Healthcare for children? Will the HMOs leave them uncovered?
Kip Sullivan

The last election affected Governor Tim Pawlenty the way Marley’s ghost affected Scrooge. Pawlenty – the governor who cut 38,000 people from MinnesotaCare in 2003, who early in 2005 referred to MinnesotaCare as “welfare health care” and demanded that 40,000 more Minnesotans be kicked off it, and who shut down the state in the summer of 2005 to enforce that demand – that governor announced one week after his narrow re-election that he wanted to “chart a path toward universal health insurance.” “We should start with covering all kids,” he said. Pawlenty’s u-turn on this issue, coupled with the DFL takeover of the House and the recent endorsements of universal coverage by the insurance industry, has raised the odds that the Legislature will conduct a serious debate about universal health insurance in 2007.

Amid the good news, there is some bad news: A trap awaits proponents of universal coverage. The trap works like this: Politicians who normally oppose expansion of government-financed health insurance agree to support expansion of existing programs or the creation of new ones, but only on the condition that the expanded or new program be privatized, that is, that the tax dollars going into the program go directly to HMOs, not to doctors and hospitals.

Funneling the money through HMOs raises the total cost of the program by roughly 15 percent. After they cut spending on patients by about 5 percent, the HMOs add 20 percent in the form of administrative costs to pay for useless things not previously financed by tax dollars, including advertising, arguing with doctors about how patients should be treated, lobbying, huge executive salaries, and, in the case of for-profit insurers, profit. Some liberals, thinking it’s more important to take the money being offered by the conservative than to argue about whether it is spent efficiently, bite on the offer.

President George Bush deployed this trap to enact the horribly complex Medicare Part D program which began on January 1, 2006. Early in 2003 Bush proposed adding drug coverage to Medicare but only on the condition that it be privatized, that is, that seniors pay premiums to insurance companies if they wanted the extra drug coverage. AARP and some Democrats fell into the trap.

The result was the deplorable Medicare Part D program. It offers meager drug coverage. The worst defect is that the coverage punks out at $2,250 and does not resume until annual drug expenses reach $5,100. This scrawny coverage is costing the taxpayer twice as much as it would have if the cost if the drug coverage had been simply added to the traditional, “unprivatized” Medicare program. Not surprisingly, fixing the huge defects in the program is turning out to be difficult. The sole reform the Democrats are talking about now that they’ve taken control of Congress is giving Medicare the authority to negotiate drug prices with the drug manufacturers. They are not talking about ousting the insurance companies from Part D.

Setting the trap in Minnesota

The insurance industry has spent much of the last six months setting a similar trap for universal-coverage advocates. Last July the CEO of HealthPartners, Minnesota’s third
largest plan, announced in an op-ed for the Star Tribune that HealthPartners supported universal coverage as long as it was privatized. Last September two Blue Cross Blue Shield executives made similar announcements. On November 13, the day before Governor Pawlenty announced his conversion, America’s Health Insurance Plans (AHIP, the trade group for the national insurance industry) released a proposal in Washington, DC calling for universal coverage of children within three years and 95-percent coverage of adults within ten years, all to be paid for with tax dollars funneled through insurance companies (see AHIP’s Web site at www.ahipbelieves.com). Then, on November 25, the Star Tribune published an op-ed by the Minnesota Council of Health Plans, which represents Blue Cross and seven of the more tightly managed health insurance companies in Minnesota, announcing they too support universal coverage, starting with kids.

The insurance industry has not explained why it chose 2006 to bait the trap, but it’s a good bet the timing is explained by the enactment of a Massachusetts law last April that its advocates claim will halve that state’s uninsured rate, from 11 percent in 2004 to about 5 percent by 2010. That law, which requires that Massachusetts residents buy health insurance by July 1, 2007, and which provides tax-financed subsidies to lower-income residents so they can afford to obey the new law, was showered with favorable publicity across the country largely because it was passed by a Democratically controlled legislature and signed by a Republican governor. Although the law is going to fail because it is so costly (that’s what you get when you funnel tax dollars through insurance companies), the fact that it passed with bipartisan support has been interpreted by pundits and many politicians as a sign that the pressure for universal coverage is higher than ever and significant expansion of coverage, if not universal insurance, is coming soon.

