20178 Policies

PUBLIC HEALTH CARE PROGRAMS

Employers across Minnesota annually rank reducing government spending as a top legislative concern, with many consistently reporting that state taxes used to fund state public programs have become increasingly burdensome.

These concerns are highlighted when placed against the backdrop of Minnesota's public health care programs, because Minnesota's public program health care benefits are more expensive and expansive than other peer states. As an example, while Minnesota has the 19th largest Medicaid population in the country, we rank seventh in the country for highest Medicaid spending per enrollee – largely driven by our per enrollee spending on disabled individuals (2nd highest nationally) and low income children (7th highest nationally).[1] While today's Medicaid growth in Minnesota is primarily due to the non-elderly population, we need to be cognizant of the growing senior demographic, and encourage Minnesotans to plan and save for their own long term care needs. ~~As an example, Minnesota ranks ninth in the country for highest Medicaid spending per enrollee, largely driven by its per enrollee spending on individuals with disabilities (4th highest nationally), low income children (6th highest nationally), and the aged (12th highest nationally).~~ Minnesota's business community has an interest in ensuring that the public health care programs funded by state taxpayers provide access to quality, affordable health care coverage to eligible Minnesotans. However, employers want to ensure these programs provide this coverage in a financially sustainable way balancing costs for providing care with accessibility for populations in need, and preparing enrollees for eventual private-sector coverage.

OUR GOALS

Ensure health care public programs: are sustainable in size and scope; promote choice and empower enrollees as consumers; utilize market-driven programs when and where possible; are accessible to those populations in need of them; are supported by sustainable and equitable financing mechanisms; reward outcomes through delivery and value-based payment reform; promote personal responsibility for financing future service needs; and leverage federal dollars to the greatest extent possible.

OUR KEY PRIORITIES FOR THE 20178 SESSION INCLUDE:

- ~~Provide sustainable health care coverage to the MinnesotaCare population.~~
- ~~Establish an advisory commission for the state's Medicaid program.~~
- MinnesotaCare & Health Care Access Fund Reforms.
- Long Term Care Financing Reform
- Prepare public program enrollees for transition to private coverage.
- ~~Pursue a health insurance exchange model that meets the state's needs.~~
- Increase access to the federal health insurance tax credits and subsidies.

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[1] FY 2014 Data, State Health Facts, Medicaid & CHIP, Kaiser Family Foundation

~~PROVIDE SUSTAINABLE HEALTH CARE COVERAGE TO THE MINNESOTACARE POPULATION~~

~~Minnesota offers subsidized health coverage to individuals between 138% and 200% of the federal poverty level (FPL) through MinnesotaCare. We're one of only two states to provide this coverage. The program's largest funding source, the 2% provider tax or "sick tax" that's levied on virtually all health care services, will sunset in 2019. The program also offers very generous benefits, which has a financial impact as well and presents enrollees with a disincentive to pursue upward economic mobility, because any increase in their income above 200% FPL would make them ineligible for the program and its rich benefit set.~~

~~To ensure the long-term viability of coverage for the MinnesotaCare population, the state should pursue all available federal funding, smooth the benefits "cliff" that provides a disincentive for enrollees to increase their income above 200% FPL, and prepare for the financial implications of the expiring provider tax.~~

~~ESTABLISH AN ADVISORY COMMISSION FOR MEDICAID~~

~~The state's Health and Human Services (HHS) budget, roughly one-third of total state spending, is expected to grow by 12.7% in the next biennium – far outstripping growth in other areas of the state budget.[2] Medical Assistance (MA), the state's Medicaid program, is the largest program in the HHS budget, with spending on benefits for the disabled, low-income children, and the aged accounting for more than 80% of the MA budget.[3] Through MA, the state serves very vulnerable populations, which is why more must be done to ensure the program remains financially sustainable and viable over the long term. To provide input and recommendations about reform and other opportunities to strengthen the MA program, Minnesota should establish an independent advisory commission for Medicaid similar to the federal Medicaid and CHIP Payment and Access Commission (MACPAC). Like MACPAC, whose commissioners are selected by the U.S. Government Accountability Office's Comptroller General, appointments to Minnesota's Medicaid commission should be made by the state's Legislative Auditor, whose own work to bring transparency, accountability and reform to the state's public health care programs will provide Minnesotans assurances about the independence of the new commission and the soundness of its recommendations.~~

