REFORM ON A DIET: AMERICA'S HEALTHIEST STATE WEIGHS IN

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I. INTRODUCTION

With the dawn of the new millennium, America headed again

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into the Bermuda Triangle of health care finance. Previously held at bay by managed care in the 1990s, health care premiums began to escalate. Fewer employers offered health insurance as a benefit. America grew grayer as Medicare costs spiraled upwards. Then, recession hit in 2001 and newly unemployed workers turned to public health care programs. Enrollment increased. State budgets, like boats in uncharted water, careened. Soon after, forty-five million Americans lacked health insurance.[1]

Washington D.C. is hardly a beacon of light in these turbulent times. But at the state level, where officials face both rising health care costs and the need to actually balance budgets each year, innovative programs are introduced, passed, and tested in the marketplace.[2] Illinois enacts a program to insure all kids.[3] Massachusetts passes a health insurance mandate.[4] Maine embraces comprehensive reform centered on a new public-private effort, the Dirigo Health Plan.[5] West Virginia moves toward a stated goal of universal coverage by broadening its children's health plan and freeing insurance companies to offer no-frills coverage to individuals.[6]

Where does Minnesota fit today on the list of states striding toward universal coverage and cost containment? In one respect, Minnesota is at the top; this state leads the country in the percentage of residents with health insurance. It is lauded as the "healthiest state."[7] Ten years ago, any thoughtful article on state health care reform would have listed Minnesota as a leader; but that is not uniformly the case today.[8] Over the past decade, the

1. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INS. IN THE UNITED STATES: 2004, 16 (2005), http://www.census.gov/prod/2005pubs/p60-229.pdf.

2. As Thomas Oliver pointed out, "[i]n the natural order of our political system, inaction at the top begets action below." Thomas R. Oliver, *Ideas, Entrepreneurship, and the Politics of Health Care Reform*, 3 STAN. L. & POL'Y REV. 160, 160 (1991).

3. *See* discussion *infra* Part IV.A.1.

4. *See* discussion *infra* Part IV.A.2.

5. *See* discussion *infra* Part IV.A.3.

6. *See* discussion *infra* Part IV.A.4.

7. UNITEDHEALTH FOUND., AMERICA'S HEALTH RANKINGS: A CALL TO ACTION FOR PEOPLE AND THEIR COMMUNITIES (2005), http://www.unitedhealthfoundation.org/shr2005/Findings.html [hereinafter 2005 HEALTH RANKINGS].

8. *Compare* Pamela A. Paul-Shaheen, *The States and Health Care Reform: The Road Traveled and Lessons Learned From Seven that Took the Lead,* 23 J. HEALTH POL. POL'Y & L. 319, 319 (1998) (noting that Minnesota was one of seven states that "had progressed the furthest in enacting comprehensive statutes designed to

debate in Minnesota shifted from how to progress towards the dual goals of increased access and cost containment to a debate about the status quo. Should we continue to fund Minnesota's health care programs or should we reduce the "health welfare" programs to a level more consistent with other midwestern states?

This article briefly reviews the evolution of health care finance over the past sixty years.[9] It then explores the current health care programs in Minnesota and their development.[10] It traces the progress made in Minnesota toward universal coverage in the 1990s and the retreat from this goal during recent years.[11] Next, it examines recent health reform initiatives in other states.[12] Finally, the articles analyzes why bold health reform measures currently appear in other states—but not in Minnesota—and the implications for the state's progressive tradition.[13] It concludes that the state is at a turning point—and that only to the extent that its leaders possess both the passion for health care reform and the willingness to build bipartisan coalitions to work towards long-term solutions, will Minnesota continue to retain its ranking as the healthiest, if not the most progressive, state.[14]

II. THE EVOLUTION OF HEALTH INSURANCE IN THE TWENTIETH CENTURY

A. *Creation of Private Health Insurance*

Before the 1930s, health insurance in America was largely

expand health insurance coverage and slow the growth of health care costs"), Thomas R. Oliver & Pamela A. Paul-Shaheen, *Translating Ideas into Actions: Entrepreneurial Leadership in State Health Care Reforms*, 22 J. HEALTH POL. POL'Y & L. 721 (1997) (discussing Minnesota's health innovation during the 1990s), Howard Leichter, *State Model: Minnesota, the Trip from Acrimony to Accommodation*, 12 HEALTH AFFAIRS 48, 48 (1993) (profiling Minnesota's health care reform efforts in the 1990s, suggesting that Minnesota is a "model for accomplishing state and federal reform"), *and* Barbara P. Yawn et al., *MinnesotaCare (HealthRight) Myths and Miracles*, 269 JAMA 511 (1993), *with* Rick Mayes, *Universal Coverage and the American Health Care System in Crisis (Again)*, 7 J. HEALTH CARE L. & POL'Y 242, 279 (2004) (concluding that "[m]aybe individual states, such as Maine and Oregon, will lead the way in innovative policymaking").

9. *See infra* Part II.
10. *See infra* Part III.
11. *See infra* Part III.
12. *See infra* Part IV.A.
13. *See infra* Part IV.B.
14. *See infra* Part V.

unknown.[15] Experts believed that adverse selection was an insurmountable hurdle to broad coverage so that a purchase of health insurance then was akin to a purchase of flood insurance today—you only spent the money when very likely to be sick. Despite this mindset, in 1929, Baylor University Hospital took an extraordinary step and agreed to provide hospital care to a group of teachers for six dollars a year.[16] The arrangement spread to other groups of enrollees and then to additional hospitals. While these first ventures were competing efforts by single hospitals, the concept evolved from single-hospital plans into the formation of BlueCross.

The American Hospital Association established the BlueCross system during the Great Depression largely to guarantee more patients (and a more consistent revenue stream) during this time of economic hardship.[17] Under the BlueCross insurance plan, an insured individual chose from any participating hospital. BlueShield plans, begun by physician groups to cover non-hospital medical expenses, followed shortly thereafter.[18]

During the 1930s subscribers to these plans were largely individuals. The advent of group enrollment came in the next decade, not as a result of health planning, but due to both the gains in the labor movement and in reaction to the wage controls enacted during World War II.[19] Firms competing for workers (and unions engaged in collective bargaining) may have been limited by price controls for wages, but quickly turned to a wider benefit package, including hospital insurance, to meet their goals.[20] By 1942, 20% of the population had hospital insurance, but no

15. *See generally* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982). Starr recounts the emergence of health insurance in the United States and contrasts it with the "compulsory sickness insurance" programs developed in European countries generations earlier. *Id.* at 237–43.

16. *Id.* at 295–97. *See generally* BLUECROSS BLUESHIELD ASS'N, HISTORY OF BLUECROSS BLUESHIELD (2006), http://www.bcbs.com/history/bluebeginnings.html.

17. STARR, *supra* note 15, at 306–10.

18. *Id.* at 306.

19. *See* Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. & POL'Y 1, 10 (2005) (stating that "wage controls [were enacted] to prevent escalation during the tight labor market"). S*ee also* STARR, *supra* note 15, at 310–12.

20. Thomas Bodenheimer & Kevin Grumbach, *Paying for Health Care*, 272 JAMA 634, 636 (1994).

coverage for other medical expenses.[21] By 1954, however, over 60% of Americans had some type of hospital insurance.[22] Today, either private or public health insurance covers 85% of Americans.[23]

B. Development of Federal Health Insurance and the Growth of Health Care Spending

While employers provide health insurance to the majority of Americans, beginning in the 1960s, portions of the population gained coverage through new public plans. Today, over 25% of Americans are covered by government programs, which account for 44% of the total health care costs.[24] This apparent disparity makes sense upon examination of the populations covered by the government programs as they developed.

Medicare, a program including hospital insurance for the elderly and certain needy children under Social Security, became law in 1965.[25] The first layer of the program, Part A, provided compulsory hospital insurance to Social Security recipients.[26] Part B was a government-subsidized voluntary insurance to cover physicians' bills for these same beneficiaries.[27] Medicare's alignment with the Social Security program brought broad popular support.[28] In 1973, individuals receiving Social Security Disability

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21. STARR, *supra* note 15, at 311.

22. *Id.* at 313.

23. In 2004, the Census Bureau estimated that 45.8 million Americans (almost 16% of the population) lacked health insurance. DENAVAS-WALT, *supra* note 1, at 16.