In fact, Governor Pawlenty’s November 14 announcement of his newfound belief in universal health insurance was delivered during his keynote address at a conference at the University of St. Thomas, sponsored by David Durenberger’s National Institute of Health Policy, at which the main topic of discussion was the Massachusetts law (see the Institute’s web site, nihp.org, for details). Pawlenty invited Massachusetts Governor Mitt Romney to speak at that conference with him. Romney could not come but was represented by Timothy Murphy, Massachusetts’ Secretary of Health and Human Services, the agency that oversees implementation of the new law. By participating in this event and inviting Romney, and by mentioning during his speech his support for a requirement that individuals buy health insurance, Pawlenty made it clear the Massachusetts model appeals to him.

In sum, the favorable response to the Massachusetts legislation from the media and many politicians signified that the universal coverage train might at long last be leaving the station. It is reasonable to infer that the insurance industry decided, probably around the spring of this year, that if they wanted to influence the train’s direction they had better jump on board with some proposals of their own. And, not surprisingly, their proposals promise universal coverage but only on condition those who want it accept a privatized version.

Insurers promote the Massachusetts law

The HealthPartners and Blue Cross proposals closely resemble the new Massachusetts law. Both insurers propose to treat health insurance like auto insurance –
you have to buy it or pay a fine. This requirement, known as an “individual mandate” (to be distinguished from an “employer mandate” which makes employers buy health insurance for their employees), would be enforced with annual financial penalties. In Massachusetts, the penalty is on the order of $1,500 to $2,000 per person.

Recognizing that the average working stiff cannot afford to fork over $11,000 and up per family per year to the insurance industry, the Massachusetts law and the HealthPartners and Blue Cross proposals call for tax-financed subsidies for residents who make less than three times the federal poverty level (about $60,000 for a family of four and about $30,000 for an individual). Blue Cross estimates these subsidies will cost $1 billion a year in Minnesota.

The insurance industry and its allies are going out of their way to make sure Minnesotans understand they are not promoting a single-payer system. (Under such a system, tax dollars bypass insurance companies and flow directly to clinics and hospitals. See sidebar for a definition of “single-payer”). “Please know that universal coverage does not mean ‘single-payer,’” said Blue Cross’s CEO, Mark Banks, in his speech to the St Paul Chamber of Commerce on September 13. “I’m going to repeat that statement,” he continued, “because too many people instantly reject the idea of universal coverage because they reject the idea of a single-payer system. Universal coverage does not mean single payer.” Governor Pawlenty’s office has likewise issued statements distinguishing Pawlenty’s interest in expanding coverage from interest in a single-payer system.

Unfortunately, Pawlenty and the health insurance industry are not the only powerful players in this debate who are insisting that any significant expansion of tax-financed health insurance be privatized. The Minnesota Medical Association (which represents a majority of Minnesota doctors) took that position in a report published in January 2005. “Pawlenty aligns policy with MMA” said the MMA Web site (www.mmaonline.net) on November 15, 2006, the day after Pawlenty’s announcement. The Childrens’ Defense Fund, which has been fighting for better coverage for children for two decades, is lobbying for legislation to insure all kids but on the condition that the parents of these children enroll them in HMOs.

DFL leadership has been part of the problem

In addition to the insurance industry, the MMA, some advocates for children, and Governor Pawlenty, the forces demanding that any new tax dollars for expanded coverage be routed through HMOs includes the handful of DFL legislators who have set health care policy for their party as chairs of the health policy and health finance committees in the House and Senate over the last two decades. The influence of these DFLers can be seen in Minnesota’s three public health insurance programs – MinnesotaCare, Medical Assistance (MA), and General Assistance Medical Care (GAMC). All three programs were privatized during periods when the DFL controlled the Legislature. MA and GAMC were privatized gradually beginning in 1985; MinnesotaCare was privatized overnight in 1996. That’s right. Thanks to the support of DFL “leaders” on health policy, HMOs have been inserted into all three of these programs.

When Blue Cross and HealthPartners come to the Legislature next year to propose universal coverage (either for the entire population or for kids only) on the condition that
the coverage is privatized, they will come with the backing of some powerful groups and some powerful politicians, notably Governor Pawlenty and some senior DFL legislators. If you were a betting person and knew nothing about the grassroots movement for a single-payer, you’d bet that the Blue-Cross-HealthPartners-MMA-Pawlenty alliance, with help from DFL “leaders,” will succeed in embedding insurance companies in any program to expand health insurance coverage, if not next year, then over the long haul.

