

Health Care Solutions Still Depend on State Efforts

Peter J. Nelson, J.D.
Policy Fellow

Overview

A month ago, federal health care legislation seemed all but certain to pass. This legislation appeared to obviate the need for many state-based health care initiatives, especially efforts that dealt with Medicaid and insurance markets. In addition, Minnesota's general assistance medical care (GAMC) program seemed to need only a temporary fix to bridge the gap between now and when new federal programs kicked in. However, as everyone knows, political winds took a dramatic shift in January. The election of Scott Brown (R-Massachusetts) to the U.S. Senate eliminated the Democrats' filibuster-proof majority, which has effectively required Congress to step back and carefully re-examine their entire plan to transform America's health care system.

The lesson here is that Minnesota cannot rely on the federal government to take responsibility for our health care system. Therefore, Minnesota policymakers should continue efforts to make health care more accessible and affordable through Medicaid and insurance market reforms. Also, initiatives to fix GAMC need to start taking a longer view, in terms of both the program and the state's budget mess.

Stalled federal legislation underscores continued need for state-based solutions

The loss of the Democrats' filibuster-proof majority in the U.S. Senate provides a helpful pause—a moment to more fully examine congressional

efforts to centralize and federalize America's health care system. Even after months of heated debate, key provisions that would transform the regulation and administration of health care have not received serious public scrutiny. Public discussions focused on the public plan option at the expense of a meaningful dialogue over insurance mandates, a national insurance exchange, federal benefit setting, and other provisions that would put health care under federal control. While there are certainly some health care initiatives that benefit from federal leadership (tax code reform is one), states are generally the better test bed.¹

Though it might seem that we've given state laboratories of democracy more than enough time to sort this out and that, therefore, it's time to hand it over to the feds, states are only just beginning to embark on more holistic solutions. Massachusetts became the first test case for a comprehensive approach in 2006.² In 2008, Minnesota seriously

¹ With fewer substantial political obstacles, innovative ideas gain easier passage at the state level. Similarly, and maybe more importantly, failing ideas are easier to abandon. Indeed, consider the various initiatives in the U.S. House and Senate proposals—individual insurance mandates, employer mandates, Medicaid expansion, individual insurance market subsidies, community rating and guaranteed issue insurance regulations, insurance exchanges, insurance risk adjustment, etc. Nearly all of these initiatives took shape first at the state level, where they have been refined through years of trial and error.

² It may be more accurate to identify Hawaii as the first test case, but it's difficult for many states to draw lessons from the island's unique political, economic, geographic, and historical setting.

considered the Massachusetts approach, but, instead, adopted substantial changes that focus on value-based provider payments and market transparency. Further, there's enough difference among the states to warrant different approaches versus a centralized federal solution. Differences in health care delivery systems, medical education, legal environments, and cultures all point to the fact that what works in Minnesota might not work in Florida or Massachusetts. The primary role for the federal government should be to remove federal barriers—such as Medicaid, employee benefit, and tax code regulations—that block state efforts to adopt comprehensive reforms.

But whatever you might think about the advantages or disadvantages of state versus federal efforts, the now dim prospect for a federal solution underscores the fact that states are back in the driver's seat. Therefore, policymakers in Minnesota need to pick up any lost steps and continue their state-level efforts to improve Minnesota's health care system.

Reinstating GAMC is of immediate concern

Last year, Governor Pawlenty vetoed General Assistance Medical Care, a health care program for very poor adults without children. In his veto letter, the governor carefully noted that his action needn't be the final word on GAMC. "The impact of this item veto," he wrote "will not occur immediately. As a result, the legislature will have an opportunity to address this change further if it chooses."

Since that time, lawmakers, hospitals, and advocates for the poor have been working feverishly to reinstate GAMC. Sen. Linda Berglin (DFL-Minneapolis) and Rep. Erin Murphy (DFL-St. Paul) deserve special recognition for their extraordinary efforts to bring parties together and broker a solution. Their respective proposals would more or less halve GAMC program costs by

lowering eligibility, reducing reimbursement rates, and eliminating certain benefits.