24. *Id.*; KAISER FAMILY FOUND., TRENDS AND INDICATORS IN THE CHANGING HEALTH CARE MARKETPLACE § 1, Ex. 1.8 (2005), http://www.kff.org/insurance/7031/index.cfm (last visited Nov. 12, 2006) [hereinafter TRENDS AND INDICATORS].

25. *See* Social Security Act Amendments, Pub. L. No. 89-97, 79 Stat. 286 (1965).

26. Today, Part A continues to pay for inpatient hospital, skilled nursing, and hospice care. *See* KAISER FAMILY FOUND., COMM'N ON MEDICAID FACTS, MEDICAID AND THE UNINSURED: THE MEDICARE PROGRAM AT A GLANCE (2006), http://www.kff.org/medicaid/upload/7235.pdf [hereinafter MEDICAID FACTS]. A tax of 2.9% of earnings paid by employers and employees funds Plan A. *Id.*

27. *Id.* Part B pays not only for physician services, but for other outpatient and preventive services as well. *Id.* General federal funds, as well as beneficiary premiums fund Plan B. *Id.* Medicare Part C covers private Medicare Advantage plans, which provide Part A and B benefits to participants through managed care plans. *Id.* Part D refers to the outpatient prescription drug benefit, funded largely by general federal funds and beneficiary premiums that went into effect in January 2006. *Id.*

28. STARR, *supra* note 15, at 370–71.

Insurance became Medicare beneficiaries as well, adding an additional two million individuals.[29] Today, Medicare provides coverage to nearly forty-two million largely elderly and disabled Americans.[30] Thirty percent of Medicare enrollees have three or more chronic health conditions and 27% suffer from a cognitive or mental impairment.[31]

During the same period, Congress enacted Medicaid, the nation's public health insurance program for low-income Americans. Today, Medicaid provides health care to fifty-five million individuals.[32] It accounts for one-sixth of all personal health care spending and over 40% of all nursing home care.[33] Elderly and disabled enrollees comprise 25% of Medicaid's population, yet they account for 70% of the program's expenditures.[34] For example, in Minnesota, the elderly and the disabled or blind accounted for 76% of Medical Assistance (the state's Medicaid program) spending in 2005, although only 30% of total eligibles are in these two groups.[35]

Unlike Medicare, the Medicaid program is jointly funded but largely state administered. The federal funding "match" varies by state from a floor of 50% to a high of 77%.[36] The formula for the match percentage is tied to a state's personal income level. This means that Minnesota and eleven other states have matching rates of 50% (so that every other dollar spent on Medicaid draws an additional federal dollar) while Mississippi has a match of 76%.[37]

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29. *See* KAISER FAMILY FOUND., MEDICARE: A TIMELINE OF KEY DEVELOPMENTS, http://www.kff.org/medicare/timeline/pdf_entire.html (last visited Oct. 20, 2006).

30. *See* MEDICAID FACTS, *supra* note 26. Most of Medicare's enrollees are seniors, but 6.3 million are permanently disabled individuals under age 65. *Id.*

31. *Id.*

32. MEDICAID FACTS, *supra* note 26, at 1.

33. *Id.*

34. *Id.*

35. RESEARCH DEP'T, MINNESOTA HOUSE OF REPRESENTATIVES, MEDICAL ASSISTANCE 19 (2006), http://www.house.leg.state.mn.us/hrd/pubs/medastib.pdf [hereinafter HOUSE SUMMARY].

36. KAISER FAMILY FOUND., COMM'N ON MEDICAID FACTS, MEDICAID AND THE UNINSURED, STATE FISCAL CONDITIONS AND MEDICAID (2005), http://www.kff.org/medicaid/upload/4087-04.pdf.

37. KAISER FAMILY FOUND., COMM'N ON MEDICAID AND THE UNINSURED, LOW MEDICAID SPENDING GROWTH AMID REBOUNDING STATE REVENUES: RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY STATE FISCAL YEARS 2006 AND 2007 13 (2006), http://www.kff.org/medicaid/upload/7569.pdf. The eleven other states with a 50% matching rate are California, Colorado, Connecticut, Delaware, Illinois, Maryland, Massachusetts, New Hampshire, New Jersey, New York, and

After the passage of these landmark public programs in the 1960s, the country saw a dramatic shift in health care finance. An access crisis became a cost crisis. Low-income seniors and public assistance recipients increased their use of medical services.[38] Medicare and Medicaid both paid providers on a fee-for-service basis, providing incentives to maximize services and further contribute to rising health care costs. During the 1970s, health care expenditures increased from $69 billion to $230 billion in 1980.[39]

These numbers no doubt contributed to the dearth of successful large-scale federal access initiatives until 1997 and the passage of the State Children's Health Insurance Program (SCHIP). SCHIP opened up a new stream of funding through state programs to provide health insurance to children.[40] The program provides a capped amount of federal matching funds to states for coverage of children and some parents with incomes too high to qualify for Medicaid, but for whom private health insurance is either unavailable or unaffordable. It provided the largest expansion of government health insurance since the enactment of Medicare and Medicaid.[41] In 2005, SCHIP covered approximately four million children.[42]

Despite these government programs aimed at specific populations, employer-based health insurance remained the backbone of America's health finance system at the end of the twentieth century, as it had for the last fifty years. Employers provide coverage to almost 54% of the population overall and 61% of non-elderly Americans.[43] Indeed, the late 1990s saw the

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Washington. *Id.*

38. STARR, *supra* note 15, at 373.

39. *Id.* at 380; U.S. DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., HISTORICAL NUMBERS, http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp (last visited Oct. 20, 2006). These numbers increased to $717 billion by 1990. *Id.*

40. Balanced Budget Act of 1997, § 4901, Pub. L. No. 105-33, Title IV, § 4901(a), 111 Stat. 552 (1997) (codified at 42 U.S.C. §§ 1397 aa–jj).

41. *See generally* Mayes, *supra* note 8, at 242 (discussing problems associated with United States health care system, including failures of the Medicare and Medicaid programs).

42. KAISER FAMILY FOUND., SCHIP ENROLLMENT IN 50 STATES DECEMBER 2004 DATA UPDATE (2004), http://www.kff.org/medicaid/upload/7348.pdf.

43. KAISER FAMILY FOUND., COMM'N ON MEDICAID & THE UNINSURED, THE UNINSURED: A PRIMER: KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 2 (2006), http://www.kff.org/uninsured/upload/7451.pdf [hereinafter PRIMER]. Half of those insured through employer plans are covered as a worker's

culmination of an expansion in employer-provided coverage and a decrease in uninsured children.

The reasons for continued employer-provided coverage, after a decade of double-digit health care cost inflation, were twofold: an economic boom and the advent of managed care.[44] Between 1988 and 1993, health insurance costs had grown by at least 8% each year and as the premiums grew, the number of workers receiving health benefits declined.[45] But in the mid-1990s, employers embraced new "gate-keeper" and other managed care models for containing costs. Through these methods they were able to achieve modest, affordable health care cost increases through the mid and late 1990s.[46] By 1996, private health insurance premiums' rate increases had dropped to 0.8%.[47] This period of flat costs ended as 9% to 10% premium rate increases returned in 2001.[48]

Perhaps managed care made all the necessary changes and squeezed out the "fat" by the end of the last century. Perhaps the

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dependent. *Id.* Overall, the health coverage of the non-elderly population in 2004 is as follows: 61% employer sponsored, 18% uninsured, 16% Medicaid/other public insurance, and 5% private, individually purchased insurance. *Id.*

44. Thirty years ago, solo and small-group practitioners primarily provided health care. Ninety percent of Americans were insured under the "fee-for-service" arrangements that had prevailed for decades. Under this system, physicians treated patients on demand while insurers paid the physicians their fee for the services provided. Since that time, in response to rising health care costs, corporate managed care rapidly came to replace fee-for-service medicine. The term "managed care" can describe any number of groupings that attempt to reduce costs and promote better outcomes. BARRY R. FURROW ET AL., LIABILITY AND QUALITY ISSUES IN HEALTH CARE 482–87 (5th ed. 2004). Typically, managed care organizations (MCOs) have three features: (1) they select a restricted group of health care providers to serve the enrollees; (2) they accept a fixed payment per subscriber in exchange for the promise to provide necessary medical care; and (3) they attempt to control costs through techniques such as bonuses, incentives, "gatekeepers," preauthorization requirements, incentive systems, and utilization review. *Id.* at 518. In short, today, MCOs both arrange and pay for health care. The prevalence of managed care in the present marketplace is remarkable. In 1980, fewer than 10% of Americans were enrolled in MCOs. *Id.* Today, over 90% of the insured workforce is enrolled in a managed care plan. Hermer, *supra* note 19, at 22.