MINNESOTACARE & HEALTH CARE ACCESS FUND REFORMS

Lower income Minnesotans are eligible for two different publicly subsidized health care programs: Medicaid, which covers about 1.1 million individuals who are disabled or who have incomes below 138% of the federal poverty level (FPL), and MinnesotaCare, which covers about 115,000 individuals with incomes between 138% and 200% of FPL. Only one other state offers health care coverage similar to MinnesotaCare (New York). MinnesotaCare is funded through the Health Care Access Fund (HCAF), which is paid for with a 2% provider tax or "sick tax" levied on virtually all health care services and a 1% premium tax on certain fully insured health insurance products sold in Minnesota. As part of the Affordable Care Act, Minnesota was able to draw down federal funding for Minnesota Care – funds which are projected to cover nearly 90% of the program's cost in FY18. However, federal approval of Minnesota's reinsurance program for the individual insurance market has prompted a roughly 45% cut in federal funding for MinnesotaCare. This loss in federal funding coincides with the scheduled sunset of Minnesota's provider tax in 2019. The shifting landscape around the financing of MinnesotaCare will require legislative action in the near future to continue the program. Options

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Rising health care costs in Minnesota pose significant budget challenges for employers, individuals, and the state. According to some analyses, Minnesota nears the top of the list when ranked for its commercial health care costs (5th highest nationally)[2] – with year over year increases in the cost of care consistently outstripping general inflation.[3] As noted above, we also have some of the highest per enrollee Medicaid spending in the country. Ever increasing commercial health care costs continue to strain employers' budgets and their ability to keep their employees insured, healthy, and productive at work. Similarly, the state's Health and Human Services (HHS) budget, roughly one-third of total state spending, is expected to grow by 15.4% in the current biennium – far outstripping growth in other areas of the state budget.[4] Minnesota cannot sustain these types of health care cost increases forever – whether in the commercial market or in state public programs. This is especially true when considering the costly demographic challenges we'll soon face[5] and the positions we *already* hold atop national rankings of costs and spending. Escalating costs will eventually erode Minnesotans' access to care and the quality of the care they receive – regardless of whether they have public or private coverage. ¶

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To provide input and recommendations about how we as a state can better achieve improved care and health outcomes at lower costs through our commercial market and public programs, Minnesota should establish an independent Health Policy Commission. This independent Commission should work to understand why Minnesota ranks so high in health care costs and spending, identify what the drivers are of escalating health care costs and spending in Minnesota, and offer recommendations about policy, legislative, and market reforms that could be undertaken to bend the cost curve and improve care and access for all Minnesotans. It should provide regular reports and input to the Legislature and should be supported by permanent, professional staff with the expertise and skill set necessary to help the Commission fulfill its mission. ¶

include: (1) removing the provider tax's scheduled sunset; (2) allowing the tax to sunset in favor of using General Fund resources instead; (3) reforming the program to reduce its costs and reforming the flow of funds into and out of the HCAF to better align its revenues and expenditures; and (4) ending the program altogether.

If the Legislature chooses to continue MinnesotaCare, the Chamber supports reforms to the program because its very generous benefits increase the program's costs and present enrollees with a disincentive to pursue upward economic mobility. We also support a right-sizing of HCAF expenditures. In recent years, hundreds of millions of HCAF dollars have been diverted to non-MinnesotaCare purposes, like paying for a share of the state's Medicaid program. These diversions from the HCAF highlight the fact that the state has been significantly over collecting the provider and premium taxes paid into the HCAF. If the Legislature chooses not to transition funding for MinnesotaCare to the General Fund, any collection of the premium and provider taxes in the future must be significantly lowered to match the actual needs of the MinnesotaCare program and must be rebalanced to address the reality that the current tax structure disproportionately impacts small and medium sized fully insured employers.

PREPARE PUBLIC PROGRAM ENROLLEES TO TRANSITION TO PRIVATE COVERAGE

Beyond providing care for populations in need, our public programs should seek to prepare enrollees for eventual private-sector coverage. To do this, and to increase consumer choice and portability, Minnesota should utilize market-driven solutions (e.g. defined contribution arrangements) within our public health care programs when and where possible.