The tricky part is how to pay for a new GAMC program without adding to the budget deficit or raising taxes. Right now, proposals rely primarily on increasing the Medicaid surcharge on hospitals, which advocates argue is not a tax. The surcharge certainly smells like a tax. However, so did the health impact fee on cigarette users. In fact, the health impact fee is arguably more tax-like because the fee effectively funnels straight to the state's general fund, whereas the hospital surcharge is more clearly allocated back to hospitals.

It's unclear where Governor Pawlenty stands on the current proposals. However, if efforts to reinstate GAMC fail, the Department of Human Services is prepared to automatically enroll GAMC recipients in MinnesotaCare.

Medicaid remains troubled and requires a substantial overhaul

The list of well-known problems with Minnesota's assorted Medicaid programs remains long. The following outlines some of the more major problems with these programs.

- To start, they're costly and gobble up increasing portions of the state budget.
- These programs fail to offer incentives, financial and otherwise, that encourage enrollees to take responsibility for their health care decisions. This results in both overuse (e.g., emergency room visits) and underuse (e.g., preventive care) of certain medical services.
- Many who are eligible for public health plans fail to enroll and, instead, remain uninsured.
- Provider payment rates fail to cover costs and, consequently, providers must charge private payers higher rates to cover the difference. This unequal payment rate also encourages unequal, second-class treatment.

- Public health plans are not portable when enrollees' life situations change, which undermines the continuity of their care delivery.
- MinnesotaCare gives adults a false sense of financial security, a sense that they are insured, when there is actually a \$10,000 limit on in-patient hospital charges.
- Finally, these programs crowd out private insurance options—options that could provide portability and financial security.

Recent legislative action primarily expands access to these severely broken programs.³ The fact is, Minnesota's budget cannot sustain the current Medicaid program, let alone these perennial expansions. A substantial overhaul to Medicaid is necessary to keep Minnesota's budget balanced and to maintain an efficient, equitable, and accessible health care safety net.

Health care markets need more competition

Markets that work well—those that are efficient and responsive to consumers—are shaped and steered by competitive pressure. Unfortunately, markets for health insurance and medical services lack the competitive pressure necessary to deliver the results that American consumers expect. Competition lags primarily because the payer for health insurance and medical services is usually a third party, not the consumer. This third party—whether an employer buying insurance or an insurance company buying medical services—doesn't share the same interest in obtaining value than the actual consumer. Consequently, they fail to apply the necessary competitive pressure to keep these markets efficient and responsive. Competition is also compromised by state and federal regulations that limit what consumers can

³ Appended to these recommendations is a list of the most recent expansions and their projected cost at the time they passed.

and cannot buy. To make health care markets more competitive, individuals need greater control over their health care dollars and purchasing decisions.

Recommendations

- **Adopt a scaled-down temporary GAMC program similar to the short-term fix proposed by DFL legislators, but maintain current provider reimbursement rates and pay for it through cuts in the Departments of Health and Human Services budgets.** While the proposed temporary GAMC program is far from ideal, it is programmatically the best proposal on the table. The fiscal note for the proposal estimates that it will cost about the same as the governor's fall-back plan for automatic enrollment in MinnesotaCare.⁴ Thus, at the same cost, this temporary GAMC program (1) avoids entirely upsetting revenue streams for safety-net hospitals and (2) avoids any problem with GAMC enrollees' compatibility with the MinnesotaCare program. Furthermore, this mitigates the implicit tax increase in the governor's veto of the GAMC program that will occur when legally mandated care at hospitals is no longer funded through GAMC.

