2019 legislative session priorities

Preserve meaningful health care coverage for low-income Minnesotans

All Minnesotans should have meaningful health coverage that includes a broad benefit set and access to affordable, high-quality health care services. The state government plays a crucial role in ensuring that this coverage is available, especially for low-income Minnesotans.

Medicaid is a state and federal partnership providing health care coverage and long-term care services for low-income children, adults, pregnant women, elderly and disabled residents. Known as Medical Assistance in Minnesota, Medicaid is the primary source of health care coverage for about 1 out of every 5 Minnesotans. For adults without dependent children, the upper income eligibility threshold is 138 percent of the federal poverty guidelines (FPG), or about $16,600 a year for an individual.

MinnesotaCare is a unique, successful, homegrown program that was created with bipartisan support in 1992. It provides affordable, reduced-premium coverage to approximately 100,000 residents who earn between 138 and 200 percent of FPG — too much to qualify for Medicaid but not enough to afford commercial coverage. For years, the state's portion of MinnesotaCare costs was paid for with premiums from MinnesotaCare enrollees; a 1 percent health insurance premium tax; and a 2 percent tax on health care services (excluding Medicare), commonly referred to as the MinnesotaCare provider tax. These revenues are deposited into the Health Care Access Fund. Now, because MinnesotaCare qualifies as a Basic Health Plan under federal law, a large portion of its costs are financed by the federal government.

- MHA is concerned about government-sponsored health insurance plans being sold in Minnesota's individual insurance market if they will be subsidized by payment rates to providers that are below the actual costs of the services and treatments people receive. Several proposals have been put forward, including Gov. Walz's ONECare model. At this time, however, none of the proposals provide sufficient detail for MHA to assess the impact they will have on Minnesota's hospitals and health systems or the patients, families and communities we serve.
- MHA supports maintaining public coverage for low-income Minnesotans; however, state government cannot continue to rely on cost-shifting by providers to commercial insurance markets to help pay for public program costs. The state needs to support adequate provider payments in Medical Assistance (Medicaid) and MinnesotaCare.

Repeal the sunset of the MinnesotaCare provider tax

- MHA supports repealing the sunset of the provider tax which, under current state law, will occur on Dec. 31, 2019. MHA supports a dedicated, sustainable funding source for MinnesotaCare and for a portion of the costs for people who would have been enrolled in MinnesotaCare but now qualify for Medicaid expansion coverage. The provider tax will generate about $700 million in 2019.
- Historically, the 2 percent provider tax generates more revenues than the state needs to pay its share of MinnesotaCare and Medicaid expansion costs. MHA supports decreasing the rate of the tax to more closely align with the state's costs for these programs without generating ongoing surpluses, as well as adding statutory provisions to assure that provider tax revenues are used only for their current health care purposes.

Improve access to appropriate, high-quality mental and behavioral health services throughout Minnesota

As a result of a strong collaboration among mental health advocates and a bipartisan commitment from lawmakers, Minnesota has made significant progress in reducing stigma, increasing capacity to serve residents with mental and behavioral health care needs at Anoka Metro Regional Treatment Center and in local

Community Behavioral Health Hospitals, improving access to community-based mental health services and developing new and innovative models of care. Yet, Minnesotans continue to face barriers to access needed care and our capacity remains insufficient for the 1 in 4 Minnesotans who will experience a mental illness. We need additional and sustained state resources for mental health professionals, additional capacity in communities across the state and at all levels of care, and investment in pilot projects and demonstrations to test new and better ways to meet the mental and behavioral health needs of Minnesotans.

Take action to address the opioid crisis (HF 400)

Bipartisan opioid stewardship legislation would recoup a small fraction of pharmaceutical companies' profits from the sale of opioids to defray the cost of the opioid epidemic on Minnesota's health care system and county social services.

- Create an opioid stewardship fee to raise approximately $20 million per year from opioid manufacturers to help fight Minnesota's opioid crisis. Opponents will claim this approach will increase health care costs. The truth is, opioid addiction will continue to drive up our health care costs. From 2010 to 2017, substance abuse emergency department visits increased 146 percent. A recent analysis of a White House Council of Economic Advisors' report showed that opioid addiction cost Minnesota nearly $5.5 billion in 2016.
- Increase capacity and accessibility of addiction treatment services by spreading successful models of care and make it easier for providers to prescribe medication-assisted treatment, such as Suboxone.
- Provide resources to improve the state's Prescription Monitoring Program (PMP) so it can better integrate with health care providers' electronic health record systems. The more accessible PMP data are when providers and patients are making care decisions, the better and safer those decisions will be.

Modernize Minnesota's Health Records Act to improve coordination of patient care (HF 831/SF 1575)

Minnesota's Health Records Act (MHRA) should more closely align with federal Health Insurance Portability and Accountability Act (HIPAA) laws. Today's misaligned dual regulatory framework makes it more difficult for providers to access the information they need to deliver the safest, timeliest and most effective care for patients. In addition, it creates confusion and frustration for patients and their families, adds unnecessary costs to Minnesota's health care system and burdens health care providers with administrative work. A coalition of the Minnesota Hospital Association, the Minnesota Medical Association, the Minnesota Council of Health Plans, the Minnesota Chamber of Commerce, the Minnesota Business Partnership and numerous health advocacy organizations supports changing Minnesota's law to have a more streamlined patient consent process, which is already in place and working well in 48 other states.

Reject government-mandated nurse-to-patient staffing ratios

- For the past decade, the National Nurses United-Minnesota Nurses Association (NNU-MNA), a union representing less than 20 percent of the nurses in the state, has pursued legislation to impose government-mandated nurse-to-patient staffing quotas or ratios in Minnesota hospitals. NNU-MNA's proposal does not account for the health care needs of the individual patient; the skill set and experience of the nurses at the bedside; the availability and abilities of other health care team members, including physicians; or the need for flexibility so nurses can respond if emergencies occur in other units of the hospital. Decisions about the size and makeup of the care team to provide the best care for the specific needs of the individual patient in a hospital should be made by the trained, experienced health care professionals closest to the bedside based on the acuity and needs of their patients; not by legislators in St. Paul picking a fixed, one-size-fits-all number. If enacted, this legislation would lead to higher health care costs and exacerbate workforce shortages across the health care continuum. MHA strongly opposes this misguided proposal.
- Minnesota's hospitals prepare and publicly post an annual staffing plan and actual nurse staffing levels at www.mnhospitalquality.org.