cream skimming" by health plans and discriminate against persons with certain types of health conditions.

We must now approach benefit set issues in the context of a system that includes global limits on cost increases across the entire system and that eliminates cost shifting. We believe that when all costs to society are considered, a comprehensive benefit set is the most appropriate and affordable approach.

A commitment to this approach to benefits means that a process must be established for defining and refining the comprehensive benefit set.[7] Covered services should be identified on the basis of their benefit to society and the patient, based on reliable data on outcomes and effectiveness.

[7]A process for defining and refining the uniform benefit set is described in the ISN/RAPO Implementation plan developed by the Commissioner of Health in consultation with the Minnesota Health Care Commission.

Plan Component: Benefit set

- By January 1997, a universal, comprehensive benefit set will be established as the minimum standard of coverage which all Minnesotans would be required to maintain. This benefit set will also serve as the minimum standard for health coverage offered in ISNs and the regulated all-payer option.

- The universal benefit set will form the basis for coverage under the MA, GAMC and MinnesotaCare Programs. However, because many low-income persons served by these government programs cannot afford to pay the copayments required under this benefit set and because many need, but cannot afford to purchase on their own, some supplemental services that are not covered in this benefit set, wraparound programs will be developed to provide additional assistance to these persons to cover these costs.

Education and Outreach

Consumers often lack access to the information that would increase their knowledge of the health care system and empower them to use that system more effectively and efficiently. Consumers need information and assistance to make healthy choices about lifestyles and behaviors which reduce the prevalence of illness and injury. Consumers also need information to make good decisions about health care and to use the health care system appropriately.

The Commission believes that the state must continue and even expand its programs for reaching out and educating individuals regarding their need for health care, and assisting them in obtaining health care coverage. Existing programs such as the Information Clearinghouse, the Data Institute, community health services educational programs, and information and outreach programs within the Minnesota Department of Human Services, should be supported and adequately funded. Future efforts should expand upon these activities, and should be coordinated with public health activities as well as the "grass roots" activities of community and neighborhood groups. In particular, education and outreach efforts should target young children and their families.

Plan Component: Education and Outreach

- Education and outreach programs will be established and maintained by state agencies, by ISNs, and by employers and purchasers, to educate individuals regarding their need for health care and to assist them in obtaining health coverage.

- Education and outreach programs must be tailored to take into account the cultural diversity of our state; programs should be culturally sensitive and should strive to remedy the problem of unequal access to information that today prevents many Minnesotans from making full and effective use of the health care system.

- Existing education and outreach programs such as the Information Clearinghouse, the Data Institute, community health services programs, and information and outreach programs within the Minnesota Department of Human Services, must be supported and adequately funded.

- Monitoring and evaluation activities described in other sections of this report should be designed to determine which Minnesotans do not have access to affordable health coverage, are not enrolling in coverage when it is available, or are not receiving needed health care services. This information should be used to tailor consumer education and outreach programs to help these Minnesotans obtain coverage and services.

APPENDIX A

Special Studies

The Minnesota Health Care Commission will review the results and recommendations of each study described below and compile the information into one summary report which will assist in evaluation of overall reform efforts and development of recommendations for future strategies.

Robert Wood John Foundation Project Grant

Minnesota was awarded a Robert Wood Johnson Foundation (RWJF) grant just after the passage of the 1992 HealthRight Act to ensure that reform initiatives were properly designed at the outset and to bring the benefit of national experts and consultants to Minnesota. In addition to providing assistance in the development of cost control structures and a data collection plan, the grant project has several other components:

- The project was designed to evaluate the implementation of the MinnesotaCare program and related health insurance reforms to understand the interface between these two efforts and their effect on health care reform. As part of this effort, the Rand Corporation surveyed a sample of 2000 households in Minnesota to establish baseline data on whether Minnesotans can afford the health care they need. This includes specific estimates of the uninsured population and their characteristics as well as gaps in health care use and health status. The project began surveying families in May 1993, and the data is scheduled to be available in April 1994.

- The RWJF will also assist the state in evaluating the effect of reforms in the individual and small group insurance market. As part of this effort, Rand Corporation is surveying a sample of 2000 Minnesota employers to establish baseline data so that the effects of MinnesotaCare legislation on insurance offered by small employers can be assessed over time. The main areas of interest concern the effect of small group and insurance reform on the number of employers offering insurance, the type of coverage purchased, and the effects of reform on the MinnesotaCare subsidized insurance pool. The project began surveying employers in October 1993, and the data is scheduled to be available in April 1994.

- In the next stage of the project, the Rand Corporation will assist Minnesota in developing a long-term financial model for the MinnesotaCare subsidy program.

APPENDIX A: Special Studies

Department of Human Services

The Department of Human Services recently completed a study of the impact of MinnesotaCare on the increase in medical assistance enrollment and costs, as well as other factors which may be contributing to the increase in medical assistance enrollment.

Department of Health

The Department of Health recently completed a study of the feasibility of establishing medical savings accounts similar in concept to individual retirement accounts (IRAs) to help provide incentives for persons in Minnesota to forego unnecessary medical treatment and to shop for the best value in cases where treatment is necessary. This study was completed January 15, 1994.

Department of Commerce

The Department of Commerce is analyzing the effects of phasing out rate bands and moving to community rating on the availability of coverage, average premium rates, the number of uninsured and underinsured residents, the types of health benefit plans chosen by employers, and other effects on the market. This study will be completed by December 1, 1994.

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BOOK RATE