⁴ According to the fiscal note, the temporary GAMC program with cost \$282 million in the current biennium whereas auto enrollment in MinnesotaCare would cost \$254 million. Department of Human Services, "GAMC & MinnCare Mental Health Mod," Fiscal Note - 2009-10 Session, Bill #S2168-0, Feb. 7, 2010, available at http://www.mmb.state.mn.us/bis/fnts_leg/2009-10/S2168_0.pdf; and Minnesota Management and Budget, *Minnesota Financial Report* (November 2009), available at <http://www.mmb.state.mn.us/forecast/916-fu-09-nov/49299-fu-comp-nov09>. A transition to MinnesotaCare would lose over \$18 million in federal disproportionate share hospital payments, which more than accounts for the difference in cost. Of course, making a transition to MinnesotaCare shifts this cost to the Health Care Access Fund, which helps put the general fund into balance over the short term. Making one balance sheet more balanced at the expense of another is no way to address Minnesota's long-term budget problems.

It should be noted that reducing reimbursement rates by up to 50 percent, as the DFL plan proposes, is also an implicit tax increase. To make up for this reduction, hospitals will shift costs to private payers. Any plan to reinstate GAMC should maintain current reimbursement levels in order to avoid this tax on private payers. Though this will raise program costs, the cost is necessary to maintain transparency and accountability within the program.

The temporary GAMC program should be funded through various cuts to the Department of Health and Human Services budgets. Over the past five legislative sessions, lawmakers passed hundreds of millions of dollars in health care program expansions.⁵ Scaling back these expansions would more than pay for GAMC. Indeed, the governor's FY 2010-11 budget recommended \$634 million in cuts to health care programs that were never enacted. No one can argue that scaling back programs to 2005 standards sends Minnesota back to the Dark Ages. Even by those standards, Minnesota will fund one of the most generous collection of health care programs in the country. Of course, applying these cuts to a temporary GAMC program means that they cannot be applied to trim the budget deficit. However, to balance the budget, there are plenty of lesser priorities that deserve to be cut well ahead of GAMC.

- **Establish a process to identify a long-term solution for GAMC.** It is unfortunate that all these months of hard work to reinstate GAMC focused only on developing a short-term fix. Even if federal health care proposals gain passage, the state would still need to develop a more efficient, engaging, and fiscally

⁵ For instance, since 2007, income eligibility limits for childless adults in MinnesotaCare increased from 175 to 250 percent of federal poverty guidelines. A list of these expansions is appended to these recommendations.

transparent way to serve this population through Medical Assistance. This need remains to be met, and lawmakers should identify a long-term solution that better meets the needs of the GAMC population and fits future budgets. Importantly, establishing a process to identify a long-term solution will guard against any short-term fix extending into the long-term.

- **Develop the legal construct necessary to create Health Insurance Premium Accounts where tax-advantaged contributions from individuals and employers can be aggregated to pay for health insurance.** The Legislative Commission on Health Care Access recommended establishing a health insurance exchange in 2008.⁶ As explained in a report by the Minnesota Department of Health, an “exchange could enable some employers to shift to a ‘defined contribution’ model of employee health insurance benefits; for some this could be an alternative to dropping coverage entirely.”⁷ An exchange facilitates a defined contribution model by aggregating health insurance premium payments from individuals and their employers and remitting these payments straight to the insurer. By facilitating a defined contribution model, an exchange (1) gives individuals the opportunity to own a portable, employer-subsidized insurance plan and (2) provides small businesses with an alternative to Minnesota’s expensive small group insurance market. Moreover, the pool of people with individual insurance coverage would increase, thereby making the market

⁶ The Legislative Commission on Health Care Access, *Final Report: Recommendations Submitted to the Minnesota State Legislature* (February 2008), available at <http://www.commissions.leg.state.mn.us/lchca/HCAC%20Report%20final%202-08.pdf>.

⁷ Minnesota Department of Health, *Health Insurance Exchange Study* (February 2008), available at <http://www.health.state.mn.us/divs/hpsc/hep/publications/legislative/exchangestudy.pdf>.

more competitive and the pool more stable. The exchange failed to pass in 2008 due to controversy over how it might reorganize and regulate the insurance market.