45. PRIMER, *supra* note 43, at 12.

46. KAISER FAMILY FOUND. & RESEARCH AND EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2003 ANNUAL SURVEY 2 (2003), http://www.kff.org/insurance/ehbs2003-abstract.cfm (follow "Summary of Findings" hyperlink); Hermer, *supra* note 19, at 15–16; TRENDS AND INDICATORS, *supra* note 24, § 3.

47. TRENDS AND INDICATORS, *supra* note 24, § 3; Hermer, *supra* note 19, at 15–16.

48. TRENDS AND INDICATORS, *supra* note 24, § 3.

cost escalation began again because these were only "one-time" savings. Or, perhaps the savings came at a cost that consumers and employers were unwilling to live with, and therefore the administrative restrictions at which physicians and patients chafed were undone. Accordingly, as the restraints were undone, costs escalated.

III. DEVELOPMENT OF HEALTH INSURANCE IN MINNESOTA

Although experts differ on how best to quantify the uninsured, they agree on one point: Minnesota historically leads the country in the percentage of its citizens with health insurance.[49] Depending on how you view the numbers, only 7.4% or 8.9% of Minnesotans were uninsured in 2004, compared to a 16% nationwide uninsured rate.[50] The reason Minnesota is lauded as a high-access state is twofold. First, Minnesota employers are far more likely, on average, to provide health insurance for their employees. While 53% of Americans are covered by employer-provided insurance, 63% of Minnesotans enjoy employer-provided insurance.[51] Second, Minnesota public programs provide coverage to a wider set of individuals, including adults without children, who typically would not qualify for coverage in many other states. Below, the article sets out the various programs, which combine to complete the public health puzzle in Minnesota. Examination of the genesis of the

49. MINN. DEP'T OF HEALTH & THE UNIV. OF MINN. SCH. OF PUBLIC HEALTH, HEALTH INS. COVERAGE IN MINN.: TRENDS FROM 2001 TO 2004 1 (Feb. 2006), http://www.shadac.umn.edu/img/assets/18528/MNAccess2004Reprt.pdf [hereinafter MINNESOTA COVERAGE]. This survey supports the proposition that 7.4% of Minnesotans lack health insurance, while U.S. census data pegs Minnesota at an 8.9% uninsured rate. *Id.* at 1–4. The Demographic Supplement to the Census Bureau is the most commonly used data source for estimating rates of insurance coverage at the state level and it is these estimates that are used to allocate federal funding through the State Children's Health Insurance Program (SCHIP). Lynn Blewett et al., *Monitoring the Uninsured: A State Policy Perspective*, 29 J. HEALTH POL. POL'Y & L. 107, 117 (2004). However, different states utilize varied surveys, resulting in a myriad of estimates of health insurance coverage. *Id.* at 111, 118–24.

50. KAISER FAMILY FOUND., http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi (click on Minnesota under "Start with a state or a category"; follow "Health Coverage & Uninsured" hyperlink) (last visited Oct. 20, 2006). S*ee also* MINNESOTA COVERAGE, *supra* note 49, at 1–4.

51. KAISER FAMILY FOUND., http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi (click on Minnesota under "Start with a state or a category"; follow "Health Coverage & Uninsured" hyperlink; follow "Total Population" hyperlink) (last visited Oct. 20, 2006).

public side of the picture may lead one to believe that it is this set of government initiatives that primarily accounts for Minnesota's high insurance rate. This, simply stated, is not the case. Minnesota's status as a high-access state is due as much to the willingness of state employers to provide health insurance as it is to the politicians at the state's Capitol in St. Paul.

A. *Progress Toward Universal Coverage in Twentieth-Century Minnesota*

Minnesota has been a longtime leader in health care quality, beginning with the founding of the "group practice" in America at the Mayo Clinic, in Rochester. The state also led health care access and finance reforms in the twentieth century. One of the first physician-controlled, prepaid health plans had its origin in mining communities on the Iron Range in the early 1900s.[52] The state's first hospital prepayment plan (which predated the much heralded Baylor University program[53]) grew out of the efforts of one nun of the Order of St. Benedict selling tickets to lumberjacks in the camps of northern Minnesota. These tickets (ranging from fifty cents to five dollars) entitled the holder to full hospitalization at any of the five hospitals operated by St. Mary's for a year.[54] Decades later, Minneapolis physician Paul Ellwood became one of the architects of prepaid comprehensive health plans later known as HMOs.[55] Today, the second-largest managed care company in America is UnitedHealth Group, headquartered in Minnesota.[56]

The advent of Medicaid provided Minnesota a stage for increased participation in the public arena as well. The Federal

52. STARR, *supra* note 15, at 302.

53. *See* discussion *supra* Part II.A.

54. BLUE CROSS AND BLUE SHIELD OF MINNESOTA, THE BLUE CROSS AND BLUE SHIELD OF MINNESOTA STORY: A SIXTY YEAR HISTORY 3 (1993).

55. Ellwood's promotion of HMOs as an alternative to the fee-for-service system (and one that would both promote better health through preventive medicine and save money by doing so) became part of the national health care debate in the 1970s. STARR, *supra* note 15, at 395–97. An HMO "takes fixed periodic payment from its enrollees; in return it provides for the financing and delivery of their medical services for a fixed period of time." Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians,* 22 AM. J.L. & MED. 399, 401 (1996). This system (based upon "capitation" payments), is in direct contrast to "fee for service" payments, where patients, either directly or through their insurers, reimburse physicians retrospectively for care on a fee-for-service basis. *Id.* at 402–03.

56. *See generally* UnitedHealth Group, http://www.unitedhealthgroup.com/ (follow "About UnitedHealth Group" hyperlink) (last visited November 12, 2006).

Medicaid Program requires that states cover certain populations (the "categorically needy") and provide certain core benefits in order to receive federal matching funds.[57] It further provides states the option of covering far more individuals and providing additional benefits—while still receiving federal funding.[58] Since the adoption in 1966 of Medical Assistance (MA), Minnesota's Medicaid program, the state generally opted to provide the broadest Medicaid coverage in terms of both optional eligibility groups and benefits. For example, federal law requires states to cover pregnant women with incomes of less than 133% of the Federal poverty level.[59] States can choose to cover pregnant women with higher incomes; in 2002, Minnesota covered women with incomes up to 275% of the federal level.[60]

With regard to benefits, while federal law requires that physician, nursing home, inpatient hospital, and laboratory services (among others) be provided to all Medicaid recipients, in 2006, the state provided thirty-two categories of "optional services" ranging from dental to emergency hospital to mental health to hospice care and private-duty nursing services.[61] In 2004, MA covered a monthly average of approximately 464,000 low-income senior citizens, children, families, and people with disabilities.[62]

While Minnesota provided insurance to a wide group of Medicaid-eligible individuals, low-income adults without children

57. U.S. DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.hhs.gov/MedicaidGenInfo (follow "Technical Summary" hyperlink; then scroll to "Basis of Eligibility and Maintenance Assistance Status") (last visited Oct. 26, 2006) [hereinafter MEDICAID SUMMARY].

58. U.S. DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID AT-A-GLANCE 2005 1 (2005), http://www.cms.hhs.gov/Medicaid GenInfo/Downloads/MedicaidAtAGlance2005.pdf.

59. MEDICAID SUMMARY, *supra* note 57.

60. HOUSE SUMMARY, *supra* note 35, at 8.

61. Minnesota Dep't of Human Svcs., Health Care, http://www.dhs.state.mn.us/ (follow "Health Care" link; follow "Medical Assistance" link) (last visited Nov. 12, 2006). Income limits for MA vary, depending upon assets and medical bills. MINN. DEP'T OF HUMAN SERVS., MINN. HEALTH CARE PROGRAMS FACT SHEET 1 (2005), http://www.dhs.state.mn.us/main/dhs_id_048802.pdf [hereinafter MINNESOTA FACT SHEET]. Examples of income limits effective in 2006 are $19,136 in annual income for adults with children under nineteen years of age in a household of four. *Id.* The limit is higher for pregnant women ($35,304) and for households of two with infants under two years old ($35,928). *Id.* Although families, children, and pregnant women made up almost 70% of MA enrollees, they accounted for only 22% of expenditures. The balance was spent on the elderly or people with a disability. HOUSE SUMMARY, *supra* note 35, at 19.

