89-0093

An Overview Of Implementation Issues and Options For **Healthspan**

A Proposed State-subsidized Health Insurance Program For Minnesota's Uninsured

Prepared for The Minnesota State Legislature
By The Minnesota Department of Human Services

January, 1989

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EXECUTIVE SUMMARY

Minnesotans are concerned about people who lack health insurance and about the problems lack of insurance creates for health care providers and payors as well as the uninsured, themselves.

At any given time of the year, more than 342,000 Minnesotans lack health insurance. People who do not have health insurance delay or forego timely, appropriate medical care and, as a result, they may develop advanced conditions that can be more expensive to treat. They are more likely to use costly hospital-based services. Price competition in the health care industry has increased the financial pressures on providers who are less able to distribute the costs of the uncompensated care among the major purchasers. As a society, we are in general agreement that we want people to have ready access to health services. However, we can no longer rely on the charity of health care providers to fulfill this obligation.

In the past five months, the Department of Human Services has considered the policy implications of the uninsured and studied the proposal of the Healthspan report prepared by the Minnesota Department of Health and initiatives underway in various other states. At the request of the Legislature, the Department issues this report and makes the following recommendations to the Legislature to implement a state plan of health insurance to provide coverage to uninsured Minnesotans:

- **Adopt legislation that strongly supports establishment and implementation of a state health insurance plan for all uninsured Minnesotans within five years. Employers, insurers, health care providers, and clients will thereby have notice of the State's serious intent to assure access to health care services for all residents.**

- **Appropriate in this biennium sufficient funds to the Commissioner of Human Services to support the initial research and development that will provide the informational base for the detailed program design.**

- **Appropriate in this biennium sufficient funds to the Commissioner of Human Services to support two to four pilot projects to be initiated in the second year of the biennium. These pilot projects will test certain program design features on a small population before a comprehensive program is exposed to the larger population. There is still much to be learned in Minnesota as well as in other states.**

A report entitled "The Challenge of Providing Financial Access to Health Care in Minnesota" issued in 1987 by the Minnesota Department of Health stimulated public debate and legislation increasing access to medical care for low-income people. The report proposed

- a state-subsidize health insurance program called "Healthspan" that would bridge the gap between public medical assistance programs and private health insurance plans

- funding from state, local, and federal sources through an expansion of the Medical Assistance Program (MA) to the full extent allowed under federal law

- preservation of the current charity care system

That report and others issued concurrently outlined public policy options to address the financial access problem. Policy makers were challenged to provide the direction and financing for implementation even though detailed program designs were not prepared.

In the spring of 1988, the Legislature appropriated $25,000 and directed the Commissioner of Human Services to develop a plan with options by January 1, 1989 to implement the Healthspan proposal. Efforts to contract for the report were unsuccessful. With additional financial assistance from the Minnesota Department of Health, a professional staff person was hired to coordinate and prepare this report. A resource group was formed to provide technical assistance and offer the diverse points-of-view necessary for discussion of these complex policy issues.

Although the 1988 legislation used the term "program" to describe Healthspan, the Healthspan report in fact outlined only a program model. The Healthspan concept proposed

o universal coverage, up to 250 percent of the federal poverty level

o voluntary participation by uninsured individuals and employers

o a private insurance solution, relying on pre-paid plans, chosen under competitive bidding administered by the state

o financing by all levels of government, participating employers, enrollees on a sliding-fee basis, and possibly supplemented with additional revenues from insurers and providers

o a phase-in by geographic region over a five-year period

- a projected monthly premium of $65 per enrollee; projected administrative costs at eight percent of premium costs; and projected cost to the state of $135 million in the year of maximum likely enrollment (expressed in 1987 dollars)

The conceptional framework of Healthspan as described in the Department of Health's report is the starting point of our analysis of the issues and options related to implementation of a statewide health insurance plan for all uninsured Minnesotans.

This report is based on the following assumptions.

- All Minnesotans should have basic access to essential health services.

- Access to health insurance does not assure access to health care services for low-income families and individuals unless premium costs, co-payments and deductibles are heavily subsidized.

- The current system of paying the health costs of the uninsured through cross-subsidies is breaking down under price competition and must be replaced with an explicit and equitable method of financing.

- Private health insurance benefits are heavily subsidized. Any state-sponsored program which extends access to the uninsured will be expensive and require significant public subsidies, and possible private financing through employer and employee mandates as well.

- Costs related to uncompensated care will decrease but not disappear.

- A state-subsidized health insurance program is likely to require a multi-year implementation period. Accordingly, incremental strategies will be outlined as part of a broad, integrated approach which is intended to ultimately offer universal coverage.

The report begins by describing the various population groups that make up the "uninsured". For policy purposes it is important to understand how and why the uninsured differ from the insured.

The overview is followed by a description of other state initiatives. While these initiatives have only recently been enacted, each has taken a different approach to address the same problem. These state initiatives will be referred to in our discussion of Healthspan.

In the two years since Healthspan was first proposed, more information has become available. In Part Three, we present the conceptual framework in the Healthspan proposal, examine each of the issues, then describe various options for implementation. Legislative proposals for a state health insurance plan, will be differentiated by the way each addresses these issues and options. Where the Department of Human Services disagrees with the Healthspan proposal, the Departmment makes a specific recommendation. For example, the Department does not support folding the GAMC population and funding revenues into Healthspan for the reasons given in this section.

Part Four describes how a Healthspan program would coordinate with other publicly funded health care programs. Existing programs are described and recommendations are made as to whether or not the program could or should be folded into such a plan.

Because Healthspan's implemention would require a major commitment of state resources, and becuase it would be necessary to phase it in or otherwise delay full implementation for a few years, this report includes targeted approaches to increase access to health care services in Part Five. While these proposals do not replace a comprehensive program, they do reduce the number of uninsured.

In the final section, this report makes recommendations for the next steps to implement a state health insurance plan. Implementation of a state health insurance plan will be very expensive. Commitment and preparation for this major initiative are important.

INTRODUCTION

The Problem

At any given time in the year, an estimated 342,000 Minnesotans lack health insurance. People without health insurance may delay or forego timely, appropriate medical care. As a result they may develop advanced conditions which can be more expensive to treat, and they are more likely to use costly hospital-based care. Competitive pressures in the health care industry now limit the ability of hospitals to distribute the costs of uncompensated care for uninsured people among major purchasers placing uninsured people at risk.

Background

In 1987, the Minnesota Department of Health studied the problem of financial access to health care in Minnesota and issued a report proposing the following solutions.

- o Establish Healthspan, a state-subsidized insurance program providing managed, prepaid care to the uninsured and underinsured poor

- o Expand Medical Assistance (MA), the state, local and federally funded health insurance program for medically indigent Minnesotans to the full extent allowed under federal law

- o Preserve the current charity care system

The State Legislature reviewed this report and other reports prepared by community groups and the University of Minnesota.

During the 1987 Session, the Legislature

- Expanded MA for the elderly, blind and disabled, and for families with children

- Dedicated one cent of the state's cigarette tax to a new Children's Health Plan for uninsured pregnant women and children up to six years of age in families making less than 185 percent of the federal poverty guidelines for primary and preventive care

During the 1988 Session, the Legislature

- Expanded MA benefits which include inpatient hospital services, mental health and chemical dependency services to pregnant women and infants up to one year of age in families making less than 185 percent of the revised federal poverty guidelines

- Amended the Children's Health Plan to include children from one to eight years of age; only ambulatory, primary and preventive care services remain covered

(For a family of four the maximum annual income allowed under these programs in 1988 was $21,552.)

- Provided funding to address the issues of the uninsured

  o $200,000 to the Health Ensurance Coalition for a demonstration program that will enroll employed, uninsured residents in nine counties in northeastern Minnesota in a health benefits plan

  o $40,000 to the Willmar area CAP for a demonstration project that will address the concerns of the insured in four rural counties

  o $25,000 to the Department of Human Services to develop a plan with options to implement Healthspan, a statewide, state-subsidized plan of health insurance proposed by the Minnesota Department of Health in 1987 (See Appendix A, Enabling Legislation.)

The Healthspan proposal was reviewed, and interested legislators sponsored hearings across the state. The Minnesota Department of Human Services was directed in spring 1988 to develop an implementation plan for Healthspan by January 1, 1989. The Department respectfully submits this report to the Legislature, pursuant to Minnesota Statutes 1988, Chapter 689, Article 2, Section 249.

Scope and Purpose of Report

This report provides an overview of the implementation issues and options associated with Healthspan, the proposed state-subsidized health insurance program for uninsured Minnesotans.

This report is not a program blueprint. A considerable investment of time and resources well beyond the scope of this effort is necessary before Healthspan can be fully developed. Critical policy decisions setting direction and parameters must first be made in order to lay the groundwork for establishing a successful program.

The goal of this report is to stimulate and guide informed discussion of the major implementation issues and options. It is intended to help the Legislature and other policy makers evaluate different approaches for structuring and funding this initiative. The Department of Human Services hopes that this report will lead the Legislature to specific pathways that will enable the state to develop and execute a plan for assuring access to health care for all Minnesotans.

Assumptions

This report is based on the following assumptions.

- All Minnesotans should have basic access to essential health services.
- Access to health insurance does not assure access to health care services for low-income families and individuals unless premium costs and deductibles are heavily subsidized.
- The current system of financing the health costs of the uninsured through cross-subsidies is breaking down under competition. It must be replaced with an explicit and equitable method of financing.
- Private health insurance benefits are heavily subsidized. Any state-sponsored program which extends access to the uninsured will be expensive and require significant public subsidies and possibly private financing as well. Costs related to uncompensated care will decrease but not disappear.
- A state-subsidized health insurance program is likely to require several years to fully implement. A broad, integrated approach to universal coverage using incremental strategies is recommended.

Methodology

This report was researched and prepared over a three month period beginning in August 1988 by a team of part-time and temporary staff assembled by the Department of Human Services with financial assistance from the Minnesota Department of Health. The team was assisted by a Resource Group composed of 45 individuals representing the state legislature, state agencies, employers, labor, insurers, providers, consumers, and county governments. (See Appendix B, Resource Group.)

Information gathered from interviews with these and other individuals, small group discussions on specific issues, and Resource Group meetings was used to develop this report. The team also studied initiatives from other states, federal legislation, and related public programs in Minnesota.

The Department of Jobs and Training recently funded COACT to convene a series of local focus groups around the state to heighten awareness of the issues related to a lack of health insurance. This effort will bring more public input to the discussion.

The appropriation of $25,000 did not allow for actuarial analysis, market research, or expert technical assistance. States that have funded surveys and actuarial work found the investment worthwhile in generating credible objective data to promote public understanding, inform legislative action and guide program development.

Contents

This report is organized in six parts.

Part One describes the numbers and characteristics of Minnesota's uninsured and reasons why people are uninsured.

Part Two describes approaches taken by other states to bridge the financial access gap to health care.

Part Three describes Healthspan and addresses the implementation issues that were specified by the Legislature. The major questions associated with each issue are identified and discussed, and different options are evaluated.

Part Four describes current public programs and their potential relationship with Healthspan.

Part Five describes targeted approaches to reducing the number of uninsured individuals and describes current and proposed initiatives in Minnesota which use these approachs.

Part Six recommends next steps.

The report concludes with four appendices. Appendix A contains the legislation requesting this Healthspan implementation plan. Appendix B contains the Resource Group roster. Appendix C summarizes other state initiatives. Appendix D contains federal legislation on the uninsured. Appendix E describes Minnesota public programs providing health coverage.

PART ONE
OVERVIEW

THE UNINSURED

The uninsured are people who lack private or public health insurance.

NOTE: The following profile of uninsured Minnesotans is drawn from "Analysis of Health Insurance Coverage and Health Care Utilization and Expenditures in Minnesota for 1985" conducted by the consulting firm ICF Inc. for the Minnesota State Planning Agency. By applying statistical projection techniques to data from the 1977 National Medical Care Expenditures Survey and the 1976 Survey of Income and Education, ICF projected the numbers and characteristics of uninsured Minnesotans for 1985. These projections are consistent with current national statistics and represent the best data available at this time.

Numbers

In Minnesota

- 60 percent of residents receive subsidized health insurance through employment.

- 21 percent receive subsidized health insurance through public programs such as Medicaid or Medicare.

- 11 percent purchase individual health insurance policies.

- 8 percent have no health insurance.

Figure 1 shows the percentage of insured and uninsured in Minnesota.

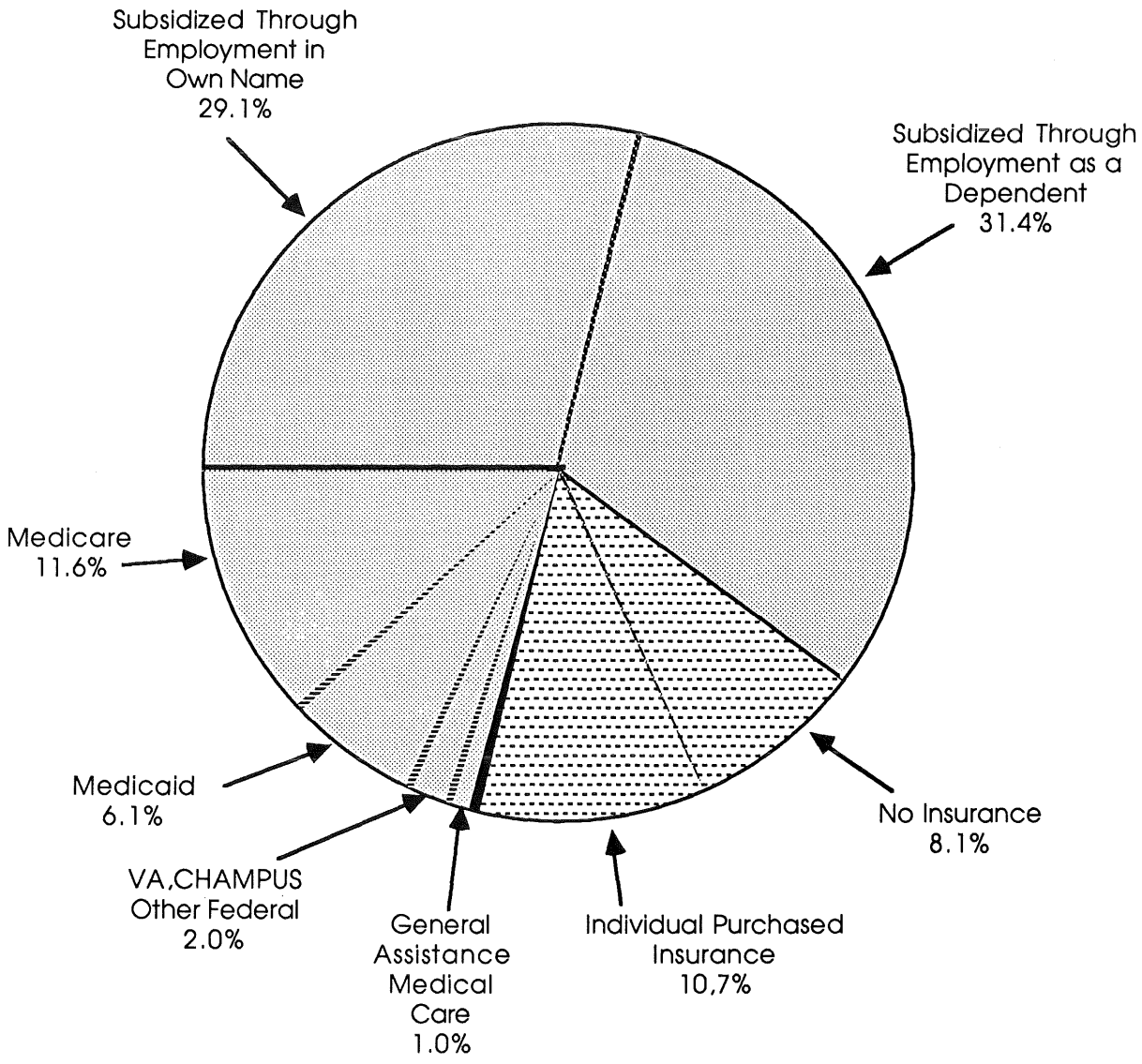
Nearly 11 percent of state residents are uninsured for all or part of the year. At any given time, 342,000 people--8 percent of the population--have no insurance.

- 246,000, 5.8 percent, are without insurance for the entire year.

- 209,000, 4.9 percent, are without insurance part of the year.

Figure 1

Percent of Minnesota Residents With and Without Health Insurance



For Uninsured Project
Information for this Chart
From Department of Health Healthspan Report, p2.
Based on Kennel and Sheils Study Conducted
1985 for State Planning Agency

Characteristics

Income

in Minnesota

Half of the uninsured have low incomes.

- 52 percent earn less than 200 percent of the federal poverty level--an annual income of less than $23,334 for a family of four.
- 31 percent have incomes below the federal poverty level--an annual income of $11,627 for a family of four.
- Most uninsured children are poor, while most uninsured adults are not.

Figure 2 shows the percent of Minnesota's uninsured by income.

Figure 3 shows the percent of Minnesota's uninsured by income and by sex.

Figure 4 shows federal poverty guidelines by annual income and hourly wage.

Figure 5 shows the percent of uninsured below federal poverty intervals.

Age

In Minnesota

- Over half of the uninsured are under 25 years of age; 30 percent are children under 18.
- About 41 percent are between the ages of 25 and 54.

Figure 6 shows the percent of population that is uninsured by age.

Race and ethnic origin

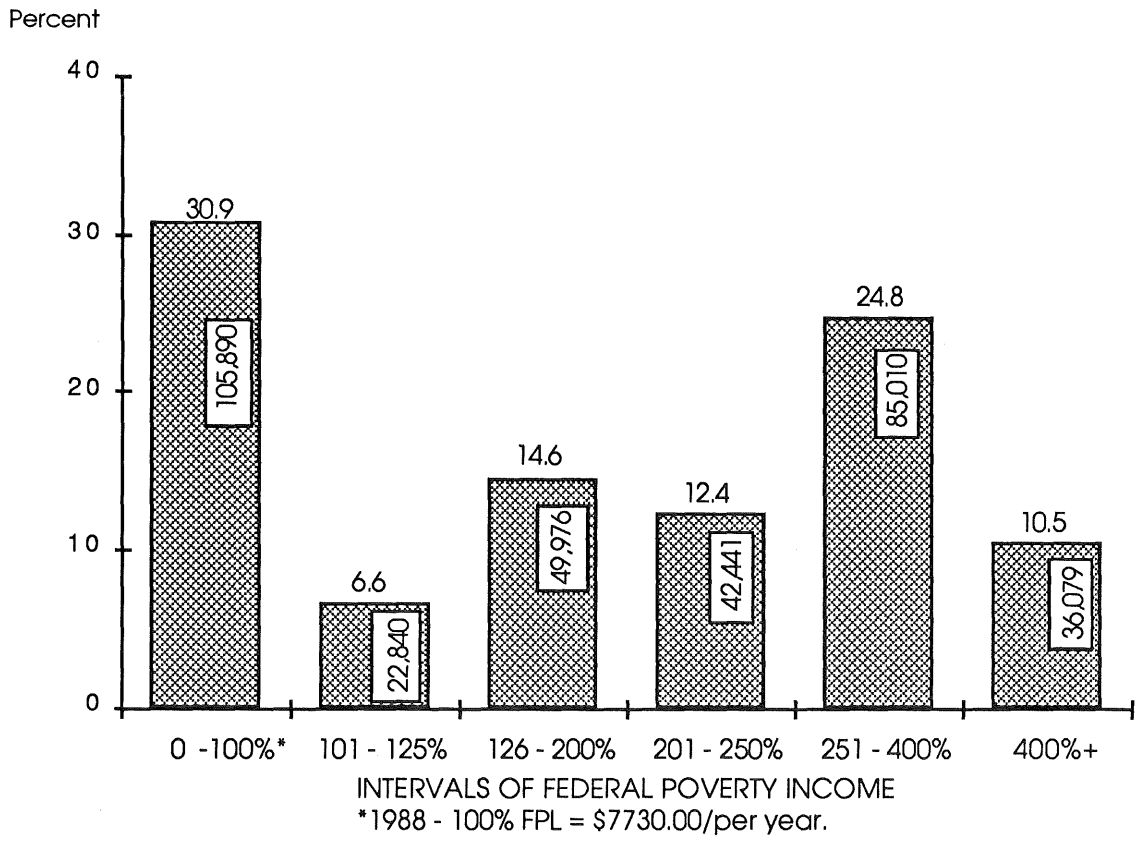
In Minnesota

The uninsured include persons of all races and ethnic orgins.

- Blacks are more likely to be uninsured than whites or Hispanics.