The single-payer movement grows

But two developments over the last two years have placed speed bumps, and perhaps serious barriers, in the path of the privatization juggernaut. First, two single-payer coalitions have geared up to prevent the growing momentum for universal health insurance from being parlayed by the insurance industry into momentum for privatization. These coalitions – the Minnesota Universal Health Care Coalition (MUHCC) and the Greater Minnesota Health Care Coalition (GMHCC) – have undertaken a campaign to “deprivatize” MinnesotaCare, MA and GAMC. Their research indicates Minnesota could cut the cost of those three programs by 10 to 20 percent if the HMOs were booted from those programs. The arguments presented by the MUHCC-GMHCC campaign to roll back privatization will obviously apply as well to any proposal to expand privatized coverage, either to all children or to all Minnesotans.

The second development that will impede the privatization freight train is the election results. The November election not only gave the DFL greater control over the legislature, it brought into office new legislators who support single-payer or who, at minimum, do not accept the HMO propaganda that privatization of state programs is a good idea. Several of these new legislators have been appointed to the health committees.

The MUHCC-GMHCC deprivatization campaign began formally in August 2004 with a meeting between MUHCC representatives and then-DFL House Minority Leader Matt Entenza (St. Paul). MUHCC asked Entenza for help determining whether any research existed indicating that the privatization of state programs had worked as the HMOs and their DFL and Republican allies had said it would. Entenza agreed to write a letter posing that question to Kevin Goodno who at that time was the commissioner of the Department of Human Services (DHS), the agency that runs MinnesotaCare, MA and GAMC. In December 2004, Goodno replied that DHS had never done any research to address that question.

With Commissioner Goodno’s admission in hand, MUHCC and GMHCC, with help from Rep. Entenza, drafted legislation to remove Medica, HealthPartners, Blue Plus and the other HMOs from the three state health insurance programs. The bill was introduced in the House by Rep. Neva Walker (DFL-Minneapolis) (Keith Ellison was among the five co-authors) and in the Senate by Senator Leo Foley (DFL-Anoka). The House bill got a short hearing in the House health committee last March. When Rep. Walker and two speakers (including the author of this article) were done testifying, Goodno and three HMO representatives testified against the bill. Not one of the four opponents of the bill attempted to rebut Rep. Walker’s evidence that privatization had raised the cost of state programs by 10 to 20 percent.

But thanks to opposition to the bill by the Republicans and the senior Democrat on the committee, Rep. Walker did not ask for a vote. Because of similar opposition on
the Senate health committee (including the senior Democrat), MUHCC and GMHCC did not ask for a hearing in the Senate.

MUHCC’s and GMHCC’s expectations for the 2007 legislative session are higher than they were for the 2006 session largely because the pro-HMO, pro-privatization DFL leadership in both houses has been diluted by legislators who are single-payer advocates or, at minimum, supportive of single-payer and deprivatization and skeptical of the claims made for HMOs. This is especially true in the Senate where Senator John Marty (DFL-Roseville) will chair the Senate health policy committee. Marty authored legislation to create a single-payer health care system in the mid-1990s when most of his colleagues were swept up in the mania for HMOs, and he spoke openly about his support for a single-payer system during his 1994 campaign for governor.

Massachusetts: The Ghost of Christmas Future

The heightened interest in universal health insurance, the takeover of the Minnesota House by DFLers, and Pawlenty’s ostensible conversion from opponent of public programs to supporter has created a more promising climate for all advocates of universal health insurance. The issue is not whether universal coverage will be discussed seriously in the 2007 session, but whether universal coverage advocates inside and outside the Legislature will fall into the privatization trap. The issue is whether they’ll endorse privatization in exchange for a significant step toward universal coverage and thereby make maintenance of existing coverage more difficult, and render any future expansions of coverage more difficult, because coverage will be so costly.

The struggle Massachusetts is going through now to implement its new “universal health insurance” law serves as a warning to universal coverage advocates in Minnesota who believe expanding access to health insurance is so important it is worth sacrificing real cost containment to get it. The comments of Massachusetts Governor Romney after he signed the law on April 12 illustrate this risk. Romney, who will probably announce his presidential ambitions soon, told the New York Times, “This is really a landmark for our state because this proves … that we can get health insurance for all our citizens without raising taxes…. The old single-payer canard is gone.” Romney is a healthy man in his 50s. He will live to eat his words.