Health Insurance Premium Accounts can provide a similar arrangement to aggregate premium payments with similar benefits as the exchange, but without the more controversial elements.⁸ These accounts would operate as trust funds that aggregate insurance premium contributions from various sources, including individuals, employers, and possibly government, charities, and relatives. In theory, the trust arrangement would be the individual's health plan for tax purposes. Admittedly, this would be a controversial interpretation and application of the federal tax code, as well as other federal employee benefits statutes. Lawmakers must, therefore, be careful to not encourage any violation of federal law by individuals or businesses.

- **Establish an Interstate Health Insurance Compact as proposed by Governor Pawlenty.** An interstate health insurance compact would create uniform regulatory standards across member states that allow individuals to purchase health insurance products from these other states. This compact would operate much the same way as the Interstate Insurance Product Regulation Commission, an organization that “serves as a central point of electronic filing for certain insurance products, including life insurance, annuities, disability income and long-term care insurance to develop uniform product standards, affording a high level of protection

⁸ For a more detailed discussion of Health Insurance Premium Accounts, see Peter J. Nelson, “No Consensus on Health Insurance Exchanges: Congress Should Rely on States and Consider Health Insurance Premium Accounts,” *Center of the American Experiment Policy in Detail*, No. 6, October 1, 2009, available at http://www.americanexperiment.org/publications/2009/20091001_Exchanges_Premium_Accounts.php.

to purchasers of asset protection insurance products.”⁹ A similar compact would provide consumers with access to more competitive health insurance products without sacrificing consumer protection standards.¹⁰

- **Convert federal funding for Medicaid long-term care for the elderly into a block grant in order to give Minnesota the flexibility and the incentives necessary to implement reforms that can control spending growth.** Medicaid is currently funded as an individual entitlement program where the federal government matches state funding. This creates the perverse incentive for the state to game the system and expand state funding in order to maximize the federal match. Furthermore, federal rules restrict the state from making significant programmatic changes related to eligibility, cost-sharing, and benefit design. Funding Medicaid through a block grant would free Medicaid from these perverse incentives and obstacles. In general, a block grant will provide Minnesota with a fixed allotment of federal funds each year to spend on health care programs. Taking a fixed allotment versus a federal match removes the state incentive to maximize federal funding because the funding is fixed.

Shifting the entire Medicaid program to a block grant, while a good long-term goal, may be too overwhelming. Instead, policymakers should focus on shifting just Medicaid long-term care for the elderly to a block grant. According to the report of the Minnesota

⁹ Interstate Insurance Product Regulation Commission, *About the IIPRC*, at <http://www.insurancecompact.org/about.htm>.

¹⁰ Note that this is no cure-all for the absence of competition. Recall that the primary obstacle to competition is the fact that employers, acting as third party payers, are the primary purchaser of health insurance. Furthermore, out-of-state insurers may find it difficult to compete with the reimbursement rates Minnesota health plans negotiate with providers.

Budget Trends Study Commission, “the aging of the population means that a larger share of the population will become eligible for and begin using expensive long-term care services under the Medical Assistance program.”¹¹ Due to this rising demand and the substantial portion of state spending already devoted to long-term care, the state will get the most mileage out of a block grant focused on long-term care financing.

- **Convert MinnesotaCare into a premium subsidy program that enables enrollees to afford individual health insurance.** MinnesotaCare is administered through private managed care health plans, which, being private, might seem to be similar to a subsidy program. However, managed care perpetuates most of the previously outlined problems that persist in Medicaid. MinnesotaCare is also very expensive for the benefit it provides. A premium subsidy program could offer expanded benefits at lower cost. Most important, future premiums would be subject to true competition among health plans in the individual market, which will do better at containing long-term spending growth in MinnesotaCare than annual benefit and eligibility tweaks. To begin moving in this direction, lawmakers should adopt The Healthy Minnesota Plan, sponsored by Rep. Steve Gottwalt (R-St. Cloud) and Sen. David Hann (R-Eden Prairie). The plan combines a state-funded health savings account with a high-deductible private market health plan for childless adults currently enrolled in MinnesotaCare.
- **Remove certain restrictions on the new construction and operation of health care facilities; start by repealing the radiation**

