2018 election issues

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, elderly and disabled residents. Known as Medical Assistance in Minnesota, it 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 and successful program that was started 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. The state's portion of the program's costs have been 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. Because MinnesotaCare qualifies as a Basic Health Plan under federal law, a large portion of its costs are currently being paid for by the federal government.

- MHA supports MinnesotaCare as a tested and affordable way to provide meaningful coverage to low-income working residents. MHA does not support the current MinnesotaCare "buy-in" proposal to open the plan to higher-income individuals. This buy-in proposal could jeopardize the sustainability of our health care delivery system because MinnesotaCare payments to providers are significantly below commercial payments and below the costs of providing the care. Providers have accepted these rates because of the needs and vulnerability of the population MinnesotaCare serves. In addition, expanding eligibility beyond low-income residents could destabilize the individual and small-group insurance markets.

- MHA supports a dedicated, sustainable funding source for MinnesotaCare and for the former MinnesotaCare enrollees now covered under the Medicaid expansion. The MinnesotaCare provider tax will generate about $700 million in 2019. Under current state law, the 2 percent MinnesotaCare provider tax will "sunset" on Dec. 31, 2019. The Health Care Access Fund is currently being used to support MinnesotaCare, Medical Assistance, one-time funding for the reinsurance program and other health-related expenditures. MHA is open to exploring other viable and sustainable alternatives to the 2 percent MinnesotaCare provider tax. Unless/until such an alternative is in place, however, MHA supports repealing the statutory sunset of the provider tax.

- For last few years, the 2 percent provider tax has generated more revenues than the state needs to meet its MinnesotaCare and Medical Assistance costs associated with the Medicaid expansion. If the tax continues, MHA supports decreasing the rate of the tax to more closely align with the state's costs for these programs.

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

As a result of partnering with mental health advocates and a bipartisan commitment from lawmakers, Minnesota has made significant progress in reducing

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stigma, increasing capacity of state services at Anoka Metro Regional Treatment Center and in Community Behavioral Health Hospitals, improving access to community mental health services and developing new and innovative models of care. Yet, Minnesotans continue to face barriers to access needed care and capacity remains woefully insufficient for the 1 in 4 Minnesotans who will experience a mental illness. Simply put, 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.

Modernize Minnesota's Health Records Act to improve coordination of patient care

Minnesota's Health Records Act (MHRA) should more closely align with federal HIPAA (Health Insurance Portability and Accountability Act) laws. This 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 and staff best able to care for the needs of the individual patient in a hospital should be made by the trained, experienced health care professionals closest to the bedside and should be 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 and health systems have earned a nation-leading reputation for providing high-quality, low-cost health care. The federal Agency for Healthcare Quality and Research (AHRQ) has ranked Minnesota among the best states in the nation for overall health care quality. Minnesota is ranked third in the nation for health care access, quality and outcomes by the Commonwealth Fund, an independent foundation. Minnesota is one of only two states rated in the top quartile for all five dimensions the Commonwealth Fund measured: access and affordability, prevention and treatment, avoidable hospital use and cost, healthy lives, and disparity.

- Minnesota's hospitals prepare and publicly post an annual staffing plan and actual nurse staffing levels at www.mnhospitalquality.org.