FIGURE 2

MINNESOTA RESIDENTS WITHOUT HEALTH INSURANCE BY INCOME

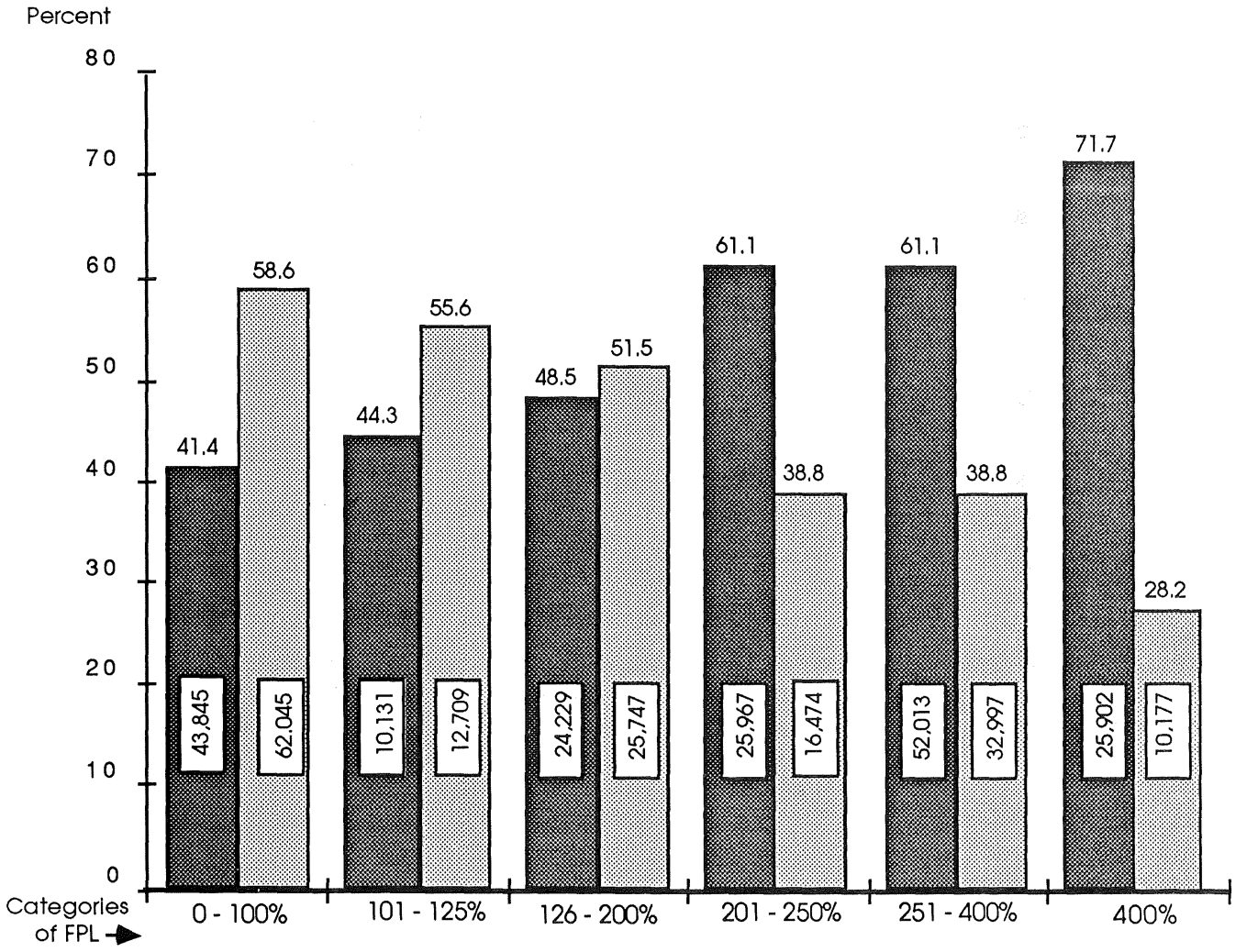


Total Number of persons in Minnesota without Health Insurance.	342,236

DEPARTMENT OF HUMAN SERVICES
UNINSURED PROJECT
Data from DHS, Reports and Statistics
November, 1988

FIGURE 3

MINNESOTA RESIDENTS WITHOUT HEALTH INSURANCE BY SEX AND INCOME



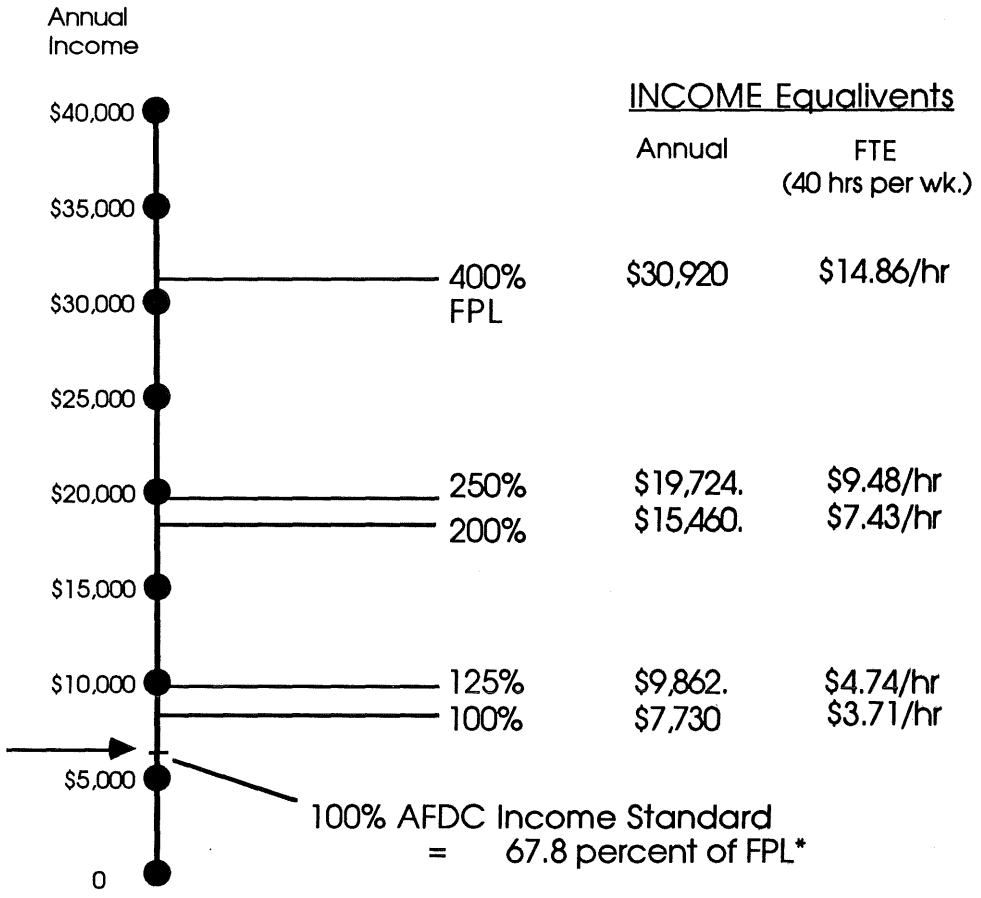
TOTAL# of Minnesota Residents Without Health Insurance.

MALE.....182,087
FEMALE.....160,149
342,236

For Uninsured Project
INFORMATION on this Chart from Department of Health Healthspan Report, p2
BASED ON KENNEL & SHEILS STUDY CONDUCTED FOR STATE PLANNING AGENCY 1985

FIGURE 4

FEDERAL POVERTY INTERVALS and HOURLY WAGE*

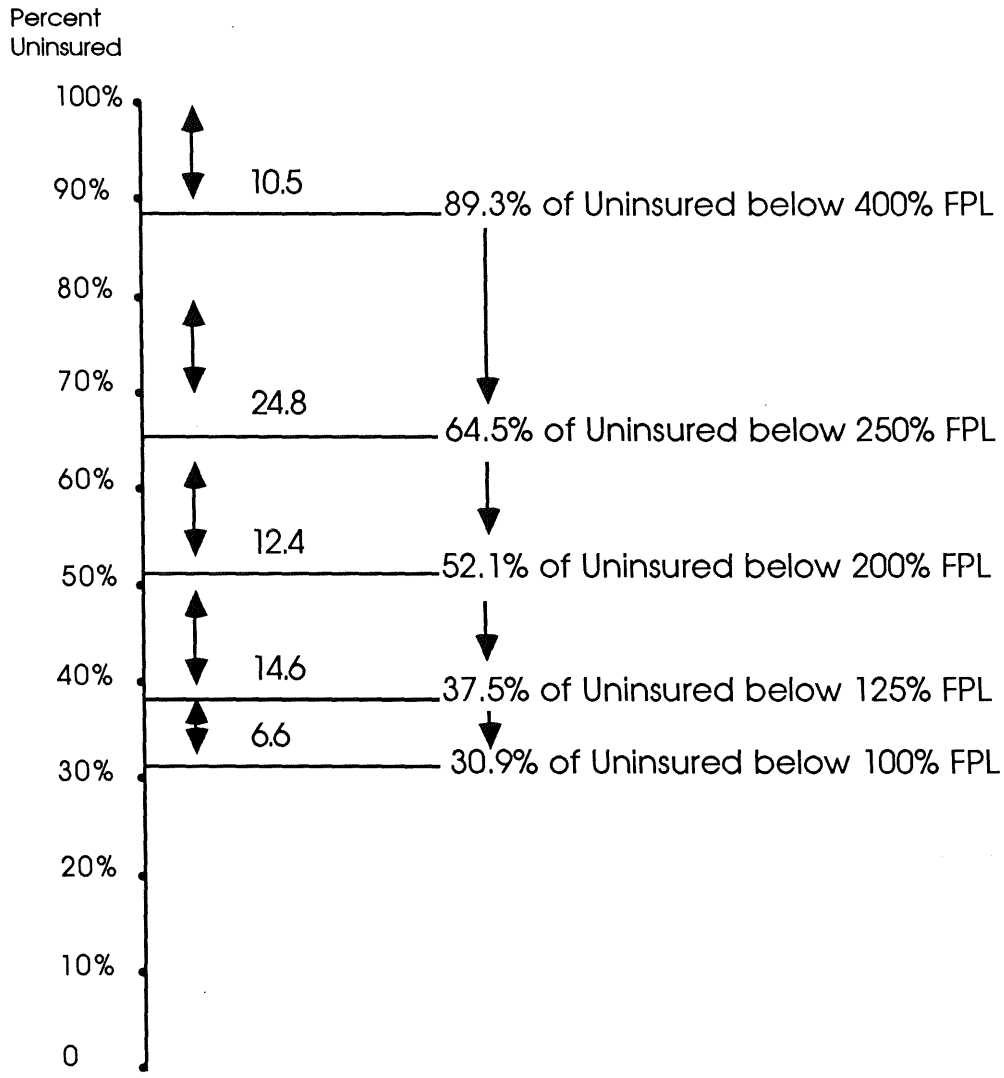


DEPARTMENT OF HUMAN SERVICES
UNINSURED PROJECT
November, 1988

*100% AFDC = $5244.00
100% FPL = $7730.00

FIGURE 5

Cummulative Percent of Persons Without Health Insurance Below FPL Intervals



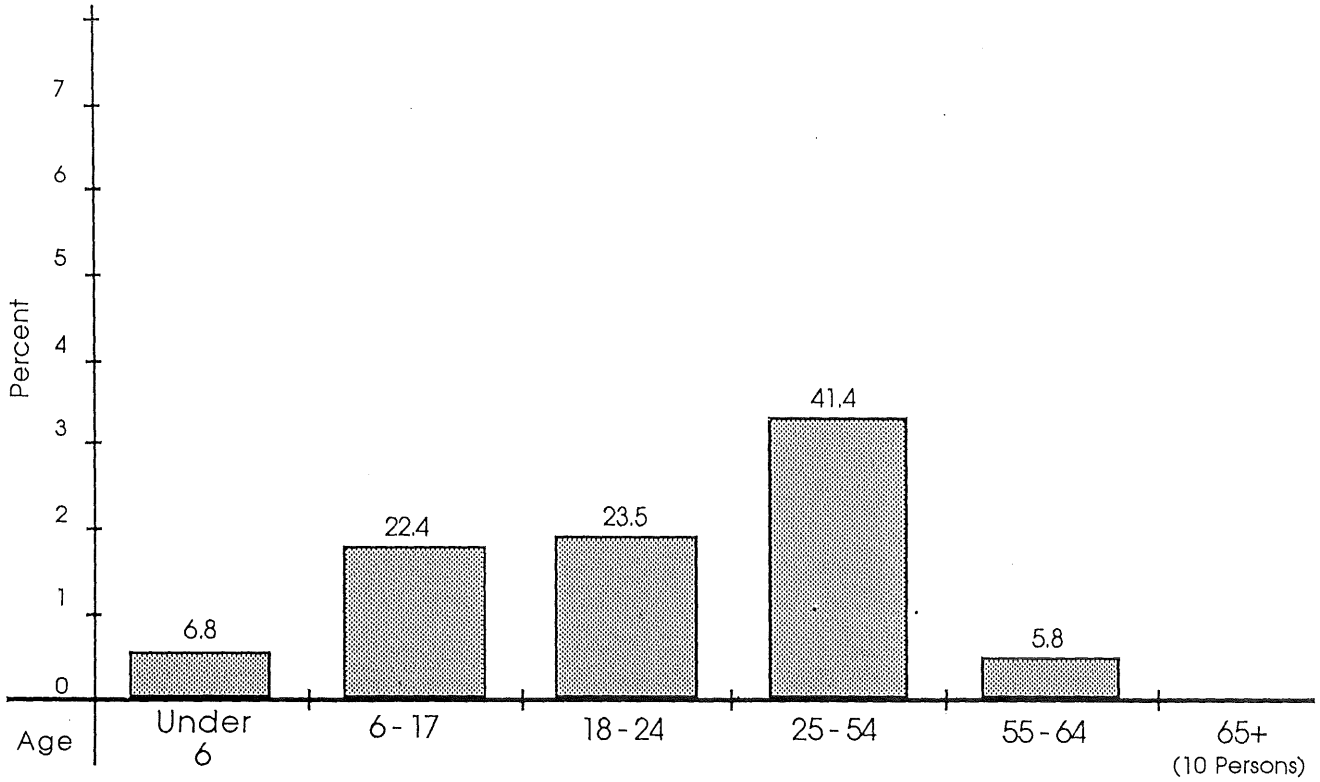
Total Number of Minnesota Residents Without Health Insurance	342,239

DEPARTMENT OF HUMAN SERVICES
UNINSURED PROJECT
November, 1988

FIGURE 6

Percent of Total Population that is Uninsured Presented by Age Categories

8.18 (Total Minnesota Population without Health Insurance



Total Number of Minnesota Residents Without Health Insurance	342,236	8.18%

For Uninsured Project
Information for this Chart
From Department of Health Healthspan Report, p2.
Based on Kennel and Sheils Study Conducted
1985 for State Planning Agency

PART TWO
OTHER STATE INITIATIVES

As a result of growing awareness of the uninsured population, many states have launched initiatives to expand the availability of health care services for those who lack health insurance and cannot afford care. Virtually all state initiatives researched for this report are directing efforts to improve the scope of affordable insurance coverage for vulnerable target groups. Three states--Massachusetts, Washington and Wisconsin--have been looking extensively at the problem of the uninsured. Each state has had a different response and has designed a more or less comprehensive health insurance program.

Figure 7 compares these three state proposals.

Massachusetts

Massachusetts has developed the most comprehensive program to date. In April 1988, Governor Michael Dukakis signed the bill which will extend access to health insurance for most of the state's uninsured.

This initiative features significant employer participation. It establishes two special taxes on employers to fund health insurance for the unemployed uninsured and the working uninsured. Since the second tax is applied only to employers who do not already provide insurance to their employees, it is an incentive for direct coverage by employers. Additional incentives include tax credits, small business health insurance pool, insurance brokering, and hardship funds.

The Massachussetts plan also includes CommonHealth, an extension of Medicaid which will provide coverage to disabled adults, disabled children, pregnant women and infants to age one, children to age five, and newcomers into the work force (welfare-to-work). The plan also addreses the management of hospital uncompensated care pools. (See Appendix C, Summaries of Other State Initiatives for further details.)

Different aspects of the Massachussetts plan will be phased in gradually through January 1992. The new Department of Medical Security is in charge of the program.

Reservations remain about the plan's extensive costs and legality. Most criticism refers to the cost and financing of the project. A challenge to the new employers' taxes on the

FIGURE 7
COMPARISON OF PROPOSALS FOR COMPREHENSIVE
STATE HEALTH CARE PROGRAMS

	WASHINGTON	WISCONSIN	MASSACHUSETTS
PROBLEM	-18.6% of population under 65 is uninsured -37% of uninsured have incomes under poverty & 57% have incomes under 200% -37% of uninsured are children -55% of uninsured work full-time or part-time.	-11.4% of population (1986) is uninsured -49% with income under 200% of poverty are uninsured -86% of uninsured live in households with one worker -33% of uninsured are children	-approximately 12% of population is uninsured
OVERALL SOLUTION	-Establish a Basic Health Plan for uninsured poor.* -Expand Medicaid eligibility. -Establish High Risk Pool for uninsurables with incomes over 200% of poverty (which bought Omaha's package) * enrollment of 20,000 individuals in five different congressional districts	Three pilot plans will be implemented in three different counties and will begin between January 1 & June 1. -The Subsidy for Low-Income Employees of Non-Insuring Firms (Pilot 1) to promote group plans by encouraging to provide health insurance to their employees (800 individuals to enroll) -The Subsidy for Low-Income Employees of Insuring Firms (800 individuals to enroll) -The Alternative Health Care Coverage Pilot to help disabled workers to get health coverage (400 ind. in the Milwaukee area)	Health Care Bill signed 4-21-88 -Creation of new Department of Medical Security whose role is to provide insurance coverage to all uninsured residents -Expansion - Medicaid eligibility with the Common Health program. -New employer mandates: a special surcharge on employers who don't provide insurance to their employees and another small one on all employers in order to finance the project -New hospital financing and cost-containment pool -School mandated benefits for students
ELIGIBILITY	Determined by BHP -have a gross family income of less than 200% of poverty -be under age 65 -not be eligible for Medicare -reside within the service area of a participating managed care system	-All Pilots: Applicants family income below 175% of poverty (prior 6 months). -Pilots 1 & 3: applicant w/ income over 175% of poverty is not eligible to participate in pilot activities -Pilot 1&2: Applicant for subsidy is working full-time or part-time (see adm. rule). Up to 20 subsidy slots per firm -Pilot 1: Firms of 19 employees and fewer	-Use income or resource test for DMS coverage -Full-time student covered by school -Five programs regrouped under the same Common Health & administered by the Dept. of Public Welfare: Disabled adults (1,000-2,000 ind.), disabled children (over 1,000), pregnant women & infants to age 1 (185% of poverty, 4,000 women), children to age 5 (100% of poverty, 5500 children) extended coverage for clients working for those employers who don't provide insurance (185% of poverty, 4,000 families, 12,000 individuals)
COVERED SERVICES	-doctor visits, hospital services, lab, & x-ray services, emergency care & ambulance services, preventive services such as full range of OB services and well child care -Long-term care not covered	-Pilot 1: CI approved group health plans with NAIC recommended scope of services; maximum annual limit for out-of-pocket costs for covered expenses of $1,000 for individuals & $2,500 for families -Pilot 2: Any grouphealth plan marketed in the state -Pilot 3: Any full Medicaid plan marketed in the state, coordinated with benefits of employer-provider plan	-Original Basic Plan included: physician care, inpatient and outpatient hospital care, prescription & lab services, preventive health services, alcohol & drug abuse treatment & home health care -Long-term care not covered -New plan to be announced -Common Health packages vary for each group (see appendix)

Employment status

In Minnesota

- 75 percent of uninsured adults are employed; 40 percent are employed the entire year; 35 percent are employed part of the year.

  The working uninsured are most likely to be employed in non-farm labor, farming, service sector, or craft and kindred.

- 25 percent are not employed.

- 36 percent of all the unemployed are uninsured.

The uninsured population is heterogeneous. It includes children, young adults, and adults. It includes workers, the self-employed, the unemployed, home-makers, and students. In general, those who are young, low-income, and without full-time employment are more likely to be uninsured.

WHY PEOPLE ARE UNINSURED

People without health insurance can be categorized into three basic groups--the uninsurable, the unemployed, and the working uninsured.

The Uninsurable

The "uninsurable" are people who have a pre-existing illness or medical condition. Because they are classified as a "poor risk," insurance companies will not offer them health coverage at standard rates. Insurance companies will either deny coverage, charge a penalty, or exclude from any purchased coverage medical costs related to the illness or condition.

(The Minnesota Comprehensive Health Insurance Plan, a risk pool of insurers and HMOs, offers coverage, at a price slightly above market premiums, to people who have been denied coverage or who would be financially penalized by either greatly increased premiums or coverge that excludes reimbursement for care related to the pre-existing illness or condition. This plan is an option for Minnesotans who can afford the premiums. Other public programs are available for children or adults who have special medical needs, are low income or have incurred medical bills that reduce their income to the eligablity level. These public programs are described in Part Four, Coordination with Other Public Programs.)

The Unemployed

The unemployed includes people and their families who 1) never had insurance and now have no job, 2) are unemployed because of a disability that would add to the employer's benefits cost, and 3) are unemployed and cannot afford to continue insurance coverage, even at group rates.

The Working Uninsured

The working uninsured are people who are employed but do not receive insurance benefits for themselves or their families. This is the largest group of uninsured people; 75 percent of the uninsured are employed or are the dependents of an employed person.