62. MINNESOTA FACT SHEET, *supra* note 61, at 1.

generally remained ineligible for this federal program. In 1975, the legislature sought to provide basic health insurance to this set of adults through a health care program funded solely with state dollars.[63] This state program was termed General Assistance Medical Care (GAMC). While the eligibility guidelines changed across the years, in general GAMC provided basic health care (not the broad array of services available under MA) to low-income adults with income at or below 75% of the federal poverty level with no dependent children and almost no assets.[64] In 2004, approximately 34,900 Minnesotans received medical care through GAMC.[65]

Another category of underinsured individuals who would not qualify for MA is those without private insurance who, because of a medical condition, cannot find insurance on the private market. In 1976, the year after establishing GAMC, the Minnesota legislature set up the Minnesota Comprehensive Health Association (MCHA) to offer policies of individual health insurance to Minnesota residents turned down for health insurance by the private market, due to preexisting health conditions.[66] In 2006, this high-risk pool insured about 30,000 Minnesota residents who pay premiums that are generally higher than rates for comparable policies in the marketplace.[67]

In 1987, a decade after MCHA's passage but a decade before SCHIP passed Congress, Minnesota became one of the first states to establish a special health insurance program for children. The Children's Health Plan (CHP) initially provided preventive and primary care services to children between one and eight years of

63. From 1976 through 1991, counties paid for 10% of the General Assistance Medical Care costs, which the state picked up thereafter. Randall Chun, Minn. House of Representatives Research Dept., Information Brief, *General Assistance Medical Care* 7 (Feb. 2006), *available at* http://www.house.leg.state.mn.us/hrd/pubs/gamcib.pdf.

64. MINNESOTA FACT SHEET, *supra* note 61, at 2.

65. *Id.*

66. *See* MINN. STAT. §§ 62E.10–.19 (2004). MCHA is a non-profit agency, regulated by the Minnesota Department of Commerce, and funded, in part, by an assessment on state-regulated health plans. Minnesota Comprehensive Health Association, http://www.mchamn.com (last visited Nov. 12, 2006) [hereinafter MCHA]. An executive staff manages the administration of the risk pool. *Id.* Since its first year of operation in 1977, MCHA has contracted with an outside organization to perform day-to-day operations of the plan. *Id.* MCHA premiums must be set between 101% and 125% of the weighted average for comparable policies. *Id.*

67. MCHA, *supra* note 66.

age in families with incomes below 185% of the federal poverty level.[68] As Medicaid eligibility expansions made coverage available—in states like Minnesota who chose to cover these additional groups—to all children under the age of eighteen in families with incomes below 185% of the federal poverty level, CHP expanded both its benefit package and the upper age limits for coverage.[69] Two CHP initiatives deserve particular note. First, both uninsured and underinsured children (those who were in plans with gaps in coverage or high deductibles, for example) were eligible.[70] Second, signing up was easy. Payment of an annual $25 per child premium (the only cost sharing) and completion of a one-page application form, which could be completed by mail, were the only prerequisites.[71] By the end of 1992, approximately 30,000 children were enrolled in the program.[72]

B. Sweeping Reform Arrives via MinnesotaCare

CHP served as both a testing ground and a stepping stone for the state legislature. Two years after its adoption, faced with continued health care inflation and ongoing access problems in rural Minnesota, Governor Rudy Perpich appointed a Health Care Access Commission. He tasked it with drafting a plan to provide comprehensive health care access. The Commission found that access was impeded by high costs throughout the system and ultimately included in its report not only access recommendations, but also proposals to control health care costs.[73] Three Democratic legislators took the Task Force Recommendations and crafted the original Minnesota Health Care Plan.[74] While the plan passed both the Democratic-controlled House and Senate in 1991, Republican

68. Ian Hill et al., *State Initiatives to Cover Uninsured Children*, 3 HEALTH CARE REFORM 2, 142, 149 (1993), http://www.futureofchildren.org/usr_doc/vol3no2 ART8.PDF.

69. *Id.* at 142. CHP raised its upper age limit to 18 in 1991. *Id.* at 149.

70. *Id.* at 150.

71. *Id.* at 149–50.

72. *Id.* at 150. These enrollees folded into MinnesotaCare in 1993 and CHP incorporated as part of the new program. *See supra* note 66 and *infra* note 78 and accompanying text.

73. THE MINN. HEALTH CARE ACCESS COMM'N, FINAL REP. TO THE LEG., 77th Leg., 1st Sess., at 5–7 (1991).

74. These legislators were Senator Linda Berglin and Representatives Paul Ogren and Lee Greenfield. Leichter, *supra* note 8, at 51.

Governor Arnie Carlson vetoed the bill.[75]

The original proponents of what became MinnesotaCare reached out—to the Republicans and the business community. In 1992, a bipartisan group of legislators, referred to as the "Gang of Seven," worked with Governor Carlson to craft comprehensive reform.[76] With Republican support, the focus of the law shifted from a plan designed to deal with the uninsured into a plan directed at rapidly rising health care costs and, indeed, redesigning the entire health care system in Minnesota.

The bill that passed the following year was one of the first comprehensive health care reform plans in any state. It set out to both control costs and increase access by: (1) reforming insurance practices in the small group and individual markets; (2) establishing a reinsurance pool; (3) providing incentives to enhance rural health care, including grants to rural hospitals; (4) revising the malpractice laws; (5) establishing limits on growth in health care spending; (6) fostering regional health planning and monitoring quality issues though a Health Care Commission; and (7) establishing a subsidized health insurance plan for the working poor.[77] The legislation, which totaled 133 pages of single-spaced text, also authorized delivery system reform through Integrated Service Networks and established six regional coordinating boards to facilitate local efforts to improve quality and access.[78] A 2% tax on providers was the principal source of financing the reforms, including the subsidized insurance, which became "MinnesotaCare."[79] Through this complex maze of laws, two

75. *See* Leichter, *supra* note 8, at 48 (discussing Governor Carlson's veto in the face of strong public support for reform).

76. *Id.* The "Gang of Seven" consisted of four Democrats and three Republicans. *Id.*

77. Keith J. Halleland & S. Olivia Mastry, *Health Right: Eliciting Health Care Reform*, BENCH & B. MINN., Aug. 1992, at 14, 14–18. *See also* Arthur L. Caplan & Paul A. Ogren, *Do the Right Thing: Minnesota's HealthRight Program*, HASTINGS CENTER REP., Sept.–Oct. 1992, at 4. The subsidized health insurance plan was aimed at the working uninsured. *Id.* at 4–5. It featured coverage (with sliding scale premiums) for working adults, as well as children and families. *Id.* at 4. With its beneficiary cost-sharing and application by mail it had the "look and feel" of employer coverage rather than Medicaid. *See* HEATHER SACKS & STAN DORN, MINNESOTA: A CASE STUDY IN CHILDLESS ADULT COVERAGE 4 (2004), http://www.kff.org/medicaid/upload/Medicaid-and-Other-Public-Programs-for-Low-Income-Childless-Adults-Minnesota.pdf.

78. The Minnesota Health Right Act, ch. 549, art. 1, § 1, 1992 Minn. Laws 1487, 1488 (codified at MINN. STAT. § 62J.015 (1992)).

79. *Id.* The name "HealthRight" was subsequently changed to MinnesotaCare

overarching goals were omnipresent: control rising health care costs and increase access to health insurance.

The initial sweep of MinnesotaCare was breathtaking. Why, at a time when the federal government and most other states[80] were paralyzed by the rising costs and corresponding rise in the uninsured, did we see this dramatic legislation in Minnesota? In some respects, the state was an unlikely venue. After all, in 1992 Minnesota health care costs were low compared to those of other states, and the access to insurance was, relatively speaking, high.[81] The quality of health care in Minnesota ranked high then, as it does now, and the managed care market (which other states and the federal government saw as presenting the cost-containment mechanisms needed to bring escalating costs to a halt) was already a mature market in Minnesota.[82] But rather than look at Minnesota's place in the health care rankings as a reason for complacency, a bipartisan group of legislators, community leaders, business people, and advocates saw it as an opportunity for leadership.