The law Romney signed will not provide “health insurance for all [Massachusetts] citizens … without raising taxes.” Even the law’s most delirious supporters were saying during the debate over the bill in the legislature that it would cut Massachusetts’ uninsured rate from 11 percent in 2004 to 1 percent by 2010. Shortly after it was enacted, its proponents were saying the uninsured rate would fall to 5 percent by 2010. The fundamental reason the Massachusetts law will never come close to insuring all citizens is that it cannot contain cost. It is just flat out impossible to insure more people for the same amount of money if you don’t cut costs somewhere. The Massachusetts law promises to cut costs by issuing “report cards” on clinics and hospitals, which is supposed to cause quality to go up and costs to go down. For several reasons, including the difficulty of measuring quality of medical care and the high cost of doing so repeatedly for numerous medical services, this promise is going to fail. Since Romney and his Democratic allies ruled out a deprivatized system, and since their so-called cost containment strategy can’t work, they have no way to reduce costs other than
to reduce coverage and/or encourage the insurance companies to ration health care. Given the average citizen’s hostility to HMO attempts to ration care, it is unlikely (although by no means impossible) that costs will be cut substantially through HMO rationing. That leaves reduced coverage as the path of least resistance.

Reduced coverage appears to be the strategy Massachusetts is adopting, willy-nilly. According to a blog maintained by Health Care For All (the citizen group in Massachusetts that led the campaign for the law Romney is so proud of and that Minnesota insurers find so attractive), the agency that is implementing the Massachusetts plan is now discussing allowing insurance companies to sell policies with very high deductibles and scrappy coverage. Moreover, that agency is now discussing permitting residents who buy these stripped down policies to offer them as proof of having obeyed the individual mandate. To be specific, the agency is considering letting insurers sell policies with deductibles of $2,500 to $3,000 for individuals (presumably these numbers are much higher for families) and limited coverage (for example, generic drugs only) (see http://blog.jcfama.org?p=648#comments). As bad as this coverage is, agency staff predict the premium will be $2,500 to $3,000 a year.

In short, Massachusetts appears to be moving toward a system in which only 95 percent and perhaps fewer of its people are insured, and many of these will be “insured” with very leaky coverage. Even so, whether this can be done without raising taxes remains to be seen. The tax-financed subsidies are going to have to be high if all residents are going to be able to afford their $2,500-$3,000 per person premium.

Health Care for All and other advocates of universal coverage in Massachusetts have paid a high price for “universal” coverage. Advocates of universal coverage in Minnesota should think long and hard before they cut a similar deal here. Let’s insure all kids as a first step toward universal coverage. But let’s leave insurance companies out of the loop. Let’s then insure all other Minnesotans with a single-payer system.

[Sidebar] Two terms explained

Health maintenance organization. Proponents of HMOs have never put forth a clear definition of “health maintenance organization.” Federal and state statutory definitions of HMOs are of little help because they are extraordinarily vague. Generally speaking, the phrase has gone through two definitions – a relatively specific definition in the early years of the phrase’s history, and a very loose definition today. When the phrase was invented in 1970, it referred to health insurance companies: that allowed enrollees to see only certain doctors; that required the doctors it contracted with to see only that company’s enrollees; that paid its doctors using methods that encouraged doctors to deny unnecessary services (and in theory, to order all necessary services); and that amended or vetoed decisions made by its doctors. Today the phrase HMO has come to mean any insurance company which gives its doctors financial incentives to deny care or which amends or vetoes physician decisions. By this latter definition, virtually all insurance companies in existence today are HMOs. The text of this article uses the modern definition of HMO.

Single-payer system. This phrase refers to a system in which one government agency replaces multiple insurance companies with a single agency or board. To put this another way, under a single-payer, the one payer reimburses clinics and hospitals
directly; it does not funnel money through insurance companies. This switch from hundreds of insurance companies (it’s more like thousands if we’re talking about the national level) to one government payer cuts administrative costs in half and total health care costs by 10 to 15 percent. The single-payer system also cuts drug prices, specialist fees, and fraud, but these savings are smaller than the administrative savings achieved by single-payer systems.

Kip Sullivan is a member of the steering committee of the Minnesota Universal Health Care Coalition, which represents 12 organizations. He is the author of more than 100 articles about health policy, and of a new book entitled *The Health Care Mess*, available at Arise Bookstore, Amazon Books, Mayday Books, Magers and Quinn, and Orr Books in Minneapolis, Mikawbers’ and Amore Coffee in St. Paul, and at authorhouse.com and muhcc.com.