Employer-sponsored health coverage is the cornerstone of America's health insurance system. A federal tax system that allows employers to buy health insurance with pre-tax dollars has led to extensive privately subsidized coverage of American workers and their families. Employers are also motivated to offer health insurance to maintain a stable, productive work force, remain competitive in the labor market, and to meet unions' collective bargaining agreements.

The Congressional Research Service reports that the most significant factor in the increasing numbers of uninsured people is declining coverage for spouses and children.

Why workers are uninsured

In order to design effective remedies to this growing problem, it is important to understand why workers and their families do not have health benefits.

o The employer has no plan.

  Businesses that do not offer health insurance share these characteristics:

  - employees have low wages

  - the business is small and disadvantaged in buying health insurance

  - the business is unincorporated and disadvantaged by tax laws

  - the business is in an industry, such as trucking, which typically does not offer insurance benefits

o The employee does not qualify for the employer-sponsored plan.

Employees may be excluded from coverage because of

- part-time status
- years on the job
- wage or responsibility level
- age
- medical condition
- other risk factors that do not meet the underwriting guidelines

o The employee chooses not to enroll in the employer's plan.

Employees may reject coverage because

- they already have coverage at lower cost or with better benefits through another source
- they cannot or feel they cannot afford the employee share of the premium
- the cost of the insurance appears to exceed the benefits
- they do not understand the value of insurance

Nationally, for every 35 people not insured through their employer, 13 are unable or unwilling to buy coverage, 12 do not qualify for the plan, and 10 work for an employer that does not offer health insurance benefits.

Policy implications

NOTE: This section draws on analysis in "Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage" by Irene Fraser, American Hospital Association, 1988.

Because of their low salaries, most of the employed uninsured are unable to afford individual policies; therefore, they must rely on employer-sponsored group policies. If a significant portion of the premium must be paid by the employee, even a group plan will be unaffordable for many.

Businesses that do not offer insurance tend to have low salaries and often low profits as well. In order for health benefits to be feasible and attractive, the costs of group coverage will have to be quite low, and, for some groups, subsidized.

Incentives for offering group health insurance appear to be stronger for large businesses, regardless of salary structure. A major component of any policy to increase employee coverage must include incentives for small businesses.

Initiatives to promote coverage must pay attention to unincorporated businesses, regardless of size. Strengthening tax incentives and educational programs to increase businesses' awareness and savvy may also help.

Creation of insurance plans in uninsured businesses address only part of the problem, since most of the employed uninsured work in businesses which already have insurance plans.

According to a knowledgeable actuary who responded to this report, employers could improve the availability of coverage in the following ways:

- Employees who are employed by employers who offer health insurance should be required to purchase it. This requirement would affect as many as 50 percent of the uninsured.

- If an employee is classified as a poor risk, the employee should enter the MCHA pool, and the employer contribution should be applied to the MCHA premium.

- The state should subsidize dependent coverage for low-income employees' children--but not spouses--in order to keep premium costs low.

- Employers should be encouraged to allow parents who are employees to continue dependent coverage past the limiting age.

- Employers should be encouraged to expand the age limit for dependents.

- Employers who offer flexible benefits should require all employees to select at least minimal coverage and not allow any employee to take cash in lieu of health insurance, if the employee cannot show evidence of coverage through a spouse.

Proposals must consider dependents as well as worker coverage. Many of the most vulnerable uninsured are living in families where the provider has coverage but has not been able or willing to pay the premium required to insure other family members.

According to the 1985 "Employer Health Benefits Survey" conducted by the Minnesota Department of Health and the University of Minnesota Center for Health Services Research, Minnesota employers who do not offer health benefits

- are small in size

- have large, part-time work forces

- are predominately in the trade and services sectors

- are located outside of the Twin Cities metro area

- have a low rate of unionization

Small business size and the expense and availability of health insurance were the most common reasons why survey respondents did not sponsor health benefits. These results are consistent with national findings. Employers and employees will need education about the costs and benefits of any state-sponsored plan; and some will need subsidies to provide sufficient incentive to purchase the plan.

FIGURE 7 (continued)

	WASHINGTON	WISCONSIN	MASSACHUSETTS
COST SHARING	-Premium Per Household: Gross family income as % of Federal Poverty Level under 75% of poverty $ 7.50/mo 75- 99% of poverty 15% 100-124% of poverty 20% 125-149% of poverty 30% 150-174% of poverty 50% 175-199% of poverty 75%)200% 100% Co-Payments Physician $5/PCP visit; $0 for authorized referral Hospital $0 Maternity $50/inpatient admission Lab & X-ray $0 Emergency & out of area $25 ($50 if non-participating provider waived if inpatient admission) Ambulance $0 Prev. Care $0	Pilot 1 & 2: Subsidy is a percent of premium based on net family income or as defined by administrative rule. -Pilot 1: insurers are asked to allow employer contributions of at least 33% of employed premium costs; $250 deductible, 80/20 co-pay. -Pilot 3: Subsidy is a percent of premium based on net family income or as defined by administrative rule; State pays the subsidy directly to fiscal agent	-Premium, co-payments and deductibles to be decided in the future. Based on a sliding-fee depending on family income and size.
ADMINISTRATION AND STRUCTURE	-Run by the Washington Basic Health Plan, an independent agency of state government -Negotiated capitated contracts with medical care plans (BHP) -Incentives for Basic Health Plan enrollees to stay in BHP -Two year emplementation (88-90) -State oversees solvency and quality of care	-Private administrator chosen throught competitive bidding -Local advisory committee to monitor quality -State Health Insurance Program (SHIP) has general oversight -Chamber of Commerce (Pilot 1) and community groups (Pilot 2) are active locally	Establishment of a Department of Medical Security, under auspicies of the office of Human Services -DMS will buy benefit plans for eligible residents will manage funds from employers' contributions & the current $325 million from the hospital free care pool. It will also carry some research on health insurance and uninsured. -In addition, DMS administers insurance brokering, small business health insurance pool, tax credits, and hardship funds to help small business providing health coverage to their employees
COSTS	Basic Health Plan -$77-80 per person per month -$38 million for two years includes administrative costs: 8%/first year, 5%/second year	$1.08 million for two year pilot programs $300,000 for administrative costs	Net cost in FY '88 $32 mill., FY '89, $56.4, FY 90 $15.34, FY '91-$195.4, FY '92 $162.7 -The Common Health will be authorized to pay hospitals up to 115% of uncompensated care costs in the prior year & 50% of any cost in the prior year & 50% of any cost above the 115% threshold.
FINANCING SERVICES	-Medicaid expansion -Appropriation of $34 million (due to start date) from the general revenues -Enrollee payments	-State -Enrolled individual	-Employers' participation is a .12% unemployment health insurance contribution on the first $14,000 of an employee wage ($16.80 per worker for employers with 6 or more employees to help finance insurance for the unemployed uninsured. -A 12% contribution on the first $14,000 of employee's wage ($1,680 per worker); for employers with 6 or more employees to help finance insurance for the employed uninsured; employers who provide health benefits can deduct this cost -Hospital free care pool $325 million-FY '88, $318 mill.-FY '89, $312 mill.-FY '90, $277 mill.-FY '91 -Medicaid expansion-See budget in appendix

basis of the Employee Retirement Income Security Act of 1974 (ERISA) seems probable. An exception from ERISA was attempted but not pursued. Specialists argue that ERISA limits are respected.

Washington

The state of Washington was the first state to pass a bill establishing a major health insurance program for the uninsured. Legislation passed in June 1987, an administrator hired in January 1988, and development began in April 1988.

Washington's Basic Health Plan is being implemented in five Congressional districts with start-up funding for two years. The plan will contract with a small number of providers. Twenty thousand individuals are expected to enroll during the funding period. An evaluation of the project will be conducted by the University of Washington. Additional funding will be required to continue the plan beyond this initial period.

Wisconsin

Wisconsin conducted extensive studies on the uninsured with help from the Robert Wood Johnson Foundation. The Legislature provided funding for three pilot projects based on this research. Each project addresses one segment of the uninsured population--employees of non-insuring businesses, employees of insuring businesses, and working disabled adults in the Milwaukee area. All will be implemented by June 1989.

Other States

In 1986-1987, the Robert Wood Johnson Foundation awarded fifteen grants under its Health Care for the Uninsured Program. As a result, fifteen states have launched programs as part of a national initiative. While each demonstration site has a special emphasis unique to the state, primary features of these programs generally include

- extending private health insurance coverage to low-income, uninsured workers employed by small businesses

- developing affordable health insurance products by limiting benefit coverage and using efficient delivery systems

- maximizing private sector financing through employer contributions for health insurance premiums

- using state subsidies to assist low income people in obtaining health insurance

Some examples are:

Maine--managed care system to serve multiple target populations, each with a separate payment mechanism: AFDC/Medicaid, employed uninsured, low-income employed in small firms, and people at or below poverty level

Michigan--create incentives to encourage low-wage employers to offer health insurance to former welfare recipients, includes premium subsidy of at least one-third and may go up to two-thirds if employee income is below 200 percent of the poverty guideline

Arizona--offer employers a choice of four benefit plans ranging from a traditional HMO plan to a catastrophic-only option; employers are encouraged to contribute

Utah--target a reduced benefit plan option to small businesses with eleven of fewer, low-income employees

States which are committed to take action need to make important policy decisions concerning program design.

At this time there is no national concensus on how to approach the problem of the uninsured. Many states are studying the issue, some are sponsoring demonstrations, and a few have launched major initiatives. Only after several years of experience will there be enough information to evaluate the different strategies now being considered and tested.

PART THREE
HEALTHSPAN: IMPLEMENTATION ISSUES AND OPTIONS

HEALTHSPAN--A CONCEPTUAL MODEL FOR MINNESOTA

Healthspan is a conceptual model for a state-subsidized health insurance program. The purpose of Healthspan is to bridge the gap between subsidized health insurance for the poor and the employed. It was proposed in 1987 by the Department of Health in a report entitled "The Challenge of Providing Financial Access to Health Care in Minnesota".

The report's intent was to stimulate discussion among the Legislature and interested public about this financial access problem. It was not necessarily intended to serve as the final solution to meeting the coverage needs of Minnesota's uninsured. The report acknowledged that extensive planning would be required if the Healthspan model was adopted by the Legislature.

Healthspan proposes

- universal coverage, up to 250 percent of the federal poverty level

- voluntary participation by the uninsured and employers

- private insurance solution using prepaid, managed care

- purchase of health insurance for the uninsured poor through competitive bidding and program administration by the state

- financing by all levels of government, participating employers, and enrollees on a sliding-fee scale possibly with other revenue sources such as insurers and providers

- five year program phase-in by geographic region leading to statewide availability

- premium of $65 per month per enrollee; administrative costs at 8 percent of premium

- projected cost of $135 million in the year of maximum likely enrollment expressed in 1987 dollars

This conceptual framework is the starting point of our analysis of Healthspan's implementation issues and options.

IMPLEMENTATION ISSUES AND OPTIONS

Employer Participation

The incentive structure of employer participation in a state-subsidized health insurance program is one of the most important policy issues facing the Legislature. It affects virtually all of the major design features including eligibility, administration, enrollment, program costs, and financing.

Washington and Massachusetts, the two states that have enacted legislation authorizing major program initiatives for the uninsured, have taken very different approaches to this issue. Washington has no formal avenues for employer participation. The state's original legislation contained an employer payroll tax; however, this measure failed to win necessary support. Massachusetts built its model on a set of incentives and penalties that are intended to both promote and preserve private insurance in the work place as well as help support state-administered programs for the uninsured.

Employer participation is critical because most of the uninsured are workers and/or their families and employer participation brings most of the uninsured into a system of health insurance.

- Nationally, 75 percent of the uninsured live in families with an employed member; over half live with a full year, full time worker. In Minnesota, an estimated 75 percent of uninsured adults work full or part-time. The uninsured may be part-time or marginal workers in large or small companies, employees of small businesses, the dependents of full-time workers, the self-employed, or those employed in certain sectors that typically do not provide coverage such as personal services and retail trade, or in uninsurable industries.

- Private coverage through employment is the most common source of payment for health insurance. State or regional efforts to extend benefits to the uninsured should avoid incentives for employers or employees to drop work place coverage. Approaches need to address the multiple causes for lack of insurance as well as meet the access needs of the uninsured.

State initiatives that seek to influence employer health benefits are limited by the federal Employee Retirement Income Security Act of 1974 (ERISA) which prohibits states from regulating employers' actions regarding their benefit programs through the tax code.

Figure 8 summarizes ERISA.

Figure 8

ERISA

ERISA is often referred to in this report, and will be summarized here[1].

ERISA is a federal law that stands for Employee Retirement Income Security Act of 1974. It refers to employee benefits plans and the extent to which employers can be regulated in this matter. **It is important that states with an interest in creating legislation that addresses health care benefits for people who are employed be familiar with ERISA and when it has the power to preempt state law.**

ERISA contains a general preemption clause at Section 1144 (a) which states that ERISA

> "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan..."

Thus, a law that requires employers to provide specified health care benefits to employees could be challenged in court and preempted by ERISA because such a law "relates to" employee benefits plans.

The one exception is the state of Hawaii. Just before ERISA was signed, Hawaii enacted a law called The Hawaii Prepaid Health Care Act. It requires most employers to contribute at least 50% of the cost of the premium for specified health care coverage for each regular employee. Using the timing factor as justification, The Hawaii Congressional delegation successfully lobbied for an exemption amendment. The language in the amendment clearly states that such an amendment will not be extended to any other states.

ERISA also contains a provision at Section 1144 (b) (2) (A) which limits the scope of the general preemption clause. This is a "savings clause" and reads as follows:

> "...nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities."

1 This summarizes a document issued by the Group Health Institute in 1988 titled "caring for the Uninsured: The Massachusetts Experience" by Daniel T. Roble.

ERISA cannot preempt laws that fall with-in the savings clause*. Although this provision identifies three exceptions to ERISA, only the insurance clause is relevant here. The insurance exception was apparently designed to maintain the business of insurance under state jurisdiction.

Minnesota is a good illustration of the insurance savings clause. In its Comprehensive Health Insurance Act of 1976, it required that certain benefits be included in any "qualified plan". The law was challenged, though not under ERISA, and was held as constitutional on the grounds that it referred to all possible insurees, whether they were employed or not, thus falling with-in the insurance savings clause.

Massachusetts also illustrates the insurance savings clause. Section 47B of chapter 175 of the Massachusetts General Laws requires that minimum mental health benefits be included in any general insurance policy, accident or sickness insurance policy, or employee health care plan that covers hospital and surgical expenses. Section 47B was challenged by insurance companies. The United States Supreme Court, ruling in favor of the state, held that Section 47B applied to insurance policies, and therefore was not preempted by ERISA.

Thus, the state can indirectly regulate the content of employee benefits plans (except for those that are self-funded) by directly regulating insurance. The effect of the Supreme Court's decision was to differentiate insured and uninsured (self-funded) plans, leaving the former open to indirect regulation while the latter were not.

*The savings clause is in turn limited by a third clause which excludes self-funded plans. This draws them under the ERISA preemption.. Thus, health care coverage benefits offered by an employer who assumes the risk for payments made on behalf of employees under the employer's plan are not subject to regulation by the state.

Healthspan Proposal

Healthspan proposes

- voluntary employee and employee participation

- an "Employer-State Joint Sponsorship Program" under which the employer and the state would share the costs for eligible employees with the long-term goal of increasing the employer's contribution and providing the state subsidy to the employee only. (See Figure 9.)

Issues

This approach raises the following questions:

What would prevent employers from dropping coverage?

Healthspan proposes to restrict eligibility to businesses without insurance coverage for the past several years and to those interested in extending benefits to new groups of previously-uninsured workers. A new business might otherwise discontinue health insurance, with the possible exception of those with low-wage workers. Few employers with large numbers of low-wage employees currently offer benefits.

What would prevent employees from dropping coverage?

Eligibility would be restricted to those who lack subsidized coverage, public or private. Healthspan would be an attractive option for insured employees whose company health plan requires greater cost-sharing or offers fewer benefits.

Would Healthspan benefits and cost-sharing set the standard for work place coverage, and would any insured employee with an inferior plan be considered under-insured and eligible for Healthspan?

This issue is related to the design premise of the benefit package comparable to employer sponsored coverage or a basic set of benefits to ensure equitable access to essential services.

How can the state resolve the equity problem of subsidizing employers who don't currently offer coverage while offering no help to those that do?

The state could focus subsidies for firms in industries in which coverage is uncommon rather than for those that typically offer benefits.

Figure 9

EMPLOYER-STATE JOINT SPONSORSHIP PROGRAM

From Minnesota Department of Health, "The Challenge of Providing Financial Access to Health Care to Minnesota," 1987, page 20.

Healthspan should include an "employer-state joint sponsorship program" to encourage employers to begin or to maintain a health benefits program. Under the program, Healthspan and the employer would share the costs of health benefits for eligible employees.

The program could operate quite simply. By registering with the state, employers could offer the health plans under contract with Healthspan directly to employees who: (1) meet Healthspan eligibility criteria; and (2) were not covered under their employer-sponsored health plan (if any) within the past several years. The state would require employers to contribute a certain share of the non-enrollee premium costs, but the program's subsidies to enrollees would remain the same.

It may be cumbersome for some employers to offer Healthspan to some employees while continuing to offer their "regular" health benefits to others. If their regular benefits are comparable to Healthspan benefits, it would seem reasonable to permit employers to substitute their own health plans for the Healthspan contractors. Under this alternative, the state would still subsidize employers at the same level.

All parties would benefit from employer-state joint sponsorship of Healthspan. Employers would be able to offer an attractive employee benefit for significantly less than its full cost. Employees would receive benefits through employment just as most people do, further reducing any welfare stigma. And the state would reduce the public subsidy needed for the program.

The joint sponsorship program should encourage employers to begin offering coverage, or to extend coverage to new classes of employees. To discourage employers from substituting Healthspan for existing coverage, the state should not share the costs for any classes of employees who had been covered within the past several years.

The joint sponsorship program would need to be fine-tuned over time. The major objective of fine-tuning would be to increase employers' share of costs in the long run. For example, the state could phase out participating employers' subsidies over a period of years, in the hope that they would maintain the benefits on their own. Or the state could vary the amount of its contribution according to a firm's size, with larger firms receiving a smaller contribution. As small firms grow, they would need (and receive) less assistance to provide health benefits. Such refinements should make it possible to increase rather than decrease the overall extent of employer contributions to employee health benefits.

- **Would uninsured employees be allowed to enroll in Healthspan if their employers elected not to participate in the Employer-State Joint Sponsorship Program?**

  It would be unfair to penalize employees of businesses which choose not to participate in this voluntary program.

- **How will the schedule of state-paid employer subsidies be structured, and what guarantees that employers will pay the premium at the point that state subsidies end?**

  A multi-year schedule of declining state subsidies could be developed to establish at outset the full contribution by the employer with time-phased assistance from the program.

These issues cannot be resolved within the scope of this report. Healthspan's voluntary approach avoids an ERISA challenge and potential opposition from the business community that financial, incentive-based or mandatory strategies are likely to face. However, it is difficult to "give substance" to Healthspan provisions for employers to participate voluntarily in a plan that lacks financial incentives or penalties.

Employer Perspectives

Nationally, employers are divided about preferred approaches to extending coverage to uninsured workers. Despite these differences, there is a growing recognition that the present system of cross-subsidies is inequitable and cannot continue.

The Health Ensurance Coalition conducted a mail survey of 4,500 businesses in nine northeastern Minnesota counties and sponsored small group meetings with small employers in ten towns. The Coalition reported that

> "... most employers want to make insurance available to their workers. At the same time, employers who do provide insurance feel they are bearing an unfair share of the cost. Not only do they pay for their employees' insurance, they also pay taxes and premiums to subsidize care for those who don't have coverage. There was a lot of frustration about the seeming inability of our society to control the cost of medical care and a strong feeling that there was nothing any individual or company could do to stem the rise."

The Department of Human Services (DHS) has invited employer input in the development of this report. While employer organizations were represented in the DHS Resource Group, with one exception, they have not issued official positions.

The National Federation of Independent Business has voiced its opposition to the Massachusetts model. The Federation proposes a tax credit for small businesses that contributes an annual specified minimum per employee for health coverage. If Healthspan were approved by the Legislature as proposed by the Department of Health, the Federation favors a general fund appropriation and a limited core of benefits.

The Minnesota Coalition on Health and the Minnesota Chamber of Commerce are currently studying the problem of the uninsured and developing responses to Healthspan as well as other models under consideration or development across the country.

Options

Tax credits

Oregon is the first state to encourage employers to provide health coverage through tax credits. Employers qualify if they have a total of 25 or fewer employees who work at least 17.5 hours per week and if they have not offered health insurance benefits in the past two years. A tax credit of $20 per employee per month is available for qualifying employers who offer catastrophic insurance. The credit is increased by $5 for those that also provide benefits for primary and preventive care. Both credits cannot exceed 50 percent of the amount paid in health insurance premiums. The cost of offering the tax credit could reach $30 million a year; however, the Oregon Legislature limited the program to 10,000 beneficiaries during its first year. An insurance pool governing board will oversee this effort.