C. At the End of the Twentieth Century, a Pause in Reform

Failure of the Clinton Health Care Plan, the 1994 "Contract with America,"[83] and a pause in the seemingly endless escalation of health care costs in the mid-1990s impacted Minnesota's road to

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which is how, for simplicity's sake, the legislation is referred to in this article.

80. Lawrence D. Brown & Michael S. Sparer, *Window Shopping: State Health Reform Policy in the 1990s*, 20 HEALTH AFF. 50, 50–51 (2001). Other states with bold plans during this period were Massachusetts and Oregon and, to a lesser degree, Hawaii. *Id.* at 52. Additional states did, however, take incremental steps to expand coverage during the 1990s. *Id.* at 52–53. Many expanded Medicaid coverage for children even prior to the enactment of SCHIP; others used demonstration waivers to provide coverage to adult populations as well. *Id.* at 56.

81. Halleland & Mastry, *supra* note 77, at 14. In 1990, as in 2005, Minnesota was ranked at the top of the list of the healthiest states. It has been in the top two states since 1990. 2005 HEALTH RANKINGS, *supra* note 7.

82. Halleland & Mastry, *supra* note 77, at 14–15.

83. As part of the "Contract with America," congressional Republicans attempted to give Medicaid funding to the states in the form of block grants, instead of as an entitlement program, thus potentially leaving millions without coverage. *See generally* THE CENTURY FOUNDATION, MEDICAID REFORM: A TWENTIETH CENTURY FUND GUIDE TO THE ISSUES, http://www.tcf.org/Publications/HealthCare/medicaidbasics-intro.htm (last visited Oct. 26, 2006) (discussing changes in Medicaid spending over the past fifteen years). This and other bills prompted a veto by President Clinton, which ultimately lead to a government shutdown. *Id.* This brand of Medicaid reform was dropped as a result. *Id.*

reform. Some Minnesotans, watching the downfall of the Clinton Health Care Plan, questioned the need for comprehensive reform. Other Minnesotans, viewing the original enactment of MinnesotaCare, believed that reform measures were already in place. The immediate need for advocacy passed. As with many long-term initiatives, health reform in Minnesota at times took steps backwards and at other times made detours. In 1995, the legislature repealed the 1997 deadline for universal coverage,[84] amended the rules governing integrated service networks,[85] adjusted MinnesotaCare expansions,[86] and repealed the all-payer.[87] During the same time frame, responding to the cry for prescription drug coverage from seniors, the state passed a pharmaceutical assistance program for low-income seniors who did not qualify for Medicaid.[88]

By the late 1990s, government-controlled health care reform was not at the top of the Minnesota political agenda in any venue. Republican Governor Arnie Carlson, who had embraced MinnesotaCare as the best way to address the high cost of health insurance and to get more welfare recipients working, left office and Jesse Ventura was sworn in as Governor. Elected to one term as Governor in 1998, Ventura's main health care legacy was legislation that created one of the country's strongest tobacco-control programs.[89] The initial $1.2 billion 1998 settlement between the state and the tobacco companies funded trust funds, with $590 million dedicated to a Tobacco Prevention and Public Health Endowment and approximately $378 million to fund a Medical Education and Research Endowment.[90]

But while the state budget had surpluses during the first three years of Ventura's term, the Governor's overall priorities were property tax reforms, income tax cuts, car license tab fees, light

84. Act of May 25, 1995, ch. 234, art. 4, § 1, 1995 Minn. Laws 2156.

85. *Id.* art. 1, 1995 Minn. Laws at 2121.

86. *Id.* art. 2, 1995 Minn. Laws at 2194.

87. *Id.* art. 3, 1995 Minn. Laws at 2150.

88. 1997 MINN. LAWS 1587, 2331–33. The legislation created the Senior Drug Program, later called the Minnesota Prescription Drug Program, which provided coverage to seniors between 101% and 120% of the federal poverty level. *Id.*

89. *See* RESEARCH DEP'T, MINNESOTA HOUSE OF REPRESENTATIVES, MINNESOTA TOBACCO SETTLEMENT (2002), http://www.house.leg.state.mn.us/hrd/issinfo/sstobstl.htm.

90. *See infra* Part IV.B.1. (describing how the next Governor and legislature depleted these trust funds entirely for a one-time fix to the annual state budget).

rail, and rebates commonly referred to as "Jesse checks,"—in other words, not health care.[91] While Governor Ventura's proposed budgets included marginal increases to provide more health insurance coverage to low-income children in addition to support for an initiative to make use of federal money to extend Medicaid to an additional 26,000 children,[92] no political party or leading health care coalition made coverage for all children a priority at the turn of the century.

But as the century closed, progress had been made. A central part of the original MinnesotaCare plan, subsidized insurance for the working poor, remained firmly in place. Minnesota's health care programs, such as MCHA and GAMC, remained national models for covering low-income adults and high-risk patients. A prescription drug program for low-income seniors was in its infancy. A "high access state" at the end of the 1990s, Minnesota retained its ranking as the healthiest state in the nation.[93]

IV. THE PICTURE DARKENS AS THE TWENTY-FIRST CENTURY DAWNS—IN MINNESOTA AND ELSEWHERE

Perhaps it was a combination: some 1990s cost savings were one-time experiences from which we benefited and others came at a price (limits on patient choice and interference with physician judgment) that we were unwilling to pay. Either way, the country as a whole quickly began to pay more for health care at the turn of the new century. Health insurance premiums rose at double-digit

91. *See* Laura McCallum, *The Political Legacy of Jesse Ventura* (Minnesota Public Radio broadcast Dec. 17, 2002), *available at* http://news.minnesota.publicradio.org/features/200212/17_mccalluml_venturalegacy.

92. *See* STATE OF MINNESOTA, FISCAL YEAR 2002–03 HEALTH & HUMAN SRVCS. BUDGET 1–4 (on file with author). The 2001 health coverage proposal to provide Medicaid health coverage to families making up to 140% of the federal poverty guidelines was termed "Cover All Kids." *See* CHILDREN'S DEFENSE FUND MINNESOTA, COVER ALL KIDS, http://www.cdf-mn.org/CAKcoalition. htm (last visited Oct. 20, 2006). Ventura also launched a "Cover All Kids" campaign, together with the Children's Defense Fund Minnesota and twenty other organizations. *Id.* This campaign marked the beginning of an effort, not to extend public programs, but to sign up families who already qualified for low-cost health coverage through MinnesotaCare or other public health programs. *Id.*

93. 2005 HEALTH RANKINGS, *supra* note 7. *See generally* ADELE KIRK & SUSAN ETTNER, HEALTH CARE COSTS: TRENDS AND RELATIONSHIPS TO INSURANCE PREMIUMS, http://www.universityofcalifornia.edu/senate/reports/hccosts.pdf (last visited Oct. 26, 2006) (citing to rankings by the UnitedHealth Foundation, which ranked Minnesota the healthiest state in the nation ten times since 1990).

rates, far out-pacing general inflation, from 2001 to 2004.[94] The cost of private health insurance jumped from a low point of 1.5% in 1996 to 9.7% in 2001.[95] These price increases may have been tenable during a period of economic prosperity, but when a recession hit hard in 2001, 1.4 million Americans lost their health insurance.[96] The recession led employers to lay off workers, who then lacked employer-provided health insurance. The recession also led employers to be less willing to offer coverage. As a result, the percentage of Americans who receive employment-based health insurance has significantly declined over the past five years. Between 2000 and 2004 over six million individuals became uninsured.[97]

Employees of small businesses were particularly hard hit. Between 1996 and 2000, small businesses offering health benefits increased from 59% to 68%, but these numbers turned south in 2001 and 2002.[98] By 2005, the percentage of small employers offering insurance returned to 59%.[99] Finally, those employers who continued to offer coverage passed costs on to employees more aggressively, making many employees who in theory had coverage unable to pay for it, particularly for dependent care.