¹¹ State of Minnesota Budget Trends Study Commission, *Commission Report to the Legislature* (January 12, 2009), available at <http://www.mmb.state.mn.us/budget-reports-trends/324-budget-trends-reports/3060-report>

therapy moratorium and by licensing birthing centers. Competition in the health care provider market is often stifled by state regulations that restrict market entry, such as certificate-of-need (CON) regulations, moratoria on new facilities, and licensing requirements. CON laws and moratoria intend to hold down expensive medical treatments by controlling their supply. However, academic research generally shows that these supply restrictions do not effectively control costs.¹² In fact, economic theory and empirical research suggest that prices increase under these restrictions because providers already in the market gain monopoly power.¹³ Therefore, lawmakers should remove the state’s various restrictions on entry into the health care provider market. To start, lawmakers should revisit the two most notable restrictions on entry from the 2009 legislative session and repeal the radiation therapy moratorium and allow the licensing of birthing centers.¹⁴

¹² Paul B. Ginsburg, *High and rising health care costs: Demystifying U.S. health care spending*, The Robert Wood Johnson Foundation, Research Synthesis Report, No. 16 (October 2008), available at <http://www.rwjf.org/pr/product.jsp?id=35368> (“The literature on the impact of state certificate-of-need (CON) laws on health care spending has not provided support to the notion that these activities succeeded in suppressing spending.”).

¹³ John J. Antel, Robert L. Ohsfeldt, and Edmund R. Becker, “State Regulation and Hospital Costs,” *The Review of Economics and Statistics*, Vol. 77, No. 3 (Aug. 1995): pp. 416-422 (“The results presented here also indicate that in many instances regulations are associated with higher cost.”).

¹⁴ Sarah Janacek wrote a sharp critique on the politics (and money) that influenced the extension of the radiation therapy moratorium. See Sarah Janacek, “Question: How much does it cost to keep a Minnesota monopoly on cancer treatment? Answer: At least a half a million bucks,” *Politics in Minnesota*, January 30, 2009, at <http://politicsinminnesota.com/blog/2009/01/question-how-much-does-it-cost-keep-minnesota-monopoly-cancer-treatment-answer-least/>.

APPENDIX

The following tables outline the health care programs created or expanded over the previous five legislative sessions in Minnesota. The tables include the projected cost for each new program or expansion at the time it was passed into law. These estimates include two biennia of costs. Generally, the second biennium better reflects the actual cost. This is because programs and expansions often take time to ramp up or include a specific time delay. The last table outlines cuts to health care programs that Governor Pawlenty proposed in the 2009 session, but failed to pass.

These tables do not account for budget increases due to one-time projects, provider reimbursement rate increases, growth in program enrollment, federal compliance, pilot projects, administration, operations, and compensation increases. Therefore, a much more substantial amount of budget increases is not reflected here. Further, these tables do not account for program reductions. The point here is not to show the net impact of health care program changes, but rather, to show the many expansions that took place over the past five years that might be cut back to help fund GAMC. Of course, these are not the only cuts that should be considered; they represent the low-hanging fruit. It should also be noted that some of the MinnesotaCare program expansions in 2005 were restoring certain cuts made in 2003.

The tables include the following acronyms:

- ESI: Employer-Sponsored Insurance
- GAMC: General Assistance Medical Care
- ICF/MR: Intermediate Care Facilities for the Mentally Retarded
- MA: Medical Assistance
- MFIP: Minnesota Family Investment Program
- MNCare: MinnesotaCare
- SSI: Supplemental Security Income