Health insurance information service

Several states are examining a health insurance information service as part of a multi-faceted strategy to promote and preserve employer-provided benefits.

Wisconsin has launched a pilot project that will inform small employers of 50 or fewer employees about available health coverage options. Research results indicated that small employers were often unaware of existing insurance products and that insurers did not typically direct significant marketing efforts to small businesses.

Financial incentives and penalties

Incentives may include

- benefit packages that would be less costly than current comprehensive benefit packages or individual policies tax subsidies for the self-employed and unincorporated businesses

- multiple employer pools to create larger groups and better premium prices

- pools similar to Taft Hartley Trusts that allow workers in high turnover jobs to "bank" their benefits

- tax credits to employers that introduce health benefits

Penalties may include a "pay or play" option. This option is a key feature of the Massachusetts Medical Security Act. All employers with six or more employees will be required to pay two new taxes.

1) Starting January 1, 1990, an unemployment health insurance surcharge equal to 0.12 percent of the first $14,000 of each employee's annual wages (maximum of $16.80 per employee per year) will be required whether or not employers provide insurance. This tax will help finance, along with premium payments, coverage of the uninsured receiving unemployment compensation.

2) Starting January 1, 1992, a Medical Security Tax equal to 12 percent of the first $14,000 of each employee's annual wages (maximum of $1,680 per employee per year) will be required. This amount can be offset if an employer already offers insurance with a greater average per-employee cost, e.g. if it were equal to $2,000, the employer would pay nothing else; if it were equal to $1,500, the employer would pay $180 per employee annually.

Taxes are due quarterly. The $14,000 wage will be indexed after 1992. If the Medical Security Tax is not paid, a penalty of $35 per day or $5 per employee, whichever is greater, will be imposed.

A surcharge does not need to be paid for the following classes of employees:

- temporary or seasonal employees who work five months or less

- part-time employees who work less than 20 hours a week

- employees who already have health benefits, e.g. under their spouse's plan

Coupled with these "pay or play" provisions are a number of programs designed to assist small businesses.

o Employers with five or fewer employees are exempt.

- A small business health insurance pool will purchase health insurance for employees of businesses with six or fewer full-time workers.

- A hardship fund will help small employers pay their medical security tax if their surcharges exceed 5 percent of gross revenues.

- Insurance brokering programs and technical assistance grants will be available.

- Tax credits will be granted for two years to any qualifying small employer providing coverage before the surcharge takes effect in 1992.

Mandated health insurance

A mandatory approach requires employers to offer **and their employees to accept group insurance.** This guarantees coverage for workers and allows the government to provide insurance to the unemployed or partially employed. To date, Hawaii and Massachusetts are the only states requiring employer coverage.

The mandatory approach has the following advantages.

- equity for employees

  Workers who do not receive health benefits through their workplace pay taxes which subsidize health insurance for other, often higher-paid workers.

- equity for employers

  Employers who offer benefits subsidize workers who lack insurance through provider cost shifts and coverage of working spouses who do not receive insurance through their own employers.

- reducing the risk of adverse selection

  Under a mandatory approach, a balanced population of workers would enroll in health plans, and insurers would not be concerned that only those who are ill would join the plan.

The mandatory approach has the following disadvantages:

- higher costs to employers which could lead to job loss among low wage workers, higher product prices, interstate job movement to escape mandated coverage, or bankruptcy of small, new, or marginal firms

- possible violations of the Employee Retirement Income Security Act (ERISA) which pre-empts state regulation of employer benefit plans

  Since Hawaii's legislation preceded ERISA, the state received an exemption. While ERISA prohibits states from regulating employer benefits, it does not limit federal authority in this area. Several pieces of federal legislation requiring employers to offer a minimum set of health benefits to certain employees have been introduced; passage is unclear at this time.

Some suggestions from other states and in the literature to minimize these negative economic consequences are

- exempt part-time employees or new or small businesses

- allow lower levels of coverage

- subsidize small employer contributions through a hardship fund for firms with actual hardships

These suggestions are not acceptable to all people. An incentive to hire part-time employees allowing for less than comprehensive coverage are not policies currently endorsed in this state. To realize the advantages and avoid the disadvantages, a workable mandatory approach requires the availability of a fully-subsidized insurance product for lower income employees, phased-in mandates for employers and employees, and tax measures.

Eligibility

Healthspan Proposal

Healthspan proposes that state-subsidized health insurance be provided to people

- with incomes up to 250 percent of federal poverty guidelines, without an asset test

- who pay the sliding-fee premium

- who do not qualify for other subsidized coverage through private or public programs

Options

Comprehensive, statewide plan

There are compelling arguments for implementing a comprehensive, statewide plan to achieve universal coverage. If properly

planned and structured, it should offer an equitable, cost-effective and coordinated approach--preferable to a piecemeal or patchwork effort--to the problem of the uninsured.

For example, the state of Washington has implemented a comprehensive plan for all uninsured under age 65 up to 200 percent of federal poverty guidelines. Available funding limits enrollment to 20,000 people in five Congressional districts.

A comprehensive, statewide plan requires

- well-organized, broad-based support
- significant financial investment that will increase over time with medical cost inflation and rising enrollment
- political consensus and a serious, long-term funding commitment

Multi-faceted, targeted responses

Alternatively, states may pursue a series of policies that reflect the heterogeneous nature of the uninsured. Together, these targeted responses seek to reduce the number of uninsured.

Targeted initiatives may be established for the uninsured poor, the working uninsured, the non-working uninsured, the disabled, the newly unemployed, and uninsured children. Coverage and program financing mechanisms that work well for one group may not be appropriate or practical for another. This approach favors a combination of public and private efforts. The 15 projects funded by the Robert Wood Johnson Foundation Health Care for the Uninsured Program demonstrate multi-faceted, targeted responses.

Adversely, target approaches can result in a collection of uncoordinated programs which fail to broadly serve the uninsured and miss opportunities for cost savings.

Include Medicare beneficiaries

Most individuals aged 65 and over qualify for coverage under the federal Medicare program and, therefore, were not included in Healthspan. The universal health insurance initiatives launched by Massachusetts and Washington do not address Medicare beneficiaries. State-subsidized Medicare supplemental coverage would add an estimated 173,000 eligible people and increase the state's cost by 50-100 percent. This policy option, therefore, has enormous financial consequences. The recently enacted federal Medicare Catastrophic Act requires coverage of deductibles, co-insurance, and premiums by the stat's Medicaid program for persons under poverty level.

Establish eligibility priorities

In view of the financial commitment and administrative efforts required to provide coverage to the state's uninsured, it may be necessary to set eligibility priorities to limit the program's scope. Priorities could be established on the basis of

- income, with low-income families given preference
- employment status, such as full-time employed uninsured or small businesses
- age, such as dependents of insured workers or children up to age 18
- enrollment cap, such as first-come-first-served basis

  (The Washington Basic Health Plan will allow 20,000 enrollees during its first two years.)

- asset test, i.e., eligibles must have limited assets in order to qualify

  (Many public programs feature asset tests, including Medicaid. While an asset test limits eligibility to fewer persons, it does add to administrative costs. Asset tests are not a standard feature of administrative services typically performed by health plans. Opinion was divided among Resource Group members on the advisability of instituting an asset test for Healthspan.)

Program costs will be affected by the eligibility limitations. For example, restricting coverage to the employed uninsured may favorably affect the perceived risk associated with the pool. A plan for children and adolescents may call for a benefit package different than one designed for all age groups.

Benefits

Healthspan Proposal

Healthspan proposes fairly comprehensive coverage comparable to an employer-sponsored plan and assumes cost-sharing features and procedural requirements to limit inappropriate use of services.

Benefits would include

- primary care
- acute care
- cost-effective preventive care

The Healthspan report described a conceptual approach to benefits without detailing its components. The report envisioned the delivery of services through prepaid, managed care plans on a state-wide basis. Given the market penetration of health maintenance organizations in the state's most populous metropolitan area, the typical employer-sponsored plan available to many employees and their families is a comprehensive package of services with first dollar coverage. The trend, however, even among large employers, is to increase employee cost-sharing requirments. The Healthspan report proposed that a state-subsidized health insurance program for the uninsured offer benefits no better or worse that those associated with employer-sponsored plans.

Issues

This conceptual approach presents several challenges.

Full or limited benefits

Businesses cite cost as the major barrier to providing health coverage to workers; therefore, the benefit package that is offered under any initiative for the uninsured must be affordable to the employer and enrollee. This requires a basic benefit plan or public subsidy; therefore, it may be necessary to seek an exemption from state mandated benefits in order to introduce a lower cost benefit package for the uninsured.

The scope, design, and subsidy level of the benefit package will determine who will join. A voluntary program requires that the package be sufficiently attractive to the uninsured. Surveys show that the uninsured would like coverage that includes both ambulatory care and hospitalization. A product limited to primary care or to catastrophic care will not have the broad appeal that a comprehensive plan would.

Cost

Over the past few years, Minnesota's health care market has been characterized by fierce price competition. Although premiums have been held down, costs have continued to rise. Physicians and hospitals now protest that quality of care will suffer unless rates are increased to adequately cover the costs of delivering services.

As a consequence, 1989 health plan rates show steep increases of 15-20 percent. Some of this increase reflects cost increases deferred from pervious years when premium price increases were held down artificially due to competitive presures. For the most part, cost pressures have led to higher premiums and greater cost sharing for employees rather than a leaner benefit package. Clearly, a comprehensive benefit package is valued by consumers. It is also difficult for employers to scale back benefits, even if the employee costs are reduced.

In 1986, the Healthspan report estimated a monthly premium of $65 per member. The cost of a comprehensive package is now considerably higher. While any benefit package will be subject to medical inflation, the higher costs associated with comprehensive benefits modeled on employer-sponsored plans warrant serious consideration of the subsidy required for a program of this magnitude.

Equity

Equity issues are likely to arise relative to state subsidies for the uninsured employed whose income levels are roughly equal to employees insured by businesses that offer a comparable or leaner package. Other concerns may be raised by employers who currently offer coverage and insured employees who are not eligible to join a state-subsidized plan that offers more attractive benefits or lower contributions than their employee-sponsored plan.

Options

Preventive and primary care

A preventive and primary care package would include routine health maintenance services. This approach guarantees financial access for preventive care as well as early diagnosis and treatment of conditions that could lead to more serious and costly medical problems. Given the choice, a preventive and primary care package would appeal more to families with children and teens than to young or middle-aged adults.

Uncompensated care costs and bad debt may be reduced for physicians and other primary care providers, but to what extent is unclear. Uninsured individuals often fail to seek care unless they are seriously ill. Many pay for their care with modest installment payments over a long period of time.

Hospitalization and catastrophic care

On the other hand, Healthspan could offer a benefit package limited to inpatient medical, surgical, and hospital care. Unlike the preventive and primary care package, this approach would provide financial protection against large, unexpected hospital costs--the original objective of health insurance. This approach may improve the financial welfare of hospitals which would otherwise write-off the unpaid bills of the uninsured.

The hospitalization and catastrophic care package would be more attractive to middle-aged adults and others who anticipate being hospitalized. Assuming voluntary enrollment, this package would probably attract a high-risk group.

Enormous hospital expenses incurred by low income uninsured persons may qualify them for Medical Assistance (MA) under the "spend-down" provision. MA, a public program for the medically indigent, is jointly funded by the state and federal government. Individuals who incur medical expenses that are very high relative to their income can be eligible for MA as "medically needy". Given the availability of federal funding, the benefit of state-subsidized hospital insurance for this segment of the uninsured is questionable.

A hospitalization and catastrophic care package is not a serious option for Healthspan. The benefits would not address the broader needs of the uninsured. Commercially, such insurance is sold infrequently, mostly as a supplement.

Market research conducted by the state of Washington indicates that the uninsured are most interested in coverage that includes physician, hospital, and emergency services. A hybrid product is more attractive than either primary or inpatient care only. Under a voluntary program, the benefits must be appealing enough for the low-income uninsured to enroll and pay a sliding-fee premium.

Costs of a full benefit package are high. Other state and regional demonstration projects have developed minimum benefit packages limited to a set of essential ambulatory and hospital services. This approach extends a basic plan to many uninsured rather than providng a broad package to fewer people.

(Appendix C describes the benefits covered and excluded under the Washington Basic Health Plan.)

The challenge of designing a benefit package for a state-subsidized health insurance program for the uninsured is to balance cost with access. The breadth of the package will drive program costs and enrollment. The objective of guaranteeing universal coverage for a minimum set of benefits, based on broad concensus, is different than extending benefits comparable to employer-sponsored plans.

Drawing upon the expertise of four Resource Group participants representing insurers, the Department of Human Services asked each to consider two benefit design options and, based upon demographic data supplied from this report, project premium rates that the Department could use to estimate program costs. These rates represent a projected range rather than a detailed program design. The two examples of benefit packages are described below.

OTHER STATE DEVELOPMENTS

Massachusetts' Universal Health Insurance Law

Massachusetts Governor Michael Dukakis signed into law April 21 legislation to guarantee health insurance coverage for the state's 600,000 uninsured residents by March 1, 1992. Under the law, a newly-created Department of Medical Security (DMS) will phase in over a four-year period an insurance program for both employed and unemployed individuals and their families who now lack coverage. The law also extends existing state medical assistance programs to cover certain uninsured population groups. Closely linked to the insurance program are provisions revising the state's hospital payment system.

Dukakis first presented his proposal for universal health insurance last September, but the complex and far-reaching plan ran into immediate opposition from some of the state's most powerful interest groups (see Project Update, March 1988). After the 1987 legislative session ended without enactment, the governor submitted a new proposal for the 1988 session, and a final bill was approved April 13, by a vote of 81 to 72 in the House and 19 to 15 in the Senate. Following are the major components of the insurance program:

Department of Medical Security

The prime function of DMS, which is within the Executive Office of Human Services, is to provide insurance coverage to all Massachusetts residents who are not covered. The department will purchase benefit plans and make them available to eligible residents. It will also manage special funds created by the law to help finance the coverage, as well as the existing uncompensated care pool. In addition, DMS is required to conduct certain studies on health insurance and the uninsured.

Employer-Based Insurance

Although the majority of employers in Massachusetts and elsewhere do provide insurance to their employees, many — particularly small businesses — do not. The law does not require employers to offer benefits to their workers but creates instead a system of incentives and penalties, dubbed "the pay or play option," to encourage employer-based coverage.

Medical Security Contribution — Beginning January 1, 1992, all employers with six or more employees must pay the state a surcharge on their unemployment insurance contribution. The payment will amount to 12 percent of each full-time worker's first $14,000 in annual wages — a maximum of $1,680 per employee. But businesses that provide insurance to their workers can deduct their premium expenses from the surcharge payment, while companies that don't provide coverage must pay the full amount. Revenues from the surcharges will go into a special medical security trust fund; DMS will use the funds to help finance insurance for eligible employees and their families. If an employer does not pay the required surcharge, the state will impose an additional penalty of $35 per day or $5 per employee, whichever is greater.

Exceptions — The law exempts employers with five or fewer workers from the above surcharge provision. In addition, new businesses have special rates: in the first year, they don't pay the surcharge at all; in the second, they pay only one-third of the rate; in the third, two-thirds; and after that, they must contribute at the full rate.

Small Business Programs — Most small businesses offer insurance, but those that don't — mainly firms with 10 or fewer workers — often cannot afford the cost of insurance. The law includes a number of provisions to encourage and assist small businesses (defined as having 50 or fewer full-time employees) in providing insurance to their workers. Most of these programs go into effect July 1, 1989.

- Insurance Brokering — DMS will phase in programs to broker the purchase of health insurance for small businesses and will provide technical assistance grants to private small business insurance brokers.
- Tax Credits — While the "pay or play" surcharge provision will not take effect until 1992, the state will grant tax credits for two years to any small business providing coverage sooner. Only employers that didn't offer insurance in the last three years and that now pay at least 50 percent of total premium costs are eligible for tax credits. In the first year the credit amounts to 20 percent of premium expenditures, dropping to 10 percent in the second year.
- Small Business Health Insurance Pool — DMS will establish a pool to purchase insurance for employees of businesses with six or fewer full-time workers. The department will also study the feasibility of expanding the pool to businesses with up to 10 employees.
- Hardship Fund — The law establishes a health insurance hardship fund to help finance small employers' medical security contributions when their surcharges exceed 5 percent of their gross revenues. Money in the fund will come from the penalties levied on employers that fail to pay their unemployment insurance surcharges.
- Studies — DMS will study small business insurance problems and recommend strategies for improvement. With the help of an advisory committee, the department will also assess the effectiveness of the tax incentives and other programs in making insurance available to small business.

Insurance for Unemployed & Others

Unemployed people without medical benefits, workers not covered under employed-based plans, and all other uninsured persons will be able to obtain coverage through DMS. The department will buy benefit packages from private insurers and then make them available to the uninsured. Under the law DMS is encouraged to contract only for managed health care plans or other cost-cutting programs and is required to offer each enrollee a choice of two or more policies. Premium contributions, deducti-

bles and other copayments will be established on a sliding-fee scale, depending on family income and size. Those with income "substantially" above the poverty line will have to pay the entire premium.

Phased-In Initiatives — DMS is required to test alternative ways of providing health insurance to the uninsured, including the use of preferred provider arrangements. The initiatives are to be phased in gradually, beginning July 1, 1988, and can be established on a regional, statewide or population basis.

Unemployment Insurance Surcharge — In addition to the premium payments, coverage of the uninsured receiving unemployment compensation will be financed with contributions from employers. Beginning January 1, 1990, all businesses, except those with five or fewer employees, will have to pay an unemployment health insurance surcharge of 0.12 percent of total wages up to $14,000. (Unlike the 12 percent medical security contribution, this surcharge is required of all employers, whether or not they provide insurance).

Other Uninsured — Funds to pay for coverage of other uninsured will come from a special public sector responsibility account, comprised of premium payments, voluntary contributions and state appropriations.

Uncompensated Care Pool

Currently Massachusetts adds a 13.25 percent surcharge to every hospital bill for the state's uncompensated care pool. Money in the $315 million pool helps hospitals cover the cost of providing free care to the uninsured. But as the state insurance program is phased in over the next four years and as more and more of those now without insurance are covered, the need for the uncompensated care pool is expected to decrease. In the meantime, the costs of caring for the uninsured will continue to be paid from the pool. But in response to the concerns of major business groups, the law made several changes in the pool system.

Management of pool — DMS will take over the management of the pool on October 1, 1988. In addition to covering the cost of hospital free care and bad debt, DMS will use money in the uncompensated care fund to purchase managed care plans for people now covered by the pool. This provision is scheduled to take immediate effect.

Employer Contributions — Under the existing system employers that provide insurance to their employees contribute to the pool through their premium payments; businesses that don't pay for employee coverage contribute nothing. To spread the free care burden more evenly, the law requires all employers, beginning in 1990, to pay the 0.12 percent unemployment insurance surcharge to help finance insurance for the unemployed. Then two years later, when the "pay or play option" takes effect, employers that don't provide employee benefits must pay the 12 percent medical security surcharge to help finance DMS insurance programs.

Cap on Pool — Large businesses had also argued that the cost of free care has been steadily rising, resulting in higher insurance premiums. The law caps the private sector's contribution to the pool at $325 million in fiscal 1988, $318.50 million in FY 1989, declining further in the next two years as the state insurance program is phased in. If the total liability is greater than the cap, the excess up to 15 percent of the cap will be covered by the state; beyond that, the state and the hospitals will share the cost equally.

Extension of Medical Assistance

The law also requires the Department of Public Welfare (DPW) to extend existing medical assistance programs or to establish new ones for certain population groups. Four programs are scheduled to start July 1, 1988.

Disabled Adults — Employed disabled adults who are excluded from employer-based plans because of their pre-existing disabilities and who are ineligible for medical assistance benefits can purchase primary or supplemental coverage from the state. Premiums will be on a sliding-fee scale. An estimated 1,000 to 5,000 adults are eligible for the new program.

Disabled Children — This program will provide benefits to disabled children who have no coverage now because their parents are employed and because of their disabilities. The program will work the same as the one for disabled adults. About 1,000 children are believed to be eligible.

Pregnant Women and Infants — The department will extend Medicaid benefits to currently uninsured pregnant women and their children up to five years of age if their income does not exceed 185 percent of the poverty line. An estimated 4,000 women and 4,000 children are eligible for enrollment.

Welfare-to-Work — This program will extend medical benefits for 24 months to people moving off welfare into jobs without insurance if their income is not above 185 percent of the poverty line. About 4,000 families are eligible to participate in this program.

Insurance for College Students

Every public and independent college must ensure that all its full-time and three-quarter time students have health insurance coverage that meets the standards to be established by DMS. The penalty for noncompliance is $5 per student per day. The college student health insurance mandate is effective September 1, 1989.

State Cost of Legislation

One of the major points of controversy over the proposal as it was debated in the legislature was the projected cost to the state government. Estimates vary, depending on the source. The Dukakis administration estimates that the law will cost the state a total of $628.2 million through fiscal 1992. The total state cost in FY 1989 is estimated at $99.7 million, but the net cost drops to $79.2 million when expected savings are deducted.

