



Minnesota Hospital Association

Senate Health and Human Services Budget Division  
February 24, 2010

*On behalf of the Minnesota Hospital Association*

Good morning, Madame Chair and members of the Committee. My name is Lawrence Massa, and I am the president and CEO of the Minnesota Hospital Association (MHA), representing the 147 hospitals and 17 health systems throughout our state.

It is extremely difficult to look at the governor's proposed budget and evaluate its impact on the hospital community without knowing if a workable solution to maintain coverage for the people enrolled in the General Assistance Medical Care program (GAMC) has been achieved. Please know that enactment of a GAMC bill remains MHA's highest priority for this legislative session. We are hopeful that a GAMC veto override is still a possibility.

Assuming a worst case scenario, however, what does it mean to hospitals and GAMC enrollees to be "automatically" and temporarily enrolled in MinnesotaCare? We believe it means less access to appropriate health care for low-income residents already struggling to make ends meet. It also means significant increases in uncompensated care, on top of the cuts recommended by the governor in his supplemental budget.

1. First, there is the issue of premiums. This population simply can't afford a premium, so they won't stay enrolled beyond whatever remains of their six months of eligibility. The Department of Human Services estimates in its Nov. forecast that less than 22,000 of the 38,000 people enrolled in GAMC will be moved to MinnesotaCare. The Department predicted that far fewer people — only 15,274 individuals who would otherwise be eligible for GAMC — would be enrolled in MinnesotaCare for 2011. What will happen to the other 23,000 individuals who were formerly enrolled in GAMC? They will join the rapidly growing ranks of the uninsured. They will depend exclusively on hospitals' emergency rooms for their health care needs. They will lose access to prescription medications resulting in a decreased quality of life exacerbating public safety concerns in our communities. And they will drive up uncompensated care costs which ultimately find their way into ever-escalating health insurance premiums.
2. Second is the issue of co-pays, deductibles and the annual \$10,000 inpatient hospital cap, which are all part of an individual's cost-sharing obligation in the MinnesotaCare program, but are not expected of GAMC enrollees. MHA estimates that imposing the \$1,000 co-pay on the GAMC population will easily result in an additional \$11 million in uncompensated care for hospitals. Capping inpatient hospitalization benefits at \$10,000 annually could rise to as much as \$34 million in additional losses for hospitals.
3. Finally, one of the most important features of the GAMC program is the ability to enroll an individual into the program in the emergency room and being able to get at least some payment for that first incident of care. MinnesotaCare will not reimburse providers for services they deliver to people before their applications to the program are signed, sealed, delivered and processed.

We have done some rough calculations and estimate the difference between Senator Berglin's GAMC legislation and the governor's proposal to move this population into MinnesotaCare, with its current program features, could be as much as an \$83 million cost to hospitals.

Now some comments on other items found in the governor's budget proposal.

### **Reductions in Coverage:**

First and foremost, eliminating coverage in the MinnesotaCare program for childless adults making more than 75 percent of the federal poverty guidelines may save the Health Care Access Fund \$129 million, but it will certainly increase Minnesota's growing ranks of the uninsured. This will lead to increased health care costs as this population loses access to primary care and clinics, and will, without a doubt, increase hospitals' uncompensated care. We've used a very conservative approach and have estimated that if hospitals receive 26 percent of MinnesotaCare payments, the hospital portion of these "savings" would amount to \$33 million in lost payments. This number could easily be doubled or tripled if these MinnesotaCare enrollees turn to hospital emergency rooms as their sole source of health care services or allow their preventable or treatable conditions to languish until emergency or inpatient hospitalization is required.

### **Reductions in Payments: (See handout sheet of the MHA analysis)**

- Delaying Medicaid rebasing saves the state \$8.6 million, but will cost hospitals \$19.7 million, when lost matching federal dollars are included.
- Reducing Medicaid and MinnesotaCare inpatient rates by 3 percent saves the state \$9 million, but will cost hospitals \$19 million, when lost matching federal dollars are included.
- Eliminating rural DRG add-on payments saves the state \$2 million, but will cost hospitals \$4.5 million, when lost matching federal dollars are included.
- Cutting Medical Education and Research Costs (MERC) funding saves the state \$21.3 million, but will cost hospitals \$44.3 million, when lost matching federal dollars are included.
- The governor's budget does not directly show how hospitals will be impacted when quarterly disproportionate share hospital (DSH) payments are eliminated. However, the Department of Human Services currently has a state plan amendment request into the Centers for Medicare and Medicaid Services (CMS) that includes a proposal to use MinnesotaCare payments as the leveraging mechanism, rather than GAMC payments, and then for the state to keep DSH dollars rather than continuing to make quarterly payments to hospitals as intended. Such a diversion of federal money from its intended purpose to help offset hospitals' uncompensated care and Medicaid losses to propping up the state's general fund should be shown in the budget pages as a proposed cut to hospitals.

There is certainly a lot of information that MHA can provide you in the days ahead to show what these proposed cuts mean to our hospitals and the patients that we serve. To put it simply, our options are limited:

1. Additional job losses;
2. Additional reductions in hospital services;
3. Additional cost shifting to private payers, if that is possible.

In closing, I would like to share with you a simple pie chart that illustrates how Governor Pawlenty is once again proposing to solve this budget shortfall by slashing into Minnesota's health care system. Of the \$825 million in proposed budget cuts, \$347 million would come from cuts to Health and Human Services. That is 42 percent of the proposed budget cuts. Health and Human Services is only 30 percent of the entire budget. Cuts need to be made more broadly and more proportionately to all areas of state spending and additional revenues need to a part of the mix.

We urge you to work with your colleagues — those who serve on the committee and those who do not; those who participate in your party's caucus and those who do not — and find alternatives to the governor's proposals. A failure to do so will undoubtedly impact access to effective and efficient care for a large number of Minnesotans.