2005 Legislative Session	Projected Cost When Enacted (in millions of dollars)					
New and Expanded Health Care Programs	2006	2007	FY 2006-07	2008	2009	FY 2008-09
Prevent homelessness for young adults demonstration project	1.1	1.1	2.2	1.1	1.1	2.2
Supportive housing services grants	5.0	5.0	10.0	5.0	5.0	10.0
American Indian child welfare project	0.0	2.4	2.4	4.8	4.8	9.6
Basic sliding fee/MFIP child care: Expand eligibility/reduce co-pays	0.8	3.3	4.1	3.3	3.3	6.6
Cap subsidized housing and SSI penalty at \$125	1.5	1.8	3.3	1.8	1.8	3.6
MNCare: Repeal \$5,000 benefit cap for adults w/o children	11.0	29.5	40.5	50.1	60.6	110.7
MA: Repeal \$500 Dental Cap	0.8	1.4	2.2	1.6	1.7	3.3
MA & GAMC: Eliminate co pays	2.5	6.3	8.8	7.2	7.8	15.0
Improve health care enrollment process	2.1	1.4	3.5	2.7	1.8	4.5
Improve mental health coverage	0.2	3.2	3.4	4.7	6.2	10.9
Implement intensive medical care management	1.5	1.5	3.0	1.5	1.5	3.0
Eliminate Alternative Care liens	4.9	8.1	13.0	8.1	8.1	16.2
Reduce ICF/MR County share from 20% to 5%	5.2	5.0	10.2	4.8	4.4	9.2
Reduce parental fees for DHS programs	1.2	1.4	2.6	1.4	1.4	2.8
Positive alternatives grant program (abortion alternatives)			2.5			
2005 Total	37.8	71.4	111.7	98.1	109.5	207.6

2006 Legislative Session	Projected Cost When Enacted (in millions of dollars)					
New and Expanded Health Care Programs	2006	2007	FY 2006-07	2008	2009	FY 2008-09
Evaluate mental health outcomes/mental health crisis infrastructure grants/development of system to monitor mental health services			1.5			1.3
MNCare: Eliminate copayments for dental services for adults < 175%				3.9	4.0	7.9
2006 Total			1.5	3.9	4.0	9.2

2007 Legislative Session	Projected Cost When Enacted (in millions of dollars)					
New and Expanded Health Care Programs	2008	2009	FY 2008-09	2010	2011	FY 2010-11
MFIP for legal non-citizens	0.9	1.1	2.0	1.2	1.2	2.4
Reduce child care program premiums	2.3	3.2	5.5	3.2	3.2	6.4
MFIP: Repeal \$125 SSI Penalty	3.8	9.0	12.8	9.0	9.0	18.0
MFIP: Eliminate MFIP 20-hour work requirement	0.3	0.6	0.9	0.6	0.6	1.2
MFIP: Integrated services projects	2.5	2.5	5.0	2.5	2.5	5.0
MFIP: Consolidated Support Services Grants	2.0	2.0	4.0	0.0	0.0	0.0
Self directed supports options	0.5	0.4	0.9	0.5	0.5	1.0
MA, MNCare: Outreach Activities	2.7	19	21.7	26.4	28.8	55.2
Transitional Medical Assistance for children	4.9	4.9	9.8	20	29.5	49.5
Extension of Critical Access Dental	4.2	5.0	9.2	6.0	7.0	13.0
Patient incentive program for health goals	0.0	0.6	0.6	0.6	0.6	1.2
MA & GAMC: Pharmacy co-payment cap, \$7	0.0	0.9	0.9	2.2	2.4	4.6
MNCare: Eliminate add-back of depreciation for farmers	0.0	1.0	1.0	1.0	1.0	2.0
MNCare: Increase income eligibility for adults w/o kids to 200% and 215%	1.4	10.1	11.5	17.2	24.8	42.0
MNCare: Eliminate verification of income and ESI	6.2	21.8	28.0	31.6	34.6	66.2
MNCare: Eliminate 6 month reviews	0.2	0.5	0.7	0.7	0.8	1.5
MNCare: Expand to homeless/lift address requirement	0.2	0.4	0.6	0.4	0.4	0.8
MNCare: Waive premiums for military members	0.0	1.5	1.5	1.6	0.0	1.6
MNCare: Eliminate MinnesotaCare premium increases	0.3	4.0	4.3	6.7	8.0	14.7
MNCare: Repeal limited benefit set	3.7	9.0	12.7	10.0	10.8	20.8
MNCare: Eliminate ESI Barrier for Students	0.7	1.5	2.2	1.7	1.8	3.5
Senior Nutrition Programs	0.3	0.3	0.6	0.3	0.4	0.7
MA, MNCare, & GAMC: Mental Health Initiatives	13.1	20.9	34.0	23.1	23.7	46.8
Compulsive Gambling - Northstar alliance	0.3	0.2	0.5	0.1	0.1	0.2
Compulsive Gambling Education, Treatment and Assessment	0.4	0.1	0.5	0.1	0.1	0.2
Service for Deaf and Hard of Hearing	0.3	0.4	0.7	0.4	0.4	0.8
Disability linkage line	0.5	0.6	1.1	0.6	0.6	1.2
Increase spending on nursing home visiting program	4.3	4.6	8.9	4.6	4.6	9.2
Restore 2003 family planning grant reductions	1.2	1.2	2.4	1.2	1.2	2.4
Fetal alcohol spectrum disorders program	0.5	0.5	1.0	0.5	0.5	1.0
Suicide prevention grants	0.3	0.1	0.4	0.1	0.1	0.2
Federally Qualified Health Center Grants	1.5	1.5	3.0	1.5	1.5	3.0
Home lead abatement	0.7	0.3	1.0	0.2	0.2	0.4
Elimination of agency sunset	0.5	0.5	1.0	0.5	0.5	1.0
2007 Total	60.7	130.2	190.9	176.3	201.4	377.7