The double-whammy of the 2001 recession and escalating health expenses cost budgets dearly as well. In general, Medicaid accounts for 17% of state budgets overall, making it the second-largest program (next to education) for most states.[100] Medicaid is

94. Hermer, *supra* note 19, at 45.

95. TRENDS AND INDICATORS, *supra* note 24, § 3.

96. ROBERT J. MILLS & SHAILESH BHANDARI, U.S. CENSUS BUREAU, CURRENT POPULATION REP., HEALTH INS. COVERAGE IN THE UNITED STATES: 2002 4 (2003), http://www.census.gov/prod/2003pubs/p60-223.pdf. An interesting question, explored by Mayes, *supra* note 41, at 243–47, is why the combination of the economic prosperity of the 1990s, the expansion of the SCHIP program and the moderating health care costs did not reduce the percentage of Americans without health insurance. As Professor Mayes concludes, "the tremendous economic wave of the 1990s that raised just about every 'boat' in society had little to no effect on the 15% of Americans without health insurance." *Id.* at 246.

97. PRIMER, *supra* note 43, at 10.

98. KAISER FAMILY FOUND. AND HEALTH RESEARCH AND EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS 2005 SUMMARY OF FINDINGS 4, http://www.kff.org/insurance/7315/sections/upload/7316.pdf.

99. *Id.*

100. KAISER FAMILY FOUND., MEDICAID BUDGETS, SPENDING AND POLICY INITIATIVES IN STATE FISCAL YEARS 2005 AND 2006: RESULTS FROM A 50 STATE SURVEY 10 (2006), http://www.kff.org/medicaid/7392.cfm [hereinafter MEDICAID STATE SURVEY].

a program intended to be counter-cyclical. As expected, when the recession hit, enrollment increased.[101] Medicaid enrollment increased to a high of 9.9% in 2002.[102] The cost of the program grew at a rate of 8% in 2003, while the gross domestic product for the period grew 2%.[103] With health care costs rising, unemployment forcing more people into public programs, frozen federal resources for expansion of health coverage, declining revenues, and state budgets that must be balanced, many states struggled and, in the context of balancing budgets, enacted cuts to public healthcare programs. Medicaid, in particular, was a natural target because of its proportion of the budget and because its costs (by its nature) increased at the very time of the budget crisis.

Beginning in 2002, most states enacted new Medicaid cost-containment measures. The most-utilized actions were freezing provider payment rates and attempting to control prescription drug costs.[104] Co-pays, premiums, and deductibles increased.[105] Disease management became commonplace.[106] But after enacting initial cost containment measures and spending "rainy day" and tobacco settlement funds to preserve Medicaid dollars, states faced a continuing challenge into 2004 and 2005 to balance their budgets as Medicaid expenditures grew.[107] And some states moved to either reduce benefits or restrict eligibility, or both.[108]

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101. *Id.* at 16. Medicaid historically has lower administrative costs and smaller annual increases than private health insurance. *Id.* at 15. The increased costs from 2000 to 2003 were largely driven by increased enrollment. *Id.*

102. *Id.* at 2.

103. ISABEL FRIEDENZOHN ET AL., STATE COVERAGE INITIATIVES ACADEMY HEALTH, STATE OF THE STATES: CULTIVATING HOPE IN ROUGH TERRAIN 2 (2004), http://www.statecoverage.net/pdf/stateofstates2004.pdf [hereinafter STATE OF THE STATES 2004].

104. *See id.* at 7, 10. Forty-five states implemented or proposed strategies for reducing pharmaceutical costs as of 2003. *Id.* at 7. For example, Kentucky implemented a preferred drug list and governors in the upper Midwest expressed interest in creating programs to import cheaper drugs from Canada. *Id.*

105. *Id.* at 11.

106. *Id.* at 28. Disease management plans focus on the chronically ill and twenty-five states implemented such plans for their Medicaid enrollees as of 2003. *Id.*

107. Medicaid cost increases diminished as the economy improved. Medicaid spending increased on average by 7.5% in 2005, as opposed to 12.7% at the peak in 2002. MEDICAID STATE SURVEY, *supra* note 100, at 15.

108. *Id.* at 21–24. In 2003, twenty-five states reduced eligibility levels for Medicaid programs. Adult enrollees (typically parents of eligible children) were targets of most of the reductions. To do so, states reduced qualifying income levels and restricted transitional medical assistance. STATE OF THE STATES 2004,

Understandably, eligibility and benefit cuts were typically viewed by states as a last resort. Federal law limited any Medicaid cuts to the "optional" eligibility groups and "optional" services.[109] But more than 60% of Medicaid expenditures are for these "optional" groups and services.[110] Most of this spending is on politically sensitive benefits, like long-term care and prescription drugs, or on politically sensitive groups, like seniors. And for every state dollar cut from these benefits, the federal match is lost as well.[111] Finally, many health policy experts understood that Medicaid reductions often just postpone preventive care and ultimately shift the cost of care from the program itself (with its federal matching money) to expensive hospital emergency rooms.

And who are these uninsured? Predominately, they are the working poor—or near poor. In 2004, 70% of the uninsured came from families with one or more full-time workers.[112] An additional 13% came from families with part-time workers.[113] Because Medicare covers the vast majority of Americans sixty-five and older, it is instructive to consider the percentage of the population under sixty-five that lacks insurance: 18%.[114] This percentage doubles to 37% for the non-elderly poor.[115] And while Medicaid and SCHIP make inroads toward covering some of the poor, these programs primarily focus on children, their parents, and individuals with disabilities. Low-income adults under sixty-five typically qualify only if they have children or meet income eligibility levels much lower than those for parents with children. Finally, the uninsured are more likely to be people of color. One-third of Hispanics are uninsured, as are 21% of African Americans.[116]

Despite the turbulent budget times, a few states continued to

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supra note 103, at 9. In other states, certain populations (such as legal immigrants) were dropped. *Id.* Eighteen states limited benefits, including imposing restrictions on dental/orthodontic, vision care, and therapy services. *Id.* at 10.

109. KAISER FAMILY FOUND., KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID MANDATORY & OPTIONAL ELIGIBILITY & BENEFITS 3–5 (2001), http://www.kff.org/medicaid/2256-index.cfm.

110. *Id.* at 12–15.

111. *Id.*

112. PRIMER, *supra* note 43, at 4.

113. *Id.*

114. *Id.* at 2.

115. *Id.* at 4. Poverty, for these purposes, is defined as an income less than 100% of the federal poverty level. *Id.*

116. *Id.* at 19.

pursue health care reform. Examples of these states, as well as the experience in Minnesota, are reviewed below.

A. *Health Reform Initiatives During Turbulent Times*

1. *Illinois Covers Children*

Like other states, Illinois faced a deep state budget crisis in 2001. During the 1990s, Illinois had expanded health care coverage several times under moderate Republican governors. Based upon SCHIP, it adopted KidCare, which brought recognition to Illinois for the fourth-highest percentage increase in the number of children covered by the SCHIP program.[117] Yet Illinois was far from a leader in health care access, as 14.4% of the state's population remained uninsured in 2004—only slightly better than the national average.[118] Despite expansions of health programs, approximately 250,000 Illinois children lacked insurance.[119]

In 2005, Governor Rod Blagojevich laid out the continuing fiscal crisis, noting that the budget deficit for the coming year was about $1.7 billion.[120] Deep spending cuts in other programs were proposed and adopted, yet the health care coverage initiative remained in the budget.[121] On November 15, 2005, the All Kids Health Insurance Act was signed into law, making Illinois the first state to offer health insurance to every child within its borders.[122] The multi-year process that lead to this landmark legislation,

117. VERNON K. SMITH ET AL., KAISER FAMILY FOUND., KAISER COMM'N ON MEDICAID & THE UNINSURED, SCHIP PROGRAM ENROLLMENT: DECEMBER 2003 UPDATE 6 (2004), http://www.kff.org/medicaid/upload/SCHIP-Program-Enrollment-December-2003-UPDATE.pdf.

118. 2005 HEALTH RANKINGS, *supra* note 7. *See* KAISER FAMILY FOUND., ILLINOIS: HEALTH INSURANCE COVERAGE OF THE TOTAL POPULATION, STATES (2004–2005), U.S. (2005) (indicating that 16% of the U.S. population is uninsured).

