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## **Yet another expansion of MinnesotaCare?**

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The Health Care Access Commission, a group of Minnesota legislators, recently recommended adding yet more people to MinnesotaCare. This would happen by raising income eligibility limits to include people making 300 percent of the federal poverty level (at 2007 levels, that's \$61,950 for a family of four). This recommendation comes on top of liberalizing changes already implemented at the beginning of the year.

The proposal of the commission was, as Charlie Shaw reported for this newspaper, part of a series of recommendations "to address what to do about an estimated 400,000 Minnesotans who lack health insurance coverage."

State Rep. Paul Thissen, chairman of the House Health and Human Services committee, framed the recommendation as a way to help the middle class obtain insurance. "Affordability is a middle class issue," he said.

Families USA is perhaps the leading advocate of expanding the role of government in health care. Late last year it said that anyone paying more than 10 percent of personal income on health insurance was facing a burden "too great to bear," and called for government action. The Minnesota panel would go even further, capping insurance at six percent of income. Currently, people enrolled in MinnesotaCare are liable to pay up to 8.8 percent of their income.

Is MinnesotaCare expansion a good way to increase the affordability of insurance? Let's first look at the costs. The most obvious one is the \$28.2 million that would be added to the state budget. If there are ways of making insurance more affordable that don't incur those costs, so much the better.

Less obvious are the opportunity costs of not using that \$28.2 million elsewhere. Education and transportation are two public-sector concerns that could use the money. If left in the private sector, the money could be used for jobs-generating investments and purchases.

Another cost of expanding MinnesotaCare is the effect it has on the private insurance market, where most people get their coverage. Encouraging more people to turn to the taxpayer for their needs would send the wrong signal to private insurers. "Don't bother

seeking to add to your market share by coming up with policies that are attractive to this segment of the population. Government will take care of that.” The health care sector needs more risk-taking by private companies, not less.

There’s another problem with the recommendation: Who can define “affordable?” People have different subjective evaluations of what is affordable and what is not. Some individuals who face “unaffordable” bills for insurance have it, meaning that insurance is not—legislative judgment aside—unaffordable.

But people respond to incentives, and the proposal offers the wrong ones. Jonathan Gruber, an economist at the Massachusetts Institute of Technology, estimates that each additional dollar spent on Medicaid causes spending on private insurance to decrease by 50 to 75 cents. That’s the consumer side of the shrinkage of the private market brought about by government action.

If making insurance more affordable is a public goal, what else can lawmakers do? To start with, they can scale back on mandated benefits. According to the Council for Affordable Health Insurance, a trade group, Minnesota imposes 63 specific mandates on insurance policies. These requirements, often established at the behest of patient advocacy groups and professional interests, increase utilization and thus increase premiums. Higher premiums translate into “less affordable.” When a mandate involves predictable expenses (such as well-baby care), we have something that is less insurance and more a bureaucratic, expensive prepayment plan. By the way, did you know that Minnesota is one of 10 states to mandate coverage for marriage therapists?

If lawmakers can’t scale back on mandates, they could let residents buy health insurance that is certified by any of the other states. Each state has its own rules for what an insurance policy can and cannot (or must) have. Letting insurance customers choose from regulatory schemes across the country would let them more closely match what is available to what they want.

Next, our lawmakers could reduce the cost of medical care itself. This can be done in a number of ways, in large measure by increasing the role of competition, which is sorely lacking. Loosen the restrictions on who can enter the health care field, and where. In public programs, give individuals money to buy their own insurance and their own treatment. For more ideas on how an invigorated market can make health care more affordable, lawmakers may wish to consult a report issued by the U.S. Department of Justice and Federal Trade Commission in 2004 entitled “Improving Health Care: A Dose of Competition.” Oligopolies are seldom good for consumers, and they’re not good for health care.

Remarkably, the health care commission is moving us beyond oligopolies towards a top-down, single payer system that robs consumers of their choices. Instead, the state could—and should—expand the ability of people to make their own choices in an invigorated market in which dynamic change can bring us new products and services.