Option 1: Comprehensive Services

Cost Sharing and Covered Care	In-PPO	Non-PPO
Deductible	0	$200 or $500
Co-Insurance	0	80 - 20
Out-of-Pocket Maximum	0	$500 per individual- $1,000 per family $1,000 per individual- $2,000 per family
Lifetime Maximum Benefit	Unlimited	$500,000
Inpatient and Out-patient Ambulatory Care	100%	
Inpatient and Out-patient Hospital Care	100%	
Diagnostic/Screening, and Preventive Services	100%	
Rx Drugs	$3 co-pay	
Medical Supplies	100%	
Emergency Services	$10 unless admitted within 48 hours	
Home Care (non-custodial)	14 days per year limit	
Mental Health	Per Minnesota Statute and subject to utilization controls applied by the insurer, such as limitations on provider choice. Describe.	
Chemical Dependency		

Option 2: Primary and Preventive Care

Cost Sharing and Covered Care	In-PPO	Non-PPO
Deductible	0	$100 - $150 - $200
Coinsurance	0	80% of all medically necessary covered services
Physician and Clinic Services	100%	
Diagnostic, Screening and Preventive Services	100%	
Dental	$200 per year limit	
Rehabilitation Therapy	100%	
Medical Supplies	100%	
Outpatient Lab and X-Ray	100%	
Vision Care	100%	
Rx Eyeglasses	Children up to 18: 1 per year limit Adults 18 years +: 1 per two years limit	
Emergency Outpatient	$10 unless admitted within 48 hours	
Rx Drugs	$3 co-pay	

Under Option 1, the comprehensive services package, insurers were asked to identify the percentage of premium costs that could be attributed to coverage of certain benefits: mental health and chemical dependency, prescription drugs and prescription glasses. We also asked for information about co-insurance levels, like deductible amounts, and the effect of premium rates. This information may be useful to policy-makers in structuring a final benefit package.

All four insurers endorsed higher co-pays than we suggested; the $3.00 on drugs should be $5.00 or $6.00, the emergency room charge should be at least $25.00 to be effective, and the out-of-plan deductible should be at least $500 and probably twice that to be effective. All agreed that what we described was much more generous than what is available on the market today. Insurance options with in-plan first dollar coverage, in general, have been demonstrated to be too costly. One cited the recent state employees experience under Aware Gold. As was stated earlier, the health insurance industry, and the large employers, are moving toward more in-plan co-insurance provisions.

Administrative costs were assumed to be 12 to 15 percent of premium costs. There was not an agreement on the amount of marketing, enrollment activity, financial reporting or member services activity this percentage included. The more reporting required, the more responsibility for enrollment or eligibility administration the state asks insurers to assume, especially if it is beyond their present activity level for their insureds, the greater the percentage administration will assume in the higher premium cost. All plans assumed the medically uninsurable will remain in the risk-pool operated by the Minnesota Comprehensive Health Association (MCHA). Otherwise, rates would need to be increased 50% or more. No distinctions were made by any plan for any rural or metro cost of care differences. Premium costs would most likely be higher outside the seven-county Twin Cities metro area because managed care arrangements are not as available.

The range of response for composit rates is as follows:

Insurer #1

In-plan only	Option 1:	$71.50 per member per month
	Option 2:	$73.00 per member per month

This plan bases its projection on their current individual rating methodology.

Insurer #2

In-plan	Option 1:	$116.47 per member per month
	Option 2:	$69.61 per member per month
Out-of-Plan	Only if referred or in emergencies. 20% co-insurance applied up to a maximum per individual per incident	

The projection is based upon current individual rating methodology but an income adjustment was applied using actuarial factors developed by a reputable national firm that has been involved with other states, like Washington, who are working on similar projects. Two income categories are used; 0 - 200% and 201% and above.

- $10 co-insurance on non-preventative physician office visits would reduce Option 1 by 3.5% and Option 2 by 2.6%

- 20% inpatient hospital co-insurance up to $500 per individual per year would reduce Option 1 by 4%.

- the following benefits contribute to premium costs:

	Option 1	Option 2
mental health/chemical dependency	3.77 %	2.09 %
prescription drugs	7.47 %	-----
eyeglasses	.53 %	.53 %

Insurer #3

Option 1: $76.50 per member per month
Option 2: not quoted

Assumptions are:

- inpatient discounts
- inpatient utilization of 300 days per 1,000 members
- enrollment split 50-50 between metro and non-metro, in-PPO available in metro only
- non-PPO deductible raised to $500, rates estimates decrease by 3%
- increase drug co-pay from $3 to $5, rate estimate decrease of 1%

Insurer #4

Option 1: $93.82 if rate adjusted for selection with a factor of 3 - $281.46

Option 2: $88.77 if rate adjusted for selection - $266.31

Assumes

- 100% enrollment, rather than multiple plan selection, and no subsidy of cost for enrollee, will increase premium base rate by a factor of three because low-income people with limited discretionary dollars who seek enrollment will be people who really need services and will really use services

- there will be a 25% increase in the base rate if existing health conditions ignored

- there will be a 25% increase to the base rate for higher than usual utilization and some abuse of services which has been observed in the Medicaid population

For Option 1:

- Primary care designation will be required
- No non-emergency out of network services will be allowed
- $100.00 deductible is worth 7-8% of the rate
- $200.00 deductible is worth 9-10% of the rate
- The medically uninsurable population is excluded from the rate since they would be covered under Minnesota Comprehensive Health Association.
- Only those mental health, chemical dependency, and chiropractic services provided by a capitated third party provider will be allowed.

For Option 2:

All assumptions for the Option 1 base rate will be used with the following additions:

- No provision for inpatient care will exist
- Dental care coverage will be provided. The benefit will include diagnostic, preventive and restorative services as well as oral surgery endodontics, gum surgery, prosthodontics and orthodontics, these services are consistent with the Medicaid benefits.
- Vision care is limited to one exam and one pair of lenses per year and one pair of frames per two year period.

In addition, the Cost of Benefit as a Percent of the Base Rate:

Mental Health and Chemical Dependency (based on third party capitated arrangements)	6%
Prescription drugs	7%
Vision Care (Option 2)	8%

Administration

Healthspan Proposal

Healthspan proposes that the Minnesota Department of Human Services (DHS) administer the state-subsidized health insurance program for the uninsured because of

- the need for close coordination between Healthspan and DHS operated Medical Assistance (MA), recognizing that changing income levels among low-income participants would lead to movement between the two programs

- the opportunity to build on the experience of the prepaid Medicaid demonstration which contracts with managed care plans in the same way Healthspan proposes

- the experience DHS has gained by administering the Children's Health Plan which targets low-income children in families not eligible for MA and not insured by private insurers for basic primary and preventive care services

Options

Minnesota Department of Employee Relations (DOER)

DOER administers the state employees benefit plans. The staff includes specialists in benefits management who perform some of the administrative functions needed for Healthspan.

DOER is developing the Public Employees Insurance Program (PEIP), a statewide benefit plan which offers health, dental, life, and disability insurance to government employees not covered by the state plan. Healthspan could potentially "piggyback" onto PEIP. This would enlarge the pool, increase the state's bargaining power with contractors, and eliminate any welfare stigma that might be associated with Healthspan.

Minnesota Department of Health (MDH)

The American Public Health Association and its Minnesota affiliate believe that state health departments should take the leadership for developing and implementing initiatives for the uninsured. MDH proposed Healthspan and continues to be very committed to its implementation.

Minnesota Department of Commerce

The Commerce Department regulates the insurance industry in Minnesota and contracts for the administration of the Minnesota Comprehensive Health Association and its high-risk insurance pool. The current administration is Blue Cross Blue Shield. Depending on the design and structure of Healthspan, the Commerce Department could be considered an appropriate administrative base.

New agency

Both Massachusetts and Washington chose to create new departments to introduce and operate their insurance initiatives for the uninsured. A new administrative body offers several advantages:

- a single focus and mission

- no competing priorities

- a committed staff and budget

- the opportunity to create its own identity and shape its own future

Enrollment

Healthspan Proposal

Healthspan proposes the following enrollment principles and procedures for the program.

- wide distribution of applications

- no underwriting (no assumption of risk by the state after the plan is fully implemented, the insurers would assume full risk for costs incurred)

- close coordination in marketing between Healthspan and Medical Assistance

- enrollment effective when the application is received, the premium is paid, and the enrollee has selected a plan

- claims paid on a fee-for-service basis by the state for those in immediate need of treatment until they are enrolled in a plan

- enrollees allowed to change plans once a year

Issues

The Resource Group subgroup on administration and contracting, along with Department of Human Service staff, identified the following as enrollment issues of greatest concern.

Marketing

In order to enroll a broad segment of the uninsured, wide distribution of applications will be important. During the phase-in period, much will be learned about effective marketing and outreach.

Many of those marketing Healthspan will be unfamiliar with Medical Assistance eligibility guidelines. Enrolling those in need of immediate medical attention creates adverse selection problems and may increase rates.

Continuity

Safeguards to ensure enrollment continuity and prevent individuals from joining only when they need health services and leaving when they no longer expect to require care could include

- a minimum enrollment period of one year
- quarterly rate payments to encourage continuous enrollment
- a waiting period or pre-existing condition exclusion for re-enrollees

Responsibilities

Outreach, eligibility determination, enrollment procedures, billing, and premium collection are only a few of the many program functions that must be appropriately distributed among the state, counties, contractors, participating employers, providers, agents, and brokers.

Roles and responsibilities need to be carefully defined and coordinated. Training will be necessary to orient organizations to the program and their responsibilities. Healthspan systems need to be developed and integrated with those of contractors and counties.

Some of these functions are not typically performed by health plans. The state may assume major administrative tasks to support Healthspan. Counties may require supplemental administrative funding similar to that provided under the Prepaid Medicaid Demonstration Project.

Contracting

Healthspan Proposal

Healthspan proposes the following contracting provisions for the program:

- contracting with managed health plans on a capitated basis
- obtaining the best price through bidding or negotiation
- requiring health plans to cover the same benefit package but permitting them to offer optional services for an additional enrollee fee
- selecting at least two contractors in every area to give enrollees a choice of plans and to promote high performance standards through competition

- requiring contractors to address non-financial barriers to care through their own resources or in cooperation with providers who traditionally serve special client groups

Issues

The Resource Group subgroup on administration and contracting along with Department of Human Services staff considered the following contracting issues of greatest concern at this stage. (Secondary issues were identified for future consideration.)

Capitated plans

Since the publication of the Healthspan report, Minnesota's health insurance industry has experienced major financial pressures. The assumption that Healthspan contractors be limited to health maintenance organizations and other managed care plans should be re-examined.

Few capitated plans are now available statewide. Most insurers report financial losses. In view of their financial instablity, they are likely to view new business prospects critically and conservatively. The uninsured population presents a large, untapped but potentially high-risk market. Moreover, plans will evaluate new "public" business in light of their mixed experience with Medicaid and Medicare.

While it is desirable for the state to contract with capitated plans for the reasons outlined in the Healthspan report, a preferred provider organization (PPO) approach is more realistic for a statewide program at this time. Both managed plans and insurers have PPO products, and all have cost containment features.

Risk-sharing

There are many uncertainties about Healthspan--Who will join? What will the utilization patterns be? Will the rates cover the actual experience? The risk to contractors and the state is a serious concern.

While it is in the state's long-term interest to have a fully-insured plan, potential contractors are likely to insist on a risk-sharing arrangement as a condition of participation in the early years. The length and structure of risk-sharing would need to be defined.

Number of contractors

The Resource Group subgroup on administration and contracting recommended that the Department of Human Services allow

contracting by region and, through competitive bidding, select one contractor per out-state region and two contractors within the Twin Cities metropolitan area.

While this approach offers the advantage of administrative simplicity, it presents problems in the event that contractors opt to discontinue participation. Although it limits enrollees' choices, a PPO product will allow enrollees access to a greater number of providers.

Standardized product

The Resource Group sub-group on administration and contracting suggested that all Healthspan contractors be required to offer the identical benefit package.

Length of contract

In the early years, contractors would prefer one year contracts with the ability to rerate based on program costs. A longer time frame could be negotiated in later years after contractors and the administering agency have experience with the program.

Implementation

Healthspan Proposal

Healthspan proposes that the program be introduced using

- a regional phase-in leading to statewide availability within two and a half years

- three designated sites including Hennepin County, the Arrowhead Region, and southwestern Minnesota, each having special insurance problems

Options

Pilot or full scale programs

Pilot programs have the following advantages:

- flexibility to test different methods

- opportunity to answer key questions, learn what works, and avoid costly mis-steps

- development of a constituency for a statewide effort

- collection of baseline data which can guide subsequent full scale implementation

- potential to attract private grant funds

- protection from jeopardizing the entire initiative if the small-scale effort fails

- better cost identification

Pilot programs can be designed to answer questions such as

Who joins and why?

What benefits are most attractive?

What benefits are most frequently used?

What marketing efforts are most effective?

What are the costs?

What implementation problems are encountered and how are they resolved?

Pilot programs may be organized as experiments, with full-scale implementation conditional on their outcomes. They may also serve as stepping-stones to a statewide initiative.

Critics argue that pilot programs fail to perform as small-scale facsimiles and do not provide information that could be generalized to a statewide effort; localized efforts may not win the support and commitment of key participants, and a full scale "roll-out" is less likely to be viewed with tentativeness.

Despite these objections, pilots are the most common approach used for testing models. Even if full-scale implementation is most desirable, funding constraints may require a more modest start-up, either in the form of pilots or program phase-ins. For example, the Washington State Basic Health Plan is limited to a total of 20,000 enrollees residing in five targeted Congressional districts in its first two years of operation.

Start-up sites

Solicit proposals from regions and select three start-up sites where there is the greatest interest and commitment.

Enrollment

o Initially open the program to the lower-income uninsured, and, as funds permit, extend enrollment over several years to those up to 250 percent of poverty.

This option may require a longer development phase to establish contracts and administrative systems statewide at the outset. Controlled enrollment growth, however, would allow for gradual staff expansion and necessary program adjustments.

- Limit initial enrollment to the employed uninsured.

- Limit enrollment to full-time employees or to small businesses.

  This pool of employers and workers would present less risk and greater stability to potential contractors.

Any phase-in option will be opposed by those it excludes. A program of this magnitude and complexity, however, will require a development period of at least two years and several years for systems testing and refinement. Massachusetts and Washington have phase-in calendars. Clearly, there are many practical reasons for starting the program on a small scale rather than attempting immediate implementation statewide.

Phase-in methods will likely emerge from policy decisions shaping overall program design.

Costs

Healthspan Proposal

Healthspan estimates premium and administrative costs in the range of $135 million (in 1987 dollars) at maximum likely enrollment, based on assumptions outlined in the report. This figure does not reflect anticipated savings nor revenues already available to offset some of the costs.

Issues

New Estimates

The legislation directed the Department of Human Services to furnish updated cost estimates for Healthspan.

Program costs are determined by many interrelated variables such as benefit design, eligibility guidelines, enrollment projections, the pace of implementation, outreach effectiveness, administrative services, and the premium amount. Developing precise estimates is not possible because 1) major policy decisions concerning program design and implementation issues have yet to be made and 2) project funding did not allow for actuarial analysis.

With generous assistance from the health plans represented in the Resource Group, rates were estimated for 1) a preventive and primary care package and 2) a comprehensive care package comparable to a typical employer-sponsored plan. Both plans are structured as preferred provider organization (PPO) products or products that will use a limited provider network.

In order to estimate costs at the point of full implementation, rates were calculated using enrollment projections based upon a mature program. Program costs were inflated by 60 percent to reflect a two year development phase followed by a four year enrollment expansion (six years of inflation at 10 percent per year).

For the comprehensive care package, the impact of different deductibles and out-of-pocket maximum cost levels were calculated. The contribution of some specific services to the rate was identified separately.

The estimated monthly range of rates per member are

Primary and preventive care package:	$ 70	to $ 266
Comprehensive care package:	$ 72	to $ 281

These estimates represent direct program costs ranging from $130 million to $730 million, without the addition of new administrative expenses that would be incurred by the state and counties.

These program costs assume voluntary participation by employers and individuals. Mandatory coverage, however, would increase the pool size and could lower the rate estimates by including many low-risk persons who would otherwise opt not to enroll.

Cost reduction

Program costs could be reduced by restricting eligibility, negotiating provider discounts, and limiting benefits. Benefit packages developed for the uninsured by other states or communities frequently exclude mental health services, chemical dependency treatment, outpatient prescription drugs, dental care, and chiropractic services. Covered hospital days may be capped and preventive services such as physicals may be limited.

Financing

Healthspan Proposal

Healthspan proposes financing the program with funds from

- enrollee premium payments, on a sliding-fee scale

- employer contributions under a voluntary employer participation plan

- state general revenues

- county participation

- other sources of revenues, such as an assessment on health services or insurance companies and health maintenance organizations

Options

Funding mix

Clearly, diversified funding is needed to implement and sustain a program of this scope. The Healthspan proposal identifies the major revenue sources commonly considered to support such a program.

The relative contribution of the proposed sources could be altered while maintaining the voluntary employer participation feature. For example, the sliding-fee scale could be revised to increase enrollee contributions. The Washington Basic Health Plan requires full payment of premium at 200 percent of poverty. In contrast, the Healthspan sliding-fee scale provides a 40 percent subsidy to those at 250 percent of poverty. The impact of greater enrollee cost-sharing needs to be analyzed before any modifications are made in the proposed scale.

Incentives and penalties

This "pay or play" option, using the Massachusetts model, would significantly change the original Healthspan proposal. It would introduce an employer incentive to offer private insurance and establish a funding stream from businesses to support state initiatives for the uninsured.

Employers who currently provide coverage to their workers may view this approach as a more equal distribution of costs. Those who do not insure their employees, particularly small businesses, may oppose this approach. The Massachusetts model includes special programs such as a hardship fund, a small business health insurance pool, and technical assistance grants to aid small businesses. Employers with five or fewer employees are exempt from the surcharge. Employer financing, however, does not eliminate the need for major general revenue appropriations by the Massachusetts program.

Tax credits

Even though Massachusetts consumer advocates considered this option to be the strongest funding proposal, it failed to win approval. Under this plan, employers, the self-employed, and employees would be charged a payroll tax of 5 percent, 6-1/2 percent, and 1-1/2 percent respectively. Employers and self-employed persons who provide coverage would receive an income tax credit of 4-1/2 percent and 6 percent respectively. The 1/2 percent residual would fund coverage for the unemployed. Insured employees would receive a full income tax credit. For uninsured individuals, the 1-1/2 percent tax would equal the premium.

This approach which places an insurance requirement on both employers and employees and which is a flat tax on income is advantagous because it

- is universal and contains no exemptions

- uses the tax system and involves no sliding-fee scale

- is a flat tax but offers elements of a progressive tax

- presents the strongest case against possible ERISA violations

According to Minnesota Department of Revenue analysis, this funding approach could yield approximately $561 million in one year.

PART FOUR
COORDINATION WITH OTHER PUBLIC PROGRAMS

Minnesota provides a number of programs that cover costs for people who cannot afford the health care they need. Each program offers a different benefit package with different eligibility criteria, usually based on income or disability. The Legislature requested that this report address strategies to coordinate or merge the plan for the uninsured with certain existing programs.

Figure 10 compares public program features.

It is important to understand the purpose of each program, the population it serves, and its specific funding source. Examining issues of duplication, administration and economies of scale is not enough. Each program was created to deal with specific problem situations. Integrating existing programs with a new plan may not be the best solution.

Medical Assistance (MA)

Healthspan recommends maximum expansion of Medical Assistance as a way of covering more people. Are there any additional measures Minnesota could take to extend coverage to more people?

Program

Medical Assistance is Minnesota's federal Medicaid program. Approximately 53 percent is funded by the federal government, 42 percent by the state, and 5 percent by counties. Target populations are a) low income families with children b) aged, blind, disabled, and other low income groups c) pregnant women and infants under one year of age. Eligibility is determined through an income and asset test with special consideration for certain health-related conditions. Benefits include nearly all those allowed by the Federal program. (See Appendix D, Minnesota Public Programs Providing Health Coverage.)

In 1987, MA served 380,219 persons with expenditures of $1,107,971,509. In 1988, MA served an estimated 387,138 persons with expenditures of $1,189,083,969.