119. *Illinois: Universal Coverage for Children,* STATES IN ACTION: A QUARTERLY LOOK AT INNOVATIONS IN HEALTH POLICY (The Commonwealth Fund), Spring 2006, http://www.cmwf.org/publications/publications_show.htm?doc_id=362631&#illinois.

120. John Bouman, *The Path to Universal Health Coverage for Children in Illinois*, 39 CLEARINGHOUSE REV. J. POVERTY L. & POL'Y 676, 686 (2006).

121. As a candidate, Rod Blagojevich made two central pledges. First, that he would not cut essential services (including health care); and second, that he would not increase sales or income taxes. *Id.* at 684.

122. All Kids Health Insurance Act, Pub. L. No. 94-693, 215 ILCS 170 (2005). The bill contains a July 1, 2006 effective date and commits to offering insurance to all children who are Illinois residents.

started under a moderate Republican governor, was signed into law by a Democratic governor, and received bipartisan support from the General Assembly.[123] While support from Governor Blagojevich was crucial, so was support from provider associations, religious-based interest groups, and businesses, among others.[124]

All Kids offers a benefit package that includes doctor visits, hospital stays, prescription drugs, vision and dental care, and medical devices.[125] Monthly premiums and co-pays are based on family income; a family of four with an income ranging from $50,000 to $60,000 pays a $40 monthly premium per child.[126]

2. *Massachusetts Mandates Insurance*

Like Minnesota, Massachusetts was a leading reform state in the 1990s as it took incremental steps toward universal coverage. As a result, it has few uninsured residents, with about 11% of its population lacking health insurance, as compared with 16% nationwide.[127] In April 2006, the state moved the national debate by enacting a plan that aims to expand health care coverage to nearly all of the uninsured by requiring all residents to purchase health insurance by July 2007.[128] It also created a state-subsidized health insurance program for residents with incomes up to 300% of the federal poverty level.[129]

Under the plan, a new "Commonwealth Health Insurance Connector" will certify and offer "high value" insurance products and connect individuals and small business with appropriate

123. Bouman, *supra* note 120, at 680–88.

124. *Id.* at 688–90.

125. Governor Rod R. Blagojevich, Illinois All Kids, http://www.allkidscovered.com (last visited Nov. 12, 2006).

126. *Id.*

127. Kaiser Family Found., http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi? (last visited Oct. 27, 2006). According to this survey, which provides estimates based on the Census Bureau's population surveys, Minnesota's uninsured rate is 9%. *Id.* Both Minnesota and Massachusetts have a high level of employer-based insurance, which provides coverage for 64% of Minnesota residents and 60% of those in Massachusetts. *Id.*

128. Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts, ch. 58, § 12 (to be codified at MASS. GEN. LAWS ch. 111M, § 2); *Massachusetts: Universal Coverage Legislation,* STATES IN ACTION: A QUARTERLY LOOK AT INNOVATIONS IN HEALTH POLICY (The Commonwealth Fund), Spring 2006, http://www.cmwf.org/publications/publications_show.htm?doc_id=362631#mass [hereinafter MASSACHUSETTS IN ACTION].

129. 2006 Mass. Acts, ch. 58, § 15 (to be codified at MASS. GEN. LAWS ch. 118E, § 9A). *See also* MASSACHUSETTS IN ACTION, *supra* note 128.

matches.[130] Individuals who can afford insurance but do not purchase it by July 2007 will be penalized on their state income taxes.[131] Companies with ten or more employees that do not provide coverage by this date face an assessment of up to $295 per worker per year.[132] In addition, a "free rider" surcharge will be imposed on employers who do not provide health insurance when an employee uses free care more than three times, or whose employees receive free care more than five times a year.[133] Insurance companies are offered incentives to create low-cost, no frills insurance plans for young adults, ages nineteen to twenty-six.[134]

Meanwhile, the Commonwealth Care Health Insurance Program will provide public sliding-scale subsidies to families with incomes up to 300% of the poverty level to purchase private insurance plans through the Connector.[135] At the same time, Medicaid coverage is expanded for children with family incomes up to 300% of the federal poverty level.[136] The overall plan is expected to cover 515,000 uninsured residents (about 95% of the uninsured) within three years, at a cost of $1.2 billion for that time period.[137]

This landmark legislation passed because of its bipartisan

130. MASSACHUSETTS IN ACTION, *supra* note 128.

131. 2006 Mass. Act, ch. 58, § 12 (to be codified at MASS. GEN. LAWS ch. 111M, § 2). *See also* MASSACHUSETTS IN ACTION, *supra* note 128.

132. 2006 Mass. Acts, ch. 58, § 47 (to be codified at MASS. GEN. LAWS ch. 149, § 188).

133. 2006 Mass. Acts, ch. 58, § 44 (to be codified at MASS. GEN. LAWS ch. 118G, § 18B); MASSACHUSETTS IN ACTION, *supra* note 128. The surcharge will be between 10% and 100% of the state's costs of services, although the first $50,000 (per employer) is exempted. *Id.*

134. *Id.* § 6; MASSACHUSETTS IN ACTION, *supra* note 128. Young adults, ages nineteen to twenty-nine, are increasingly likely to become uninsured. In fact, 13.7 million lacked coverage in 2004, an increase of 2.5 million since 2000. *See generally* S.R. Collins et al., *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help*, (The Commonwealth Fund), *available at* http://www.cmwf.org/publications/publications_show.htm?doc_id=374136 (last visited Sept. 13, 2006).

135. 2006 Mass. Acts, ch. 58, § 45 (to be codified at MASS. GEN. LAWS ch. 118H, § 3). The "Connector" is defined as "the commonwealth health insurance connector, established by subsection (a) of section 2 of chapter 176Q" of the General Laws of Massachusetts. *Id.* (to be codified at MASS. GEN. LAWS ch. 118H, § 1).

136. HEALTH CARE ACCESS AND AFFORDABILITY CONFERENCE COMMITTEE REPORT (2006), http://www.mass.gov/legis/summary.pdf.

137. MASSACHUSETTS IN ACTION, *supra* note 128. The legislative estimate assumes that only $125 million of the $1.2 billion comes in the form of new state funding. *Id.*

support, leadership from Republican Governor Mitt Romney, and a broad base of support throughout the state. It relies heavily on Medicaid funding and the assumption that employers who do not already provide coverage today will choose to do so tomorrow.

3. Maine Tackles Comprehensive Reform

In 2003, in the midst of overall state health program cutbacks elsewhere, the Governor of Maine signed into law the Dirigo Health Plan, which combined a subsidized private plan and a Medicaid expansion and cost control measures.[138] Motivated by health care cost escalation, the comprehensive plan establishes a public-private health plan and an expansion of its current low-income health coverage.[139]

The Dirigo Health Plan provides sliding-scale subsidies to enrolled individuals and to employers who offer the new plan to employees, if the employers pay at least 60% of the cost.[140] Small businesses, the self-employed, and the unemployed or part-time workers can participate in this new plan.[141] Enrollment began in 2005 in a program jointly offered between the state and Anthem Blue Cross Blue Shield of Maine.[142] Those enrolled in the first year included more than 750 small businesses.[143] In addition, the legislation expands MaineCare, the state's Medicaid and SCHIP programs, to cover more low-income adults.[144]

The Plan also contains a set of cost containment measures. Examples of these measures include a moratorium on the certificate-of-need (CON) process which is used to approve new health care facilities; an expansion of CON to cover physicians' offices; and placing the CON program on a budget to fund only limited new capital projects.[145] Each year, the Dirigo Health Agency

138. ME. REV. STAT. ANN. 24-A, § 6901-71 (2003). Today, over 130,000 working people in Maine go without health insurance. *Increase Access*, Dirigo Health, http://www.dirigohealth.maine.gov/dhlp03.html (last visited Oct. 27, 2006).

139. *See Increase Access*, DirigoHealth, http://www.dirigohealth.maine.gov/dhlp03.html (last visited Oct. 27, 2006).

140. *Id.* (follow "Good for Business" hyperlink) (last visited Oct. 27, 2006).

141. ALICE BURTON ET AL., ACADEMY HEALTH, STATE OF THE STATES: FINDING THEIR OWN WAY 26 (2006), http://www.statecoverage.net/pdf/stateofstates2006.pdf [hereinafter STATE OF THE STATES 2006].