2008 Legislative Session	Projected Cost When Enacted (in millions of dollars)					
New and Expanded Health Care Programs	2008	2009	FY 2008-09	2010	2011	FY 2010-11
Health Care Homes - Department of Human Services	0.0	0.8	0.8	0.6	2.2	2.8
MNCare: One Month Rolling Eligibility	0.0	0.3	0.3	4.3	5.0	9.3
MNCare: Premium reduction for families with kids	0.0	0.0	0.0	1.7	2.7	4.4
MNCare: Increase Family Income Cap	0.0	0.0	0.0	0.5	1.1	1.6
MNCare: Increase Adult w/o kids income limit to 250%	0.0	0.1	0.1	3.5	6.7	10.2
MNCare: Grace Month	0.0	0.3	0.3	8.9	10.4	19.3
MNCare: Outreach Incentive Funding	0.0	0.0	0.0	1.3	2.7	4.0
Statewide Health Improvement Grants	0.0	0.0	0.0	20.0	27.0	47.0
Health Care Homes - Department of Health	0.0	0.5	0.5	1.0	1.2	2.2
Federally Qualified Health Center Subsidies	0.0	1.0	1.0	1.0	1.0	2.0
2008 Total	0.0	3.0	3.0	42.8	60.0	102.8

2009 Legislative Session	Projected Cost when Enacted (in millions of dollars)					
New and Expanded Health Care Programs	2010	2011	FY 2010-11	2012	2013	FY 2012-13
MNCare: Chiropractic coverage	0.2	0.5	0.7	0.5	0.6	1.1
MNCare: Auto eligibility for children leaving foster care	0.0	0.2	0.2	1.6	2.8	4.4
MNCare: Eliminate premiums for kids under 200% / Eliminate ESI barriers for kids under 200% / Eliminate disenrollment when family income exceeds 275% / Autorenewal for children	0.0	5.8	5.8	31.3	53.0	84.3
MNCare: Eliminate add-back depreciation for farmers	0.0	1.6	1.6	1.9	2.2	4.1
Behavioral Risk Factor Surveillance Survey - Increase sample size	0.6	0.6	1.2	0.6	0.6	1.2
COBRA Premium State Subsidy	2.4	5.0	7.4	0.6	-0.1	0.5
2009 Total	3.2	13.7	16.9	36.5	59.1	95.6