Options

The Legislature has consistently approved proposals to expand Medical Assistance to cover as many Minnesota families with children as possible. Income eligibility for MA has been increased from 100 percent to 133 percent of the AFDC grant

FIGURE 10

PUBLIC PROGRAMS TO BE CONSIDERED IN UNINSURED PROJECT
Revised September 15, 1988

Program Characteristics	Medical Assistance	General Assistance Medical Care	Services for Children with Handicaps	Children's Health Plan	Maternal & Child Health	Minnesota Comprehensive Health Ass'n	University Hospital Papers
Authority	MN Stat. 256.B	MN Stat. 256.D	MCH Federal Legislation	MN Stat. 256.939	USC 42. Sec. 2191 MN Stat. 145.882	MN Stat. 62E.10	Chapter 158
Target Population	*A) Low income family with children B) Aged, Blind, and Disabled Other low income C) Pregnant women and infants 0-1	Low income persons not eligible for Medical Assistance	Children with chronic handicapping conditions	Children ages 1-8 not eligible for MA and not insured for primary care services	Mothers, children and their families who need preventive services	Persons who are medically uninsurable through other private health insurance plans	People identified at the county level who need care and are unable to pay
Income Standards	Schedule — Family Size: 1 / 2 / 4 A) $466 / 582 / 828 B) 402 / 502 / 714 C) 889 / 1,191 / 1,793	MA Schedule A or B whichever applies	Sliding scale based on 60% of state gross median income	185% of Federal Poverty Level	200% of Federal Poverty Level	Unrelated to income eligib. dependent on proof of rejection, restructive rider or rate-up	Determined by county
Asset Limitations	Schedule A, B, & C** Individual $3,000 Family of 2 6,000 Each Add'l + 200	1,000 regardless of household size	Liquid assets of less than $1,000 per family member	None	None	None	None
Premium	None	None	None	$25.00 annual premium per child	None	Average charge of 5 largest carriers in the State for similar benefits	None
Co-Payment	No co-pay allowed	No co-pay allowed	$5.00, $7.50 or $15.00 for evaluation depending on income	No co-pay allowed	None	20% co-pay for cost of covered services	No co-pay allowed if individual is eligible for MA/GAMC

FIGURE 10 (continued)

Program Characteristics	Medical Assistance	General Assistance Medical Care	Services for Children with Handicaps	Children's Health Plan	Maternal & Child Health	Minnesota Comprehensive Health Ass'n	University Papers Program
Deductible	None	None	None	None	None	#1 Plan-$1,000 #2 Plan- 500	None
Spend-Down	Yes	Yes	"Cost sharing" is a form of spend-down	None	None	$3,000 annual limit for out of pocket expenditures	University Hospital spend-down is similar to that for MA/GAMC
Number Served	'87 380,219 '88 387,138	'87 63,277 '88 68,346	'88 2,400	6,038 children 3,394 families (projected 1989 enrollment)	'88 46,000	'88 12,293 contracts	'88 817 outpt. 165 inpt. (duplicated count)
Benefits/ Services	Hospital care Nursing home care Physician svcs. Mental health substance abuse Dental svcs; dentures Laboratory and x-ray svcs. Chiropractic svcs. Podiatry svcs. Home health svcs. Certified nurse mid-wife svcs. Rehabilitative therapies Prescription drugs & medical supplies Eyeglasses and hearing aids Durable medical equipment Med. transportation	Inpatient hospital care Outpatient hospital care Eye examinations and eyeglasses Physician svcs. Chiropractic svcs. Podiatric services Dental care Prescription drugs and medical supply Rehabilitation svcs. Med. transportation Health ins. premium Laboratory & x-ray services Hearing aids and prosthetic devices Day treatment for mental illness	Diagnostic evaluation & treatment specific to handicapping condition: Physician and specialist Lab tests, x-ray Medications Appliances/ equipment Hearing aids Surgery/ Anesthesia Hospitalization Major restorative dental	Physician svcs. Clinic svcs. Diagnostic, screening Dental Rehabilitation therapy Medical Supplies Outpatient lab and x-ray Immunizations Prescription eyeglasses and vision care Prescription drugs Home care	Primary and preventive care for pregnant women and young children Formula MCH grants are limited to 1) improved pregnancy outcomes; 2) family planning service; 3) services for children with handicaps	#1 qualified plan #2 qualified plan Qualified Medicare supplement plan	University Hosp. provides necessary care and treatment Counties must pay traveling expenses of patient, per diem and expenses of person accompanying and 30% of first $5,000 of care

FIGURE 10 (continued)

Program Characteristics	Medical Assistance	General Assistance Medical Care	Services for Children with Handicaps	Children's Health Plan	Maternal & Child Health	Minnesota Comprehensive Health Ass'n	University Papers Program
Limitations on Benefits or Services	Some services require prior authorization	MA prior authorization requirements apply	$15,000 per yr. cap for each child Routine health services not related to diagnosis are not covered	No benefits for: Inpatient care Nursing home care Chem. Dependency Mental health Transportation PCA Case management Hospice	Inpatient medical care is not covered by MCH monies	6 mo. waiting period for benefits if diagnosis and/or treatment have occurred 90 days prior to enrollment	Transportation Board & Room Nursing Hm. Care Sp. Nursing Svc. Blood transfusion Other items may require prior approval
Funding- State	'87 $463,308,948 '88 492,951,877	'87 $67,789,245 '88 71,791,840(est)	'88 $3.1 Mil.	1¢ tax on cigarettes	'88 1.3 Mil.	MCHA required to share loss among insurers and HMO's (self insurers are exempt 35-40% of insurance)	'88 400,000 '89 300,000
County	'87 50,787,149 '88 53,982,932	'87 7,532,138 '88 7,976,871(est)					
Federal	'87 593,876,412 '88 642,149,160				'88 5.3 Mil.		
Agency Responsible for Program	Minnesota Department of Human Services	Minnesota Department of Human Services	Minnesota Department of Health	Minnesota Department of Human Services	Minnesota Department of Health	Minnesota Department of Commerce	University of Minnesota Hospitals

*Medical Assistance Income Guidelines Schedules A, B, and C.

**Except under Schedule C, no asset test required for pregnant women through 60 day post partum period and infants through 1 year.

***Spend-down. People who have income in excess of the MA/GAMC allowable income limit can qualify for benefits through the "spend-down" provision which requires that the applicants excess income amount be incurred in medical expenses during the month of application and/or three months prior to the month of application.

Chart prepared by staff to Uninsured Project, Department of Human Services. Draft.

amount as recommended by Healthspan. From July 1, 1987 through September 30, 1988, approximately 800 adults and 5,000 children have been added to the program (Reports and Statistics Division, Department of Human Services). For the elderly and disabled, the standard was only increased to 115 percent; this could be further increased to the 133 percent level.

In 1988, the Legislature voted into law the Medicaid option to provide health coverage for pregnant women and infants under one year of age whose family incomes are at or below 185 percent of the federal poverty level. In 1989, the Department of Human Services will propose to expand MA to provide benefits to children up to age eight whose family incomes are at or below 100 percent of the federal poverty level.

All options to expand MA eligibility, such as increasing the MA standard for elderly and disabled people to allowed federal maximum and developing more liberal policies for calculating MA eligibility, should be explored. For example, a full deduction could be granted for child care expenses. Opportunities to apply state expenditures under a state health insurance plan towards individuals "spend-down" eligibility under MA also need to be fully explored.

Figure 11 shows eligible income levels for existing state programs.

General Assistance Medical Care (GAMC)

The Healthspan report recommended that GAMC be merged with the state-subsidized health insurance plan. Would merging GAMC into Healthspan reduce administrative duplication and increase economies of scale? And would health care now provided to GAMC recipients continue to be available under the new program?

Program

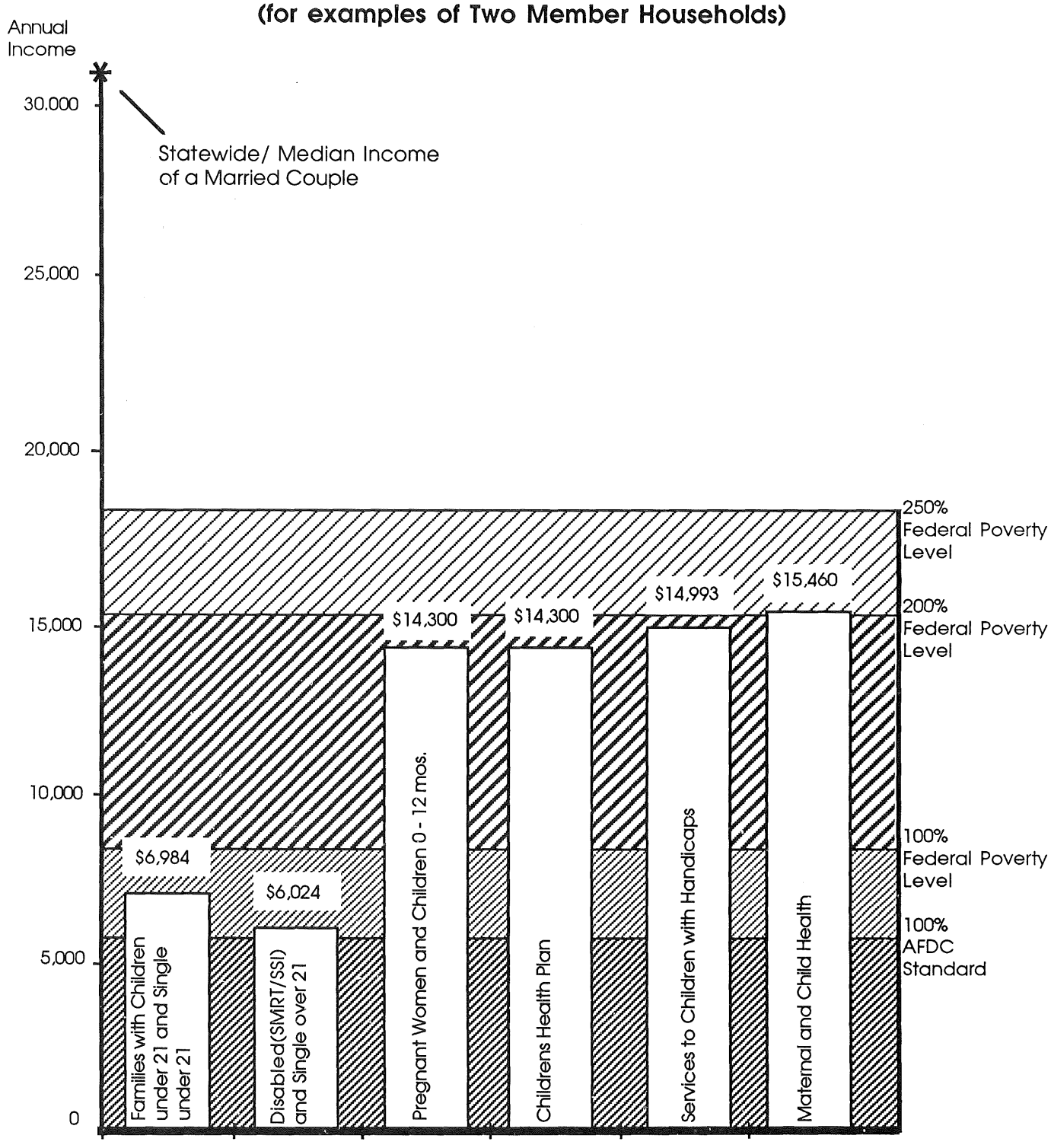
GAMC is a state-county funded (90-10 percent) health care program for low income persons not eligible for Medical Assistance and unable to pay for their care. Eligibility is based on evaluation of income and assets; spend-down can be used to qualify. Benefits include nearly all those provided through MA. (See Appendix D, Minnesota Public Programs Providing Health Coverage.)

In 1987, GAMC served 63,277 persons with expenditures of $75,321,383. In 1988, GAMC served an estimated 68,346 persons with expenditure of $79,768,711.

FIGURE 11

Income Indices of Existing State Programs In Minnesota

(for examples of Two Member Households)



DEPARTMENT OF HUMAN SERVICES
UNINSURED PROJECT
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Options

GAMC provides services to low income people unserved by federal programs. The target population includes adults without dependent children, a number of whom may have borderline mental illness, mental retardation or serious problems with drug or alcohol use.

People who now benefit from GAMC may not benefit from a health insurance program. Many GAMC beneficiaries are not capable and cannot be expected to take the responsibility of enrolling in Healthspan. GAMC recipients typically receive care on a crisis basis, illustrated by the 45 percent of GAMC expenditures for hospital costs. Merging GAMC with Healthspan would be costly for hospitals because enrollment is necessary for billing under Healthspan. The Healthspan proposal would allow fee-for-service billing for those in need of emergency care; this would be costly for the state. Retroactive billing would not be allowed as it is for GAMC. One group that must use GAMC rather than MA are adults in two parent employed families; this group would be covered under Healthspan.

Many health plans require enrollees to seek preventive care from specified providers. This is an unrealistic expectation for GAMC recipients who typically seek health care on an emergency basis, and, because they often lack transportation, use the nearest hospital or clinic. These factors will create unanticipated costs.

Substituting an insurance program for GAMC benefits would make health care less accessible for GAMC recipients. This can be resolved by automatic enrollment of all GAMC eligible persons, but the design of Healthspan would be changed. Making GAMC a part of Healthspan may deter some people from enrolling if they perceive it as a welfare program. The Ramsey Care plan in St. Paul is a managed care program for GAMC clients in Ramsey County that appears to be successful in managing this population within a limited geographic area.

Minnesota Comprehensive Health Association (MCHA)

Should MCHA remain separate from Healthspan? What would be the relationship between the two programs?

Program

The Minnesota Comprehensive Health Association (MCHA), established in 1976, provides health coverage for medically uninsurable persons. Members are all licensed insurers in this state. They are required to share costs not covered by enrollee premiums or operating and administrative expenses. This results

in rising premiums and costs filtering down. The target population includes persons who are unable to obtain health insurance because of health conditions. Eligibility is determined by proof of rejection, restrictive riders, rate-up, or limitations because of pre-existing conditions from an insurer that is a member of MCHA. Eligibility requirements are waived for certain classes specified by law. Benefits depend upon which plan--No. 1 Qualified Plan, No. 2 Qualified Plan, or the Qualified Medicare Supplement Plan--is choosen. (See Appendix D, Minnesota Public Programs Providing Health Coverage.)

As of July 1, 1988, MCHA has 12,293 contracts. In fiscal year 1987, MCHA had an operating loss of $11,280,000.

Options

The Healthspan report recommends that MCHA remain as is, at least until Healthspan is in place. Even if the two programs are administered separately, there are instances where responsibilities and accountability must be clearly defined. For instance, if Healthspan cannot turn applicants away, MCHA enrollees will want to change plans. Conversely, if Healthspan can turn people away, MCHA enrollment could be greatly increased. Guidelines governing such responsibilities must be clear to avoid troublesome consequences.

MCHA was created as an insurance alternative for medically uninsurable people, but over time other groups have been added who do not necessarily meet this qualification. This confuses the purpose of MCHA because every enrollment is not tied to a medical condition. Under new federal guidelines, the low income portion of this "exception" group may be eligible for Medical Assistance. Whether higher income individuals in this group should remain in MCHA needs to be resolved. If they were able to enroll in Healthspan, MCHA would again be reserved for medically uninsurable individuals.

University Papers Program (UPP)

What are the effects of merging the UPP with Healthspan as recommended by the Department of Health report?

Program

The University Papers Program (UPP) is funded by the state, administered by the University of Minnesota Hospitals, and controlled by the counties. Counties have discretion over when, how, and for whom the funds can be used. Treatment is provided by University Hospitals. Copayments are required by patients if they are not eligible for MA or GAMC. Travel-related expenses and other specified costs are paid by the county. (See Appendix D, Minnesota Public Programs Providing Health Coverage.)

After a period of decreased utilization and funding due to retrenchments, UPP is again in demand. The University will be increasing the funding request to $750,000 per year, twice what it was for 1988 and 1989.

Options

The UPP operates independently from other public programs. Although appropriate health care is provided, there is no assurance that people in identical circumstances have equal access to UPP.

Theoretically, nearly everyone with a low income is eligible for GAMC through the spend-down provision. Because of county discretion, UPP can intervene before spend-down takes place allowing some people to avoid having to liquidate their assets. This may be good for certain individuals, but not everyone has the option available to them. In addition, not all counties use UPP funds, so distribution is unequal between counties as well as within counties. Folding the funds into Healthspan would assure more equitable distribution and accountability.

Services for Children with Handicaps (SCH)

Does the population served by Services for Children with Handicaps require a special program for reimbursement?

Program

Services to Children with Handicaps (SCH), previously known as Crippled Children Services, is administered by the Department of Health and receives state funds for reimbursement of treatment services. Support functions such as outreach and case management are federally funded through the Maternal and Child Health block grant. The target population is children with suspected handicapping or chronic conditions. If treatment is necessary, it can be provided through SCH at a sliding fee or referred to other programs or resources. Reimbursable services are limited to those related to the handicapping condition.

In 1988, SCH provided treatment services to approximately 2,400 children with a $3.1 million budget. Benefits are limited to $15,000 per person annually.

Options

SCH provides evaluations in field clinics for a sliding fee based on family income. These evaluations would also be a Healthspan benefit, and even now, can be reimbursed through other third party payers. However, the unique feature of SCH is that the evaluations are conducted in community settings using multi-

disciplinary teams of specialists. Would Healthspan alter the need for these specialized, geographically accessible services, orjust provide another payment mechanism for them?

SCH has field staff that provide local case management for children with handicaps. Some hospitals where children receive treatment also have case managers. In addition, there are county workers that are responsible for some of these children. SCH has contracted for a study that will evaluate the provision of case management services and make recommendations for SCH's future role in this area.

Some children would receive benefits through the TEFRA option under Medicaid (Minnesota Home Care Option), which draws upon federal funding. However, most children served by SCH do not require the level of care addressed by the waiver.

SCH's billing and reimbursement system parallels that of Medical Assistance and SCH is exploring the possibility of contracting that function to the Department of Human Services in the future.

If any changes are to be made in SCH, the amount and quality of care for those served should not be diminished, costs should be controlled, and income such as sliding fee payments should continue to be recovered.

Children's Health Plan (CHP)

Would children now served through CHP receive the same amount and quality of services through Healthspan?

Program

The Children's Health Plan which became effective July 1, 1988 is funded through revenues from a one cent tax on cigarettes. The target population is children ages one through eight who are not eligible for Medical Assistance or who are uninsured for primary and preventive care services. Eligibility is determined by income using 185 percent of the federal poverty level as the maximum. Benefits include physician visits, prescription drugs, eyeglasses, dental services (except orthodontics), rehabilitative therapies, and medical supplies. Inpatient hospital, chemical dependency and mental health services are not covered. The plan reimburses covered services using the same rates and conditions as Medical Assistance.

Options

The Legislature established CHP to provide health care for children in low-income families. Healthspan would logically seek to incorporate CHP to take advantage of economies of scale and avoid duplication.

There are aspects of CHP that should be preserved in any proposed plan for the uninsured. First, active outreach to the target population has been effective. Second, first dollar coverage of these basic services has been effective in assuring access to health care, not just access to health insurance, for the low-income, working population.

Maternal and Child Health (MCH)

Would the population now receiving MCH services receive the same services through Healthspan?

Program

Maternal and Child Health services are funded by a federal-state grant program administered by the Department of Health. Funds are targeted to high risk mothers and children whose income is below 200 percent of the poverty level.

In 1988, MCH served an estimated 46,000 women and children with an $6.6 million budget ($5.3 million federal, $1.3 million state).

Options

Some of the services provided to mothers, and children, by MCH programs would be covered by Healthspan. If, however, enrollment in the plan is voluntary, people who do not enroll will still need the services now provided by MCH. Coordination of MCH with Healthspan depends on the extent of coverage offered to this target population.

PART FIVE
TARGETED APPROACHES

As the Legislature considers implementation issues and options for a state-subsidized health insurance program for Minnesota's uninsured, it is important to note that smaller, targeted efforts are currently under way. These initiatives are in different stages of maturity, ranging from the design phase to full implementation with a decade of experience. Target groups include low-income children, the medically uninsurable and low-income employed.

These initiatives have not been viewed as an organized effort to solve Minnesota's financial access problem nor is any single program likely to serve as the building block for a comprehensive statewide health plan for all of Minnesota's uninsured. They do, however, represent important programmatic responses to specific target groups and together reduce the numbers of uninsured persons.

This section of the report briefly reviews each initiative and its contribution to addressing financial access to health care in Minnesota. Other potential target groups are identified. Selected efforts taken by other states to address their insurance needs are highlighted.

Uninsured/underinsured Children: Children's Health Plan

Overview

In response to a rapidly increasing uninsured population, the 1987 Legislature passed a bill that called for health care coverage for Minnesota's uninsured children. Funding for the program was appropriated from revenues raised from a one cent tax on cigarettes. The Department of Human Services was designated as the administering agency and completed program planning and development during the 1988 session.

The Children's Health Plan started July 1, 1988. In its first six months, the Plan enrolled nearly 4,700 children statewide.

Families with incomes up to 185 percent of federal poverty guidelines pay an annual enrollment fee of $25 per child. Eligibility requirements include Minnesota residency, children aged one through eight years old, no other outpatient health insurance, and ineligibility for Medical Assistance (MA) or General Assistance Medical Care (GAMC). Enrollments are based on available funds.

Services covered include office and health clinic visits, dentist, outpatient laboratory services and x-rays, prescription drugs and eyeglasses, immunizations, as well as diagnostic screening and preventive services. The Plan does not pay for in-hospital stays, nursing home care, chemical dependency treatment, or mental health services. Children's Health Plan uses MA reimbursement levels and claims systems. All providers to the Plan must be MA-enrolled.

Proposed expansion and its impact on the uninsured

With support from the Children's Defense Fund and other organizations, the Department of Human Services (DHS) proposes to expand the Plan to serve children from one through 17 years of age, effective July 1, 1989. This expansion potentially reduces the number of uninsured children by 32,000.