142. *Id.*

143. *Id.*

144. ME. REV. STAT. ANN. 24-A, § 6910 (2003).

145. *See* Dirigo Health, http://dirigohealth.maine.gov/index.html (follow

must document estimated savings resulting from these and other cost savings measures, including savings from averted bad debt and charity care.[146] The Dirigo Plan, which received bipartisan support, has a goal of covering all Maine residents by 2009.[147]

4. Other States Experiment Around the Edges

Other states enacted less comprehensive reform measures, but measures that are significant, given the budget crises of the early twenty-first century. Wyoming increased its funding to Medicaid by $42 million, enrolling an additional 8,000 beneficiaries.[148] Oregon offered a 2005 Children's Group Plan to permit small business owners a way to provide coverage to dependent children of employees, even if the owner could not afford employee insurance.[149]

In 2005, New Mexico initiated the State Coverage Insurance program, creating a new employer-sponsored insurance program, administered by state contracts with managed care organizations.[150] The program, which enrolled 2,300 members between July and November 2005, is available to low-income, uninsured working adults who enroll through their employer or as a self-employed individual.[151] The premium is paid through contributions from both employer and employee (although self-employed individuals pay both portions) and is subsidized by public funding.[152]

Similarly, West Virginia enacted a public-private partnership to help cover employees of small businesses by giving them access to

"contains costs" hyperlink, then follow "Strengthen the Certificate of Need (CON) process" hyperlink) (last visited Oct. 27, 2006).

146. After the first year of the program, the agency estimated that the reforms had resulted in savings of $110.6 million. The Maine Insurance Superintendent asserted that the savings in the first year were actually $43.7 million. STATE OF THE STATES 2006, *supra* note 141, at 26.

147. Dirigo Health, http://www.dirigohealth.maine.gov/dhlp01.html (last visited Oct. 27, 2006).

148. STATE OF THE STATES 2004, *supra* note 103, at 11.

149. Oregon's Children's Group Plan: A Dependent-Only Option for Small Businesses (The Commonwealth Fund) (2005), http://www.cmwf.org/tools/tools_show.htm?doc_id=278328.

150. STATE OF STATES 2006, *supra* note 141, at 27. S*ee also* New Mexico State Coverage Insurance, http://nmsci.state.nm.us (last visited Oct. 27, 2006).

151. STATE OF STATES 2006, *supra* note 141, at 27.

152. *Id.*; New Mexico State Coverage Insurance, http://nmsci.state.nm.us/nmscihome.aspx (last visited Oct. 20, 2006) (follow "Plan Description" link).

the purchasing power of large public groups.[153] West Virginia followed up its 2004 initiative in 2006 with legislation intended to significantly move the state toward universal access to coverage, by opening up the state's children's health program to 300% of the federal poverty level,[154] and by allowing insurance companies to offer "no frills," scaled-down insurance plans to employers for their part-time/seasonal employees and to individuals who have been uninsured for at least the prior twelve months.[155]

Even more recently, in May 2006, Vermont Governor Jim Douglas signed extensive health care reform legislation into law.[156] The intent of the legislation is to provide state citizens with appropriate, affordable health care. In addition, health care costs are intended to be contained through better chronic care management and increased access for all citizens of Vermont.[157] The new law provides premium assistance for people with incomes under 300% of the federal poverty level, which is intended to help them pay for either employer-sponsored insurance or the new Catamount Health Plan.[158] It also reduces premiums for people in the state's Medicaid and SCHIP programs,[159] and establishes a system of chronic care management,[160] as well as free immunizations available to all Vermonters.[161]

153. West Virginia Small Business Plan, http://www.wvsbp.org (last visited Oct. 20, 2006).

154. H.B. 4021, 2006 Reg. Sess. (W. Va. 2006), *available at* http://www.legis.state.wv.us/Bill_Text_HTML/2006_SESSIONS/RS/BILLS/HB4021%20ENR.htm.

155. H.B. 4847, 2006 Reg. Sess. (W. Va. 2006), *available at* http://www.legis.state.wv.us/Bill_Text_HTML/2006_SESSIONS/RS/BILLS/HB4847%20enr.htm.

156. Press Release, Jim Douglas, Governor of Vermont, http://www.vermont.gov/tools/whatsnew2/index.php?topic=GovPressReleases&id=1887&v=Article (last visited Sept. 13, 2006).

157. Act Relating to Health Care Affordability for Vermonters, 2006 Vt. Acts & Resolves 191, § 2.

158. *Id.* §§ 2, 12, 13.

159. *Id.* §§ 11–13.

160. *Id.* § 4.

161. *Id.* § 23. A summary of the legislation is available on the Vermont legislature's website, *2006 Health Care Reform Initiatives, Quick Overview*, http://www.leg.state.vt.us/HealthCare/2006_HC_Affordability_Act_Leddy_Summary.htm (last visited Nov. 12, 2006).

B. Politics, Recession, and Revisiting Health Care Reform in Minnesota

1. The Debate: To Cut or Not To Cut?

Governor Tim Pawlenty was elected in 2002, just as the full impact of the 2001 recession hit the Minnesota state budget. At his swearing-in, he faced a daunting $4.5 billion budget deficit.[162] The signatory of a "no new taxes" pledge, Pawlenty viewed his options as limited.[163] His solution to the budget deficit hit health care hard.[164] Pawlenty proposed taking a billion dollars from the tobacco endowments (which funded anti-smoking and medical education efforts).[165] The next largest proposed cut (another billion) came from projected health and human services spending.[166]

Under the plan, $600,000 of savings would result from changes to MinnesotaCare.[167] Twenty thousand working adults without children (those earning 75% of the poverty level, or $6,750 a year or more) would lose their subsidized health care.[168] Nearly 4,500 undocumented immigrants would not be eligible for Medical Assistance.[169] Approximately 30,000 Minnesotans receiving health care through GAMC would see their health plan merge with MinnesotaCare.[170] State budget analysts projected that under this proposal, 63,000 individuals would lose their health coverage by 2007 and that uncompensated care in hospitals and clinics would increase from $56.9 million in 2004 to $135 million by 2007.[171]

The Governor noted that, even with these spending reductions, the state health budget would grow.[172] He argued that

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162. Ruben Rosario, *Stage is Set For Clash of Wills Over State Budget Fix*, ST. PAUL PIONEER PRESS (Minn.), May 3, 2003, at A1.

163. "No New Taxes" Pledge Signers, Taxpayers League of Minnesota, http://www.taxpayersleague.org/main/Pledge.htm (last visited Oct. 28, 2006).

164. Rosario, *supra* note 162, at A1.

165. *Id.* This elimination was approved by the legislature. What Governor Ventura described as his main health care legacy was gone within one year of his departure from office.

166. *Id.*

167. Jean Hopfensperger, *Health Care Spending Takes Biggest Hit*, STAR TRIB. (Minneapolis), Feb. 19, 2003, at 12A.

168. *Id.*

169. *Id.*

170. *Id.*

171. SACKS & DORN, *supra* note 77, at 7.

172. Tom Scheck, *Spending on Health Targeted in Pawlenty Budget* (Minnesota Public Radio broadcast Feb. 18, 2003), *available at* http://news.minnesota.publicradio.org/features/2003/02/18_scheckt_budgethhs/.

Minnesota spends more, per capita, on health care benefits than most other states.[173] Opponents of cuts to health care, including moderate Republicans representing some of the initial architects of MinnesotaCare, argued that cuts would be counterproductive.[174] While Democrats argued that the cuts hurt those in need the most, moderate Republicans argued that cutting MinnesotaCare would end up costing taxpayers more in the long run.[175] As former Republican Senator Duane Benson explained, when the uninsured cannot or will not pay bills, hospitals still must provide care.[176] Hospitals then shift the costs to those who can.[177] "'In a bizarre way,' Benson stated, 'everybody is covered currently. We just pay for it in the weirdest ways.'"[178]

At the end of the 2003 legislative session, with the assistance of unexpected Medicaid funds from Congress, a compromise was reached.[179] Cutbacks lessened. Roughly 18,000 Minnesotans would lose their state-subsidized health insurance as a result of the budget cuts.[180] In addition, recipients would see premiums increased and co-pays established, and providers would experience payment reductions.[181]

But 2003 was not the end of health care gridlock. In early 2004, Governor Pawlenty proposed