Governor's Proposed Program Cuts 2009 Legislative Session	Projected Savings (in millions of dollars)
Child Care Assistance Program Reductions	-4.1
Eliminate chemical dependency grants	-1.0
MNCare: Eliminate adults w/o kids	-505.2
MNCare: Eliminate eligibility for parents	-25.6
Eliminate chiropractic service coverage	-1.1
Eliminate dental coverage for adults	-33.5
Eliminate podiatry coverage	-1.1
MNCare: Maintain Current Premiums	-0.9
Eliminate Rehabilitative Service Coverage	-6.5
MNCare: Eliminate One Month Rolling Eligibility	-5.4
Eliminate additional 2 month coverage	-10.9
Eliminate Critical Access Dental	-11.7
Eliminate Outreach incentive program	-16.7
Align Medical Assistance Asset Limits	-6.1
MSOP pension reform	-4.2
Total	-634.0

Sources:

- Matt Massman, ed., *The Fiscal Review: 2009 Session*, Minnesota State Senate, available at http://www.senate.leg.state.mn.us/departments/scr/freview/2009/fiscal_review.pdf.
- Matt Massman, ed., *The Fiscal Review: 2008 Session*, Minnesota State Senate, available at http://www.senate.leg.state.mn.us/departments/scr/freview/2008/fiscal_review.pdf.
- Matt Massman, ed., *The Fiscal Review: 2007 Session*, Minnesota State Senate, available at http://www.senate.leg.state.mn.us/departments/scr/freview/2007/fiscal_review.pdf.
- Matt Massman, ed., *The Fiscal Review: 2006 Session*, Minnesota State Senate, available at http://www.senate.leg.state.mn.us/departments/scr/freview/2006/fiscal_review.pdf.
- Matt Massman, ed., *The Fiscal Review: 2005 Session*, Minnesota State Senate, available at http://www.senate.leg.state.mn.us/departments/scr/freview/2005/fiscal_review.pdf.
- Minnesota State Senate, "Health and Human Services Budget - Chapter 79 as Amended by HF1988 - Change Items," 2009 *Budget Tracking Spreadsheets* (May 18, 2009), available at http://www.senate.leg.state.mn.us/departments/fiscalpol/tracking/2009/HHS_HF1988_Final.pdf.
- Minnesota State Senate, "Health and Human Services-SF 3780, Health Care Reform Change Items, Final," 2008 *Budget Tracking Spreadsheets* (May 18, 2008), available at <http://www.senate.leg.state.mn.us/departments/fiscalpol/tracking/2008/08HealthReformChangeItems.pdf>.
- Minnesota State Senate, "Health and Human Services, Final HF 1812 Change Items," 2008 *Budget Tracking Spreadsheets* (May 18, 2008), available at <http://www.senate.leg.state.mn.us/departments/fiscalpol/tracking/2008/08hhschangeitems.pdf>.
- Minnesota State Senate, "Health & Human Services Omnibus Bill Change Items, Final - HF1078 with Vetoes," 2007 *Budget Tracking Spreadsheets* (June 7, 2007), available at <http://www.senate.leg.state.mn.us/departments/fiscalpol/tracking/2007/07HHS%20-%20HF1078%20-%20ChangeItemsLineItemVeto.xls.pdf>.
- Minnesota State Senate, "Health & Human Services Budget - Change Items," 2006 *Budget Tracking Spreadsheets* (May 21, 2006), available at http://www.senate.leg.state.mn.us/departments/fiscalpol/tracking/2006/06hhs_change_items.pdf.
- Minnesota State Senate, "Health and Human Services Budget: Change Items - Chap. 4, 1st SS," 2005 *Budget Tracking Spreadsheets*, (July 13, 2005), available at http://www.senate.leg.state.mn.us/departments/fiscalpol/tracking/2005/05hhs_cc_chitems.pdf.



Center of the American Experiment is a nonpartisan, tax-exempt, public policy and educational institution that brings conservative and free market ideas to bear on the most difficult issues facing Minnesota and the nation.

612-338-3605
612-338-3621 (fax)
AmericanExperiment.org
Info@AmericanExperiment.org