Medically Uninsurable: Minnesota Comprehensive Health Association Reform Proposals

Overview

The Minnesota Comprehensive Health Association (MCHA) is the state's high risk insurance pool for medically uninsurable Minnesotans. Established in 1976, it currently serves over 12,000 individuals, most of whom have been denied private insurance coverage as a result of their high risk medical conditions.

Proposed expansion and its impact on the uninsured

The Minnesota Department of Commerce, charged with oversight of MCHA, has proposed the following 1989 legislative initiatives:

- permit employers to "carve out" high risk employees from their group insurance plan as long as they purchase substantially similar coverage for these high risk employees from MCHA

- allow insurers to reinsure high risk disease by placing individuals who incur over $100,000 of expenses in MCHA

- expand the assessment base of MCHA to include all employers

  Currently, the assessment is paid by HMO's and health insurers who pass the cost on only to those employers who purchase health coverage. The current cost is approximately $1 per month per employee. The cost with the change would amount to approximately $.50 per month per employee.

The first proposal is expected to have a favorable impact on the ability of small employers to purchase and retain affordable insurance coverage. Due to the underwriting treatment of small groups by insurers, many small employers cannot obtain group insurance if they have one or more high risk employees. This proposed provision would lead to greater coverage among employees of small business.

Current Projects in Minnesota

Introduction

This section of the report describes two state-funded projects that focus on the uninsured employed in different regions of Minnesota, each with special coverage problems related to the local economy. As previously stated, the majority of uninsured adults work either full or part-time. Together, with their dependents, they constitute a significant, growing sector of the total uninsured population in Minnesota. These demonstration projects have the potential to offer valuable information and experience for a statewide initiative such as Healthspan.

Health Ensurance Coalition

The Health Ensurance Coalition (HEC) is a private non-profit organization established "to design and implement a demonstration project which would make low cost health insurance available to low income uninsured people in northeastern Minnesota". Conceived in 1986, the project has been guided by an active coalition of small business owners, consumers, health care providers, labor, health plans, and local government.

Seed money provided by the Northeastern Minnesota Initiative Fund, the Northwest Area Foundation, Blandin Foundation, and the Miller-Dwan Medical Center Foundation has supported the Coalition's research and development efforts. In 1989, the project will enter the implementation stage and enroll a minimum of 3,500 individuals annually. The cost of providing the insurance plan will be paid for with a combination of employee, employer, and Coalition funds.

During the 1988 Session, the Legislature appropriated $200,000 to the demonstration project to cover administrative costs if the project is successful in beginning enrollment before June 30, 1989. The Department of Human Services is administering these funds on behalf of the Legislature.

HEC's goal is "to provide a cooperative local solution to the health care access crisis which can be replicated throughout Minnesota". If at the outset the demonstration project is to be considered a building block for Healthspan, then coordination and joint planning by the Coalition and DHS is needed.

Southwest Central Minnesota Health Insurance Program Demonstration

The Minnesota State Planning Agency has provided a $40,000 grant to the Region 6E Community Action Agency (CAA) in Willmar to plan, organize, and design a multi-county health insurance program demonstration project for low-income adults and their dependents in southwestern central Minnesota. CAA and its advisory committee will study the needs and characteristics of uninsured/underinsured residents of Kandiyohi, Meeker, McLeod, and Renville counties.

By January 1, 1989 the CAA will furnish recommendations for a demonstration project to the State Planning Agency. This information will be used by the State Planning Agency to develop a proposed implementation plan for presentation to the Minnesota Legislature on February 1, 1989. The pilot is envisioned to be a public/private partnership which serves the insurance needs of the working uninsured and their families.

It is premature to say what direction this proposed effort may take and how it might relate to Healthspan. The data collection and planning phase will yield useful background information about the uninsured in this region of Minnesota and should guide the successful development of a local initiative.

Post-AFDC: Welfare-to-work Initiative

Introduction

Welfare reform efforts at the federal and state levels seek to restructure current welfare programs to serve as a transition to work, rather than provide a permanent subsidy. Lack of child care and health insurance are two major obstacles to self-sufficiency facing many Aid to Families with Dependent Children (AFDC) clients who leave welfare for work. Typically, the low paying, low skill jobs that former clients accept do not offer benefits or require cost-sharing beyond their means. In Minnesota, 12 months of post-AFDC medical coverage is available; however, most clients qualify for an average of four months.

This section describes a new federal welfare reform measure, a proposed state welfare reform initiative, and a provision of the Massachusetts Medical Security Act that address the health insurance needs of AFDC clients who try to make the transition from welfare to work.

New federal welfare reform package

In September 1988 Congress passed a national welfare bill with a number of far-reaching provisions. Relative to insurance

coverage, it will provide Medicaid benefits up to one year after a recipient leaves welfare due to increased earnings. About 10,000 Minnesota AFDC families will be affected.

Minnesota Family Investment Program

The Minnesota Family Investment Program is a major welfare reform initiative designed by a consortium of state agencies, including the Departments of Education, Finance, Human Services, Jobs and Training, the Office of Jobs Policy, the State Planning Agency, and the Minnesota Technical Institute System. As an amendment to the Congressional bill described above, it failed to survive the House-Senate conference committee. However, legislators were favorably impressed by the proposal and encouraged Minnesota to re-introduce the plan next year.

The health insurance recommendations of the program are noteworthy. State-subsidized medical care would be extended for 12 months to clients who are making the transition from cash aid to employment. The proposed benefit package would differ from Minnesota's Medical Assistance and more likely resemble the primary care benefits offered under Children's Health Plan.

Massachusetts extension of Medical Assistance

The Massachusetts plan goes a step further. Under the new law, the state Department of Public Welfare will extend medical benefits to those moving off welfare into jobs without insurance if their income is not above 185 percent of the poverty level.

Other Potential Target Groups

College students

As previously mentioned, 23.5 percent of the uninsured are between the ages of 18 and 24. Many young adults in this age group are full or part-time students in community colleges, private colleges, universities, or vocational and technical institutions. While some students may also have part-time or summer jobs, their school affiliation offers a better opportunity for health insurance coverage than their seasonal or temporary connection to the work place.

Moreover, universities, colleges, and vocational and technical schools are attracting a greater number of older, "non-traditional" students who may lack health benefits. The availability of school-sponsored group plans could significantly lower the number of uninsured.

One provision of the Massachusetts Universal Health Care Law is mandated insurance for college students. Specifically, it

requires every public and independent college to see that all its full-time and three-quarter time students have health insurance coverage that meets the standards to be set by the new Department of Medical Security. Institutions which fail to comply must pay a daily penalty of $5 per student. The college student health insurance mandate is effective September 1, 1989.

A quick survey of health coverage offered by Minnesota institutions of higher education indicates wide variation.

- The University of Minnesota charges all students registered for six or more credits for campus-based primary and preventive care services, as part of their tuition. Students must also purchase the hospital insurance plan or provide written proof of alternative coverage.

- Student insurance coverage is available for purchase but not required in the Minnesota Community College (MCC) system. Two health insurance plans are offered. While there are no statistics available, a "high participation rate" is reported by MCC officials.

- There is no standard policy for student health insurance in the Minnesota vocational and technical institution system. Each of the 34 campuses has the option of making available the health insurance plan of its choice. There are no requirements for students to carry any type of health insurance and no methods to verify student insurance status.

Uninsured/underinsured disabled

The disabled population continues to be a special concern in any realignment of Minnesota's health programs. In some instances changes may benefit several groups, but often needs of specific groups are unique and do not overlap with others. Listed below are general and specific problem areas extracted from our interviews with the disability groups.

- There is recognition of employer reluctance toward hiring persons who are disabled. Many companies make an affirmative effort to hire disabled persons, but acceptance of this as a state policy needs to be promoted.

- When a disabled person is hired, it is often in a work situation where there is no health insurance. It may be necessary to offer an incentive to employers so that health coverage is available to disabled persons who are employed.

- If the employed, disabled person gets sick or has a relapse (depending on the nature of the disability), he or she must spend-down to MA eligibility in order to obtain medical coverage. There should be a financial "buffer zone" so preventive health care is available without excessive personal loss.

- Eligibility for insurance coverage through the Minnesota Comprehensive Health Association (high-risk pool), doesn't help because most disabled people cannot afford the premium, and typically, their annual health costs do not exceed the deductible amount. A subsidy to lower the premium, deductible and copayment for disabled persons would be helpful. Always suggested is a buy-in provision to existing health care programs.

- Certain disabled persons must have medication in order to remain functional. The medications are expensive, but not quite to the point where insurance will reimburse for them. The solution to this is higher coverage for medications that are necessary for normal functioning. There is currently state and federal provisions that will help to alleviate these problems, as well as several that will be proposed.

The following provisions help to solve some of these problems.

- Medical Assistance allows a higher earned income disregard for persons who are certified disabled, and do not reside in a medical institution or long term care facility. Specifically, the first $65 and one half of the gross monthly earned income of such persons is disregarded. There is no maximum on the amount using this disregard.

- The disregard provision reduces the effect of spend-down by increasing the eligibility standards for disabled persons.

- For persons with developmental disabilities who are employed there is a special personal allowance of $80 in addition to the usual $45 personal needs allowance.

- There is a request to the 1989 Legislature to increase the AFDC income standard. Since MA eligibility for disabled persons is set at 115 percent of the AFDC standard, this would have the effect of raising the eligibility level. Federal law allows eligibility for the disabled to be 133 percent of the AFDC standard, but this change is not currently being proposed.

- A provision in the Medicare Catastrophic Legislation would allow buy-in to Medicare for certain disabled employed individuals.

- Federal legislation effective in 1991 would provide catastrophic drug benefits under the Medicare program which would help persons with on-going medication needs.

There are also health conditions such as epilepsy that do not meet the current definition of disabled, so do not benefit from these provisions.

Uninsured unemployed

When workers lose their jobs, they and their families often lose health insurance as well. In order to help the newly unemployed maintain health benefits, many states, including Minnesota, have adopted continuation and conversion policies.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that employers with 20 or more employees who provide group health insurance include continuation and conversion policies. This federal law stipulates that continuation policies

- must be provided for 18 months following job termination or a reduction of hours and for 36 months to the spouse in case of death, divorce, or legal separation from the covered employee, or loss of coverage due to Medicare eligibility

- cost no more than 102 percent of the group health policy premium

- not exclude persons with pre-existing conditions

While the COBRA measures ensure that group health insurance is available to many recently unemployed workers and their families, large numbers lack benefits because they cannot afford to pay the premium costs. Divorced or widowed spouses who have lost health insurance may also find the premium payments prohibitively high.

ERISA prevents states from taking mandatory measures to improve financial access to health care for the uninsured unemployed that apply to all employers. Specifically, states cannot require self-insured companies to cover the costs of continuation policies. However, some states have proposed or enacted special financing mechanisms for subsidizing insurance for the unemployed.

o Missouri proposed a "Med-Assist" program that would have established a health insurance trust fund for the unemployed funded with a 0.6 percent state tax on earned, reported income which could be collected via payroll deduction.

o In order to fund coverage for the uninsured receiving unemployment compensation, Massachusetts will require all businesses, except those with five or fewer employees, to pay an unemployment health insurance surcharge of 0.12 percent or total wages up to $14,000, effective January 1, 1990.

Health Insurance Information Center

The state could establish a health insurance information center to provide information to employers of 30 or fewer employees

about health insurance plans, options, costs, and comparable products. This function would also provide information to state policy makers. Eligible firms and employees would receive a subsidy to purchase appropriate insurance plans.

According to research findings, many employers do not provide health insurance to their employees because they lack information about what is available and affordable. Most are concerned about the cost and do not know about comparable packages. Similarly, insurance agents know very little about small employers and do not market to them.

PART SIX
RECOMMENDED NEXT STEPS

Legislative Mandate

The Department of Human Services recommends that the Minnesota Legislature pass a strongly worded law supporting the establishment and implementation of a statewide, state-subsidized health insurance plan for all uninsured Minnesotans. A specific time period--five to seven years-- should be designated as the goal for full implementation. This legislation will provide adequate notice to employers, insurers, health care providers, and potential enrollees of the state's serious intent to assure access to health care services for all residents.

Until this commitment is made in law, ernest negotiation and program design cannot begin. As this report describes, there are several policy issues that must be resolved and agreed to by the Legislature. All have serious cost implications. A comprehensive, universal health plan will require

o broad-based support

o significant financial investment that will only increase over time with medical cost inflation and rising enrollment

o political consensus and a serious, long-term funding commitment

Appropriation to Provide Informational Base

The Department of Human Services recommends that the Legislature appropriate adequate funds to the Commissioner of Human Services this biennium to support the initial research and development that will provide the information base necessary for detailed program design. Although some members of the Resource Group are inpatient for evidence of progress towards the goal of a fully implemented plan of health insurance for all Minnesota residents and all unsympathetic to our request to do research, considerable research is necessary. The current data base is extrapolated from national data that is ten years old. Neither the Health Department nor the Department of Human Services had funds to do the necessary in-depth research on this subject. Further research is necessary to better understand

- characteristics and health insurance preferences of individuals or households without insurance

- small employer health insurance needs and trends

- design factors for affordable small group products

- the effect of cost-sharing on enrollment and utilization for specific income populations

- health insurance issues for specific subgroups of the uninsured such as disabled adults, the unemployed, college students, and their dependents

- marketing and administrative issues for health insurers and small businesses

Research would include surveys, hearings, and the purchase of expert consultation. Technical assistance is needed to address important program design elements including rate structures, enrollment activities, benefit design, and contracting arrangements with private insurers, as well as creative financing strategies to support a state plan.

Research and development activities would be complemented by implementation of two or more pilot projects.

Pilot Projects

The Department of Human Services recommends that the Legislature appropriate sufficient funds in this biennium to the Commissioner of Human Services to support two to four pilot projects that would be implemented in the second year of the biennium. These projects would enable the state to address issues of the uninsured through a variety of strategies. The pilots will generate valuable information and practical experience that will be used to build a statewide program.

The two current projects in early stages of development have not as yet enrolled clients or contracted with insurers or health care providers. The project in Northeastern Minnesota may be able to enroll people in late spring 1989, but we still do not have data that can be used to design a statewide program. The opportunity exists, however, for both projects to contribute information and experience in the future from their different program models in different regions of the state.

Additional opportunities exist in the Twin Cities area for a pilot project or projects with a limited provider network of publicly funded health care providers who already serve a significant portion of the uninsured in this area. These pilots could yield information about client behavior and characteristics as well as benefit design, cost-sharing, marketing, outreach, contracting, and cost issues.

Another pilot should focus primarily on the employed uninsured. We need to know more about

- who is not purchasing insurance when the employer makes it available

- what are the special problems of small businesses

- what the state can do to bring smaller employers together to reduce marketing, administration and benefit costs for their businesses

Implementation of a state health insurance plan would be a major state initiative. It will always be very expensive. Commitment and preparation are important.

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APPENDIX A

Laws 1988, Chapter 689

Sec. 249. [HEALTHSPAN IMPLEMENTATION PLAN.]

The commissioner of human services, in consultation with the commissioners of health and commerce, shall develop a plan to implement the healthspan program to provide health coverage to uninsured individuals. The plan must include at least the following:

(1) estimates of the number of people eligible for the program, the expected number of individuals who will enroll, and the costs of the program;

(2) a description of benefits to be offered;

(3) recommendations for methods to determine eligibility and collect premiums;

(4) strategies for contracting and marketing;

(5) strategies to preserve and enhance employer participation in the provision of health care coverage;

(6) strategies to coordinate or merge the program with health care programs such as general assistance medical care, the university hospital papers program at the University of Minnesota hospitals, Minnesota comprehensive health association, medical assistance, Medicare, the catastrophic health expense protection program, the children's health plan, and other similar programs;

(7) timelines for implementing the program, with specific implementation plans for the 1989-1991 biennium;

(8) methods of financing the program; and

(9) recommendations for legislation to implement the program.

The commissioner shall report to the legislature by January 1, 1989, on options to implement the program.

APPENDIX B

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APPENDIX C

Other State Initiatives

Commonhealth: New Groups To Be Covered By Massachusetts Medical Assistance

Group	Summary	Services Covered	Income Requirements	Estimated Number of Clients
Welfare - To - Work	individuals moving off welfare into jobs will keep medical coverage (MA) for 24 months	Most in-patient and out-patient health services are covered. Two options: fee-for-service or HMO	Up to 185% of the federal poverty guideline	4,000 families 12,000 individuals
Pregnant Women and Infants	Financial eligibility for MA for uninsured pregnant women and infants increased to twice the current level	Medical Assistance	Up tp 185% of the federal poverty guideline No asset limit	4,000 women 4,000 infants
Children Up To Age Five	Financial eligibility for MA for young, uninsured chuildren increased to twice the current level	Medical Assistance	Up to 100% of the federal poverty guideline No asset limit	5,500
Disabled Unemployed Adults	Adults who are ineligible for both employer-based coverage (because of disability) and MA can buy coverage from the state. Premiums based on sliding fee scale.	Most in-patient and out-patient health services, basic and disability-related, are covered. (Case management, transportation, ICF/MR not covered)	None	2,000
Disabled Children	Same provisions as for unemployed disabled adults	Same as above	None	Over 1,000

WISCONSIN'S STATE INSURANCE PROGRAM (SHIP) PILOTS

Research for the uninsured and for universal access to health has been quite advanced in Wisconsin for a few years. The state received a Robert Wood Johnson Foundation grant to study this subject. The conclusions led to plans to establish five pilot programs and the hope to go statewide soon afterwards. Political changes altered these initial prospects. The whole project was put on hold after the 1986 gubernatorial elections. It resumed later but was reduced to three pilot programs. Pursuant to legislation passed on June 9, 1988, the three programs will respectively begin in January, March, and June of 1989. Details are under study.

The number of uninsured is currently estimated at about 553,000 persons. Of this number, about 85 percent are believed to be connected to the work force either as employees or as dependents of employees.

The Department of Health and Social Services, with the advice of a Council on Pilot Project Implementation appointed by the Governor and Legislature, will create the criteria for rules on location of pilots, benefits, eligibility, and a sliding scale subsidy based on income. All pilots will include an intensive outreach/education/marketing component to sensitize both employers and employees on the need for and value of health insurance.

The Subsidy For Low-Income Employees of Non-Insuring Firms (Pilot 1) will promote group plans by encouraging non-insuring employers to use their employees' subsidies (toward payment for group plan premiums. Participating employers will be able to choose from approved insurance products currently available in the marketplace. Group arrangements will be promoted in order to lower the cost of group plan premiums. The pilot will most likely be located in one of the Robert Wood Johnson Foundation grant study counties where survey analyses reveal a preponderance of non-insuring firms.

The Subsidy for Low-Income Employees of Insuring Firms (Pilot 2) will enable employees previously unable to afford their share of the company's health plan for themselves and/or their dependents to participate. Benefits will be those contained in the group plan currently offered by their employer. Except for themselves and/or their dependents to participate. Benefits will be those contained in the group plan currently offered by their employer. Except for those self-insured companies exempted by ERISA, all company policies must be in compliance with state mandates for group policies. The pilot will probably be located in a county where research indicates the presence of a large number of insuring firms spread across several second and third class cities.

The Alternative Health Care Coverage Pilot will provide a discount for qualifying persons with disabilities to buy into a Medicaid-like benefits package. The pilot will probably be placed in the state's largest city/county since it requires an environment where substantial labor needs and job opportunities exist for persons with disabilities. Furthermore, an established, accessible transportation system and provider network must be in place.

It is anticipated that the pilots will be funded past the initial six months of subsidy currently provided, most likely for at least two years. Data on enrollee participation, vendor contract compliance and the effectiveness of the SHIP effort in helping individuals gain independence through the availability of health insurance coverage will be collected and evaluated.

SUMMARY OF OTHER STATE INITIATIVES FOR THE UNINSURED

Oregon

* Beginning November 1, 1988, Oregon offers employer tax credit (up to $25 per employee per month):
  - for businesses with 25 or fewer employees
  - for businesses not providing health insurance for the last two years
  - employees must work at least 17.5 hours per week

Tax credit cannot exceed 50% of premium.
Estimated cost to state: $1-3.5 million.
Legislature limiting to 10,000 beneficiaries in the first year.
* Recommend expansion of Medicaid for pregnant women and children to full extent under federal law.

Use federal MA dollars to subsidize health insurance for persons between 58-100% poverty. (Need federal waiver)

* Seeking $15 million from state's surplus for reserve fund for a High Risk Insurance Pool.
* Seeking expansion of MA benefits up to 9 months for former AFDC recipients. State subsidy for purchasing health insurance to qualified persons (based on sliding scale).

Hawaii

* Hawaii Prepaid Health Care Act (PACA) enacted in 1974, requires employers to provide health insurance to employees:
  - who have worked at least four weeks
  - who work at least 20 hours per week
  - whose monthly wage is 86.7 times the minimum hourly wage

Employer must pay at least half of the premium.
Dependent coverage is optional.
State has a fund to subsidize employers with fewer than eight employees.

* Estimate that 98% of Hawaii's employed are insured.