~~PURSUE A HEALTH INSURANCE EXCHANGE MODEL THAT MEETS THE STATE'S NEEDS~~

~~Minnesota's experience with its state-based health insurance exchange, MNsure, has been disappointing at best. The Minnesota Chamber supports a health insurance exchange that efficiently qualifies eligible consumers for federal subsidies and state public programs, enhances consumers' ability to competitively shop for health insurance based upon quality and cost, reduces cost and streamlines administration, and preserves state flexibility to the greatest extent possible. To do this, the state should actively explore the use of products and services available in the private market through a partially privatized exchange model and should aggressively move to this model if it can efficiently deliver on these goals.~~

INCREASE ACCESS TO THE FEDERAL HEALTH INSURANCE TAX CREDITS AND SUBSIDIES

The Affordable Care Act requires eligible individuals or small businesses to receive their health insurance through ~~the state or federally sanctioned health insurance exchange~~ MNsure to access the federal tax credits and subsidies that are available to help offset the cost of health insurance. To maximize consumer choice in shopping for health insurance, in 2015 the Legislature directed the relevant state agencies to pursue federal waivers to allow eligible individuals and small businesses in Minnesota to receive federal health insurance tax credits and subsidies outside of MNsure. The need for this flexibility is now even more important, as MNSure will not offer any small group coverage options in 2018. The Legislature should push the agencies to complete work on these waivers as

soon as possible to ensure that Minnesotans can access these important financial supports whether or not they choose to use ~~the state's health insurance exchange~~ MNsure.

Long Term Care Financing Reform

By year 2020 there will be more seniors than schoolchildren, and the risk of needing long-term care services and supports (LTSS) grows with age. By the year 2030, one in five Minnesotans will be 65 of older. Approximately seven in 10 Americans who reach age 65 in the next five years can expect to need some level of LTSS[6]. Almost a fifth (19%) of Americans over age 65 are expected to have LTSS needs that last less than a year, and about 14% are expected to have needs that last more than five years[7].

Expenses associated with LTSS will double as a share of the national economy over the next 30 years.[8] Unless we find alternative approaches to LTSS financing, our ability to provide and pay for care for future generations of older Americans will be seriously impacted. Older adults themselves will not be prepared for the costs they might incur to use LTSS. In addition, our greatest source of care -- unpaid care from family and friends -- will become less available due to the dwindling supply of potential caregivers[9].

The Medicaid program has become the default payor for LTSS because there are no significant alternative sources of payment for LTSS, other than an individual's private resources, nor are there proper incentives for individuals to plan for future LTSS expenses. Few individuals are financially prepared to cover their LTSS needs once those needs become evident. In 2014, individuals aged 65 and over had median financial assets of $75,750 and median home equity of $80,600. This level of resources is not sufficient to cover the costs of retirement, let alone additional LTSS expenses.

In many cases, individuals or family members pay for a loved one's services because the care recipient can no longer afford to pay for that care, especially when the level of needed care is high. However, middle- and low-income families rarely are prepared for the financial impact of paying for LTSS. Most families falsely believe that Medicare will cover any medical expenses for their loved ones once they turn 65; as a result they have not saved for those medical and social supports that will surface as they age. The combination of lack of savings and planning, along with expenses not covered by Medicare means these families turn to Medicaid when they run out of money. With no other viable third-party funding option for middle-income individuals and families, the fiscal burden for LTSS falls directly on the Medicaid program for the subset of individuals who live with LTSS needs for an extended period of time.

[6] Favreault M. M,, & Johnson, R. W. (2015). Projections of lifetime risk of long-term services and supports at ages 65 and older under current law from DYNASIM. Washington, DC: Urban Institute.

[7] Favreault, M. M., & Dey, J. (2015). Long-term services and supports for older Americans: Risks and financing research brief. Washington, DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[8] Congressional Budget Office. (2013). Rising demand for long-term services and supports for elderly people. Washington, DC: Author.

[9] Redfoot, D., Feinberg, L., & Houser, A. (2013, August). The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers. Washington, DC: AARP Public Policy Institute

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It is important to support efforts to redesign the LTSS financing system to help individuals plan and save for likely LTSS future needs, so that fewer individuals will need to turn to Medicaid to cover the costs of LTSS. Supporting new products, such as those identified in the Own Your Future collaboration is an important step in this work.

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