Pennsylvania

* Drafting legislation to create incentives for employers to purchase health insurance for employees (still considering imposition of mandatory insurance):
  - part and full-time employees
  - dependent coverage
  - limited coverage
  - average premium rate of $1,500 per employee with a possible cap
  - no employee contribution if less than 125% poverty

* SNIP: Special Non-Group Insurance Project
For persons/families not covered by employer plan.
Cost sharing features:
- no deductible if less than 200% poverty
- $100 annual deductible if greater than 200% poverty

Income-related premium costs.
Administered and marketed by Blue Cross/Blue Shield.
All HMO's and Community Health Centers receiving state funding are required to accept SNIP clients.
Cost estimate (based on 100,000 enrollees) is $65 million from 7/1/88 to 6/30/89.

* Extend MA coverage to 15 months for former AFDC recipients.

Expand MA to full federal participation for pregnant women and infants.

* Service expansion:
- Grants to existing local provider
- Expand MD supply (loan repayment program)

New York

* Comprehensive Pilot Program for the Uninsured
Administered through New York Department of Health.
Two models:

A. Individual Subsidy Program - For persons/families less than 200% poverty. Subsidy offered on sliding scale, inversely related to income.
B. Employer Incentive Program - For businesses with 20 or fewer employees who do not offer health insurance.

State pays 50% of employer's premium cost.
Employers must apply to participate (60 day application period).
Eligibility Based on available funding

* Catastrophic Health Care Expense Program provides coverage to eligibles after available insurance benefits are exhausted.

Covered services same as Medicaid.
Cost-sharing is dependent on family income and medical expenses (similar to MA "spend-down").

Missouri

Held November referrendum on "Med-Assist" (Missouri Health Care Trust) program for uninsured.
Also known as Amendment 8; a private sector initiative.
Program establishes a trust fund for health insurance for the unemployed.

Creates an insurance program through which unemployed and uninsured can purchase state-subsidized health insurance (premiums, copays, and deductibles set on a sliding scale). Proposed 0.6% state tax on earned reported income which will be collected via payroll deduction.

Anticipated revenue for operation from three sources:
- payroll tax revenues
- federal Medicaid match
- premium payments

Specific benefit package is yet to be determined.

California

Proposed by the Health Access Foundation Coalition Canadian-like Model
100% of CA residents must be eligible for all services under the Health Plan.
Eligibility not affected by changes in health status or employment.
All consumers receive the same benefits.
Need agreement with the federal government to permit the transfer to the Trust Fund, all funds, grants, and state-entitled federal monies.
All non-Federal mechanisms currently used by the state to fund health care are to be consolidated and deposited into the Trust Fund.

Additional financing options:
- income tax to be levied on all CA residents
- income tax plus a percentage of payroll tax deposited directly into the Fund
- requirement of annual premium remittance (subsidies for low income persons/families).

Iowa

* Identified four separate categories of uninsured and two categories of underinsured:

I. Uninsured
   A. Medically Uninsurable (individual with pre-existing medical conditions/high risk and usually uninsurable.
   B. Employed Uninsured (includes full and part-time employees)
   C. Unemployed Uninsured
   D. Uninsured Children

II. Underinsured
   A. Third Party Indigent (under age 65)
   B. Medicare INdigent (65 and over)

** Underinsured definition: individual who is covered by insurance, including Medicaid, but their per capita income is not adequate to pay noncovered expenses including deductibles and catastrophic expense.

* Proposed strategies for Iowa:
Employer incentives for purchasing health insurance.
Payroll or other employer tax for those not providing health insurance.
Mandatory federal/state requirements of coverage.
Income related Medicaid buy-in for "boarderline" persons/-families.
Implement sliding scale plan similar to those proposed in WI, MA, WA.
Expand IA Medicaid program to include SOBRA options.
Use of prospective payment and managed health care as vehicle for service.
Establish and Indigent Care Revenue Pool Program.
Cooperate with IA Insurance Department to educate and market health insurance information to the public.

HEALTH CARE FOR THE UNINSURED PROGRAM

In 1986-87, the Robert Wood Johnson Foundation awarded fifteen grants under its Health Care for the Uninsured Program. Grant recipients include the following organizations:

* University of Alabama at Birmingham Hospital
* Arizona Health Care Cost Containment System
* San Diego Council of Community Clinics
* United Way of Bay Area, San Francisco
* Denver Department of Health and Hospitals
* Florida Department of Health and Rehabilitative Services
* Maine Department of Human Services
* South Cove Community Center, Boston
* Michigan League of Human Services
* New Jersey Department of Health
* Tennessee Association of Primary Health Care Centers
* Intermountain Health Care Foundation, Salt Lake City
* Health Systems Resources, Seattle
* West Virginia Legislature
* Wisconsin Department of Human and Social Services

As a result of this funding, programs have been launched in these states as part of a national initiative to expand the availability of health care services for those who cannot afford care and who currently lack health insurance. Almost all of the grants will support efforts to improve the scope of affordable insurance coverage for vulnerable target groups. While each demonstration emphasizes special foci specific to the state, the leading features of these grants can be summarized in the following way:

* Extending private health insurance coverage to low-income, uninsured workers employed by small firms;

* Developing affordable health insurance products by limiting benefit coverage, utilizing efficient delivery systems, negotiating for provider discounts, and pooling together small employers by organizing Multiple Employer Trusts;

* Maximizing private sector financing through employer contributions for health insurance premiums.

Although virtually all of the projects utilize the above strategies, the following states have developed very innovative plans which will be highlighted here and discussed further at the meeting on October 10.

<u>Maine</u>

The Maine Department of Human Services will test a managed care system that serves multiple target populations of the uninsured. Together with this initiative, the State is proposing Medicaid

expansion, and the legislature will consider establishing a state risk-sharing pool. The Managed Care Demonstration program will test at two sites and will include an insurance plan which offers both primary and acute care services. Four distinct populations will be targeted for enrollment, all with separate payment mechanisms (AFDC-Medicaid recipients, employed uninsured, low income employees of small firms, and people near or below the poverty level). Financing comes from $260,000 of unspent monies from the State's scaled down catastrophic illness program and $300,000 in new appropriations will be sought from the legislature.

Michigan

The Michigan League for Human Services, a statewide citizen advocate organization, received the grant to implement a collaborative effort between the League and the Medical Services Administration which operates the State's Medicaid Program. The main objective of the project is to create incentives that encourage low wage employers to offer health insurance to former welfare recipients. A single basic health plan (The One Third Share Plan) which provides case managed/prepaid services has been proposed. The State will pay one-third of the premium. Financing of the State subsidy would be accomplished through existing state indigent care program funds, local support, and new state appropriations. The One Third Share Plan will be tested on a pilot project basis in an urban and a rural county.

Arizona

The Health Care Group of Arizona (HCG) was designed by the Arizona Health Care Cost Containment System (AHCCCS), the State's Medicaid program. The project was implemented statewide, beginning in January, 1988, in three stages and three different areas of the state. The HCG program offers employers a choice of four benefit packages, ranging from a traditional health maintenance organization (HMO) plan to a catastrophic-only option. The premium rate structure utilizes a tier and the group's aggregate age factor, and rates vary by county and benefit option. HCG encourages but does not require an employer contribution.

Utah

The Utah Small Employer Health Plan (USEHP), is targeted at those firms with fewer than eleven employees, the majority of which have incomes less than or equal to 200% federal poverty level. The program will be offered on a demonstration basis in Salt Lake City and Ogden. USEHP expects to incorporate a variety of strategies to help reduce plan expenditures and premiums (i.e. an annual limitation of 10-15 inpatient hospital days). Intermountain Health Care is proposing to request the State Legislature to designate USEHP as the secondary payer to the State Indigent Medical Assistance Program for eligible plan enrollees. USEHP will use a managed care delivery model.

APPENDIX D

MINNESOTA PUBLIC PROGRAMS PROVIDING HEALTH COVERAGE

Medical Assistance
Minnesota Statute 256B.

Program Summary

Medical Assistance is a statewide program designed to provide medical care for needy persons whose resources are not adequate to meet the cost of such care. (256B.01)

Target Population and Number Served

Aged, blind, and disabled, other low income persons, low income families with children and pregnant women and infants birth to one year old. Number Served: 1987 - 380,219; 1988 - 387,138 (unduplicated totals)

Eligibility

Persons who are categorically needy (such as SSI, AFDC) or medically needy as determined by income level and certain health conditions.

Benefits

Services that are paid by Medical Assistance include, but are not limited to:

- hospital care
- nursing home care
- public health clinics
- physician services
- prenatal care
- mental health services
- alcohol/drug abuse treatment
- dental services: including dentures
- laboratory and x-ray services
- chiropractic services limited to manual manipulation of the spine
- podiatry services
- home health services
- certified nurse mid-wife services
- private-duty nursing services
- physical therapy or related services
- early and periodic screening, diagnosis and treatment (EPSDT)
- prescription drugs and medical supplies
- eyeglasses; contact lenses and sunglasses are only covered for certain medical conditions
- hearing aids
- prosthetic devices
- medical equipment
- emergency medical transportation

Limitation on Benefits

Some services require prior authorization by the Minnesota Medical Assistance program before they can be provided. Applicants and recipients must agree to apply all proceeds received or receivable by the person or the persons spouse from any third person liable for medical care for the person, the spouse, and the children. Persons must cooperate with the State in establishing paternity and obtaining third party payments. (256B.06, subdivision 16)

Funding

Percent share effective October 1, 1988: Federal 53.07, State 42.24, County 4.69 percent.

General Assistance Medical Care (GAMC)
Minnesota Statute 256D

Program Summary

GAMC is established by statute to provide health care for persons who meet state determined standards for general assistance but not eligible for federal health care reimbursement. (Minnesota Statute 256D.03, subdivision 4(b).)

Target Population and Number Served

Persons who are receiving general assistance from the State, and need health care but are not eligible for the Medical Assistance Program. The number of persons served by the GAMC program for 1987 was 63,277, and for 1988 is projected to be 68,346 (unduplicated totals).

Eligibility Criteria

Persons who are eligible for assistance under Section 256D.05 or 256D.051 and are not eligible for Medical Assistance under Chapter 256B; or who are residents of Minnesota and whose income is not above MA standards and with assets of less than $1,000.00. Eligibility is available for the month of application and for three months prior to application if eligible during that time. Redetermination of eligibility is required every 12 months. (Minnesota Statute 256D.03, subdivision 3.)

Benefits

Reimbursement under the General Assistance Medical Care Program shall be limited to the following categories of service: inpatient hospital care, outpatient hospital care, services provided by Medicare certified rehabilitation agencies, prescription drugs, equipment necessary to administer sugar level, eyeglasses and eye examinations provided by a physician or optometrist, hearing aids, prosthetic devices, laboratory and x-ray services, physician's services, medical transportation, chiropractic services as covered under the Medical Assistance Program, podiatric services, and dental care. In addition, payments of state aid shall be made for:

1. outpatient services provided by a mental health center or clinic that is under contract with the county board and is certified under Minnesota Rules, parts 9520.0750 to 9520.0870;
2. day treatment services provided under contract with the county board; and
3. prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization (Minnesota Statute 256D.03, subdivision 4.)

Limitations on Benefits

Requirements for prior authorization are the same as for Medical Assistance. Applicants and recipients must agree to apply any third party health and accident benefits to the cost of medical care and must cooperate in establishing paternity. (Minnesota Statute 256D.03, subdivision 3a.)

Funding

The state pays 90% of the cost of care and the county pays the remaining 10%.

1987 Expenditures		1988 Expenditures (est.)	
State	$ 67,789,245.00	State	$ 71,791,840.00
Local	$ 7,532,138.00	Local	$ 7,976,871.00

Services for Children with Handicaps
Maternal and Child Health Federal Legislation

Program Summary

Services for Children with Handicaps, formerly called Crippled Children Services, is a program for evaluation, treatment, and habilitation of children with handicapping or disabling conditions. Goals of the program are early identification of children with suspected handicapping conditions, determination of a necessary treatment plan and follow-up, leading to maximum independence and quality of life for handicapped children.

Target Population and Number Served

Any child who is suspected of having a handicapping condition, and lives in Minnesota. Residents over 21 with cystic fibrosis, hemophilia, or taking a growth hormone can be served through this program. Number served for 1988 is 2,400.

Eligibility

For diagnostic services the child must be under 21 years of age, have a handicapping or possibly handicapping condition, a completed application for services, and pre-authorization by SCH, except in medical emergencies. For treatment services, the individual must have a medically eligible condition, a completed application for services, meet financial eligibility requirements, and pre-authorization by SCH.

Benefits

Diagnostic Services are available at SCH field clinics, or at a medical center. Treatment services include:

- physician and specialty visits
- laboratory tests and x-rays
- medications
- appliances and equipment
- hearing aids
- surgery and anesthesia
- hospitalization
- major restorative dental care

Limitations on Benefits

Services are covered only as they are directly related to the diagnosed handicapping condition. There is a $15,000 per 12 month cap on services.

Funding

For 1988, state funding was $3.1 million. For diagnostic evaluation, co-pay is required on a sliding scale using the state gross median income index. Cost of care is shared by the families medical insurance, Medical Assistance or other resources. SCH pays only after these resources have been used. Depending on financial status, families may be required to share the cost of care.

Children's Health Plan
Minnesota Statute 256.939

Program Summary

The Children's Health Plan was enacted in 1987 to provide preventive health services for uninsured children one through eight years of age. State studies show that over 100,000 children in this age group are not insured for primary care services. Uninsured children are typically in families where parents work but are not offered insurance by employers, are self-employed, or cannot afford insurance.

Target Population and Number Served

Children ages one through eight who are not insured for primary care services and are not eligible for Medical Assistance. 1989 projections are for monthly average enrollment of 9,625 children, 6,135 families.

Eligibility

Minnesota residency, age one through eight, not covered by other out-patient insurance, not eligible for Medical Assistance, and with family income not exceeding 185 percent of the federal poverty level.

Benefits

The Children's Health Plan includes coverage of all physician office visits, prescription drugs, eyeglasses, dental services (except orthodontics), rehabilitative therapies, and medical supplies.

Limitations on Benefits

The Plan does not include coverage if inpatient hospital services, nursing home, mental health, or chemical dependency services.

Funding

The Plan is funded with one-cent of the State tax on cigarettes. There is an enrollment fee of $25.00 per child per year.

Maternal and Child Health
USC 42 Section 2191
Minnesota Statute 453.24

Program Summary

The Maternal and Child Health (MCH) Services Block Grant funds assure a focus within Minnesota to improve the health of mothers, children, and their families. Technical support of community health programs and agencies is the focus of other MCH supported activities within the Department, such as MCH Technical Services and Grants, Public Health Nursing, and the Center for Health Statistics. The MDH activities provide leadership and program planning and evaluation, develop program standards, provide technical consultation and training, and provide grants administration of categorical funds allocated to local services for targeted groups.

Target Population and Number Served

Funds are targeted to the health needs of mothers, children, and their families through a variety of voluntary agencies and local health practitioners. Number of people served by MCH funds is estimated to be 46,000 for 1988.

Eligibility

Determined at county level. Income guidelines based on 200% of federal poverty level.

Benefits

The Maternal and Child Health funds were used during 1987 for screening newborns and young children; comprehensive care to high risk women, children and adolescents; Public Health Nurse visits for maternity, post-natal, family planning and child health visits; vision and hearing screening of school age children; and genetic counseling.

Limitations on Benefits

Medical care is not covered.

Funding

Federal funding authorized through USC 42, Section 2191.
Fiscal Year 1988: - Federal $5.3 million
- State $1.3 million

Minnesota Comprehensive Health Association (MCHA)
Minnesota Statute 62E.51

Program Summary

The Association was established in 1976 as part of the Minnesota Comprehensive Health Insurance Act, to provide health coverage for otherwise uninsurable persons through State Plan contracts. The Association is incorporated as a non-profit corporation under Chapter 317, with required membership of all insurers, faternals, and health maintenance organizations licensed or authorized to do business in the state (self-insurers are not included although they do cover 25% of the insured state population). Each contributing member is required to share costs not covered by premiums, and further, to share in operating and administrative expenses.

Target Population and Number Served

Persons who are state residents and are unable, because of medical conditions, to obtain health insurance. The number of subscribers as of June 1988 is 12,293, double the number for 1983 which was 6,043.

Eligibility

To be eligible for coverage through MCHA, applicants must be state residents for the six months immediately preceding application, and must provide evidence of rejection, requirement of restrictive riders, rate up, or a preexisting condition limitation by any member of the Association. Persons maybe enrolled who are certified by a physician as having certain health conditions. Under certain circumstances, the Association must waive eligibility requirements to include the following classes:

- any person covered under a Medicare supplement contract where the contract has been terminated by the insurer for reasons other than non-payment of premium, provided that the option to enroll in the State Plan is exercised within 30 days of termination of the existing contract (section 62E.14, subdivision 4);
- any employee who is voluntarily or involuntarily terminated or laid off from employment and unable to exercise the option to continue health coverage is permitted to enroll, provided that enrollment occurs within 60 days of termination or layoff (section 52E.14, subdivision 5);
- any person age 65 or over who is not eligible for Parts A and B of Medicare may purchase a number 1 qualified plan or a number 2 qualified plan (section 62E.18);

- any person covered under an individual HMO, non-profit health service plan corporation or individual health insurance policy where no replacement coverage is offered to the person, and provided enrollment is exercised within 30 days of termination of the existing contract (other limitations apply as well [section 62E.14, subdivision 6]).
- any individual or group enrollee of an HMO which becomes insolvent is eligible for alternative State Plan coverage for a limited period of time (section 62D.181).

Benefits

1. Number 1 Qualified Plan ($1,000 deductible), section 62E.06, subdivision 3. This plan is offered to persons under age 65 and is also offered to persons age 65 and over who are not eligible for Parts A and B of Medicare.
2. Number 2 Qualified Plan ($500 deductible), section 62E.06, subdivision 2. Again this plan is offered to persons under age 65 and is also offered to persons age 65 or older who are not eligible for Parts A and B of Medicare.
3. Qualified Medicare Supplement Plan. By direction of the Department, the Association offers the Medicare supplement 1+ plan as the qualified Medicare supplement plan under the State Plan. The Medicare supplement 1+ plan is part of the Medicare Supplement Insurance law, sections 62A.31 to 62A.44, and its benefits are defined in section 62A.32. The Medicare supplement 1+ plan is offered to persons age 65 and over who are enrolled in parts A and B of Medicare, and is also offered to persons under age 65 who are eligible for and enrolled in parts A and B of Medicare.
4. Medicare Supplement 2 Plan. The Association was recently authorized by the Commissioner to offer a Medicare Supplement 2 plan as an alternative for persons who are eligible for a Medicare Supplement 1+ plan. The benefits of a Medicare Supplement 2 plan are defined in section 62A.34. This contract is being offered as part of the experimental delivery method authorized under section 62E.10, subdivision 9.

Limitations on Benefits

Six month waiting period for benefits if diagnosis and/or treatment have occurred within 90 days prior to enrollment. January 1, 1986 the Association implemented a preadmission authorizationsprogram for inpatient hospital stays (with a $250.00 deductible) and a concurrent stay review for hospitalizations.

Funding

Association members share in the claims expense and operating and administrative expenses in an amount equal to the ratio of the contributing members total accident and health insurance premium, received from or on behalf of Minnesota residents as divided by the total accident and health insurance premium received by all contributing members from or on behalf of Minnesota residents. The association has experienced increased operating losses since 1979 as shown by the following table.

MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION
PREMIUM/LOSS/ASSESSMENT DATA
1979-1987

Year	Earned Premiums	Claims Incurred	Incurred Claim Ratio	Operating Loss/ Assessments
1979	$ 825,000	$ 1,664,000	202 %	$ 1,081,000
1980	984,000	1,845,000	188	1,007,000
1981	1,305,000	3,078,000	236	1,925,000
1982	2,325,000	4,914,000	211	2,945,000
1983	4,082,000	7,632,000	187	3,973,000
1984	6,414,000	10,612,000	166	4,795,000
1985	9,492,000	14,125,000	149	5,507,000
1986	10,772,000	18,914,000	176	9,024,000
1987	11,407,000	21,893,000	192	11,280,000

Report to Commissioner on Health Plan Regulatory Reform from MCHA. 1988.

University Hospital Papers Program
Chapter 158

Program Summary

University Hospital Papers is a program under which the board of county commissioners can authorize payment for medical care at the University of Minnesota Hospitals and clinics for county residents who are medically indigent. (Instructional Bulletin #84-22.)

Target Population and Number Served

Target population of the program is individuals identified at the county level who are in need of care and are unable to pay.

Eligibility

Individual counties develop their own standards to determine eligibility for the University Hospital Papers program.

Benefits

Effective July 1, 1983, the payment formula for patients referred by the counties provides that the State will reimburse 60% of charges up to $11,000.00 and 100% of charges above that amount. Covered services include board and room in the hospital, routine medical care, medical services, x-ray and laboratory work, drugs and supplies and clinic fees. Patients are not charged for physician services they receive.

Limitations on Benefits

Eligibility for the program is determined by the county and may involve spend-down. The county share of cost is 40% of the first $11,000.00. (Instructional Bulletin #84-22.) Counties are required to pay traveling expenses of the patient, the per diem, and expenses of the person appointed to accompany the patient. (Chapter 158.04.)

Funding

State funding for 1988 - $400,000.00
State funding for 1989 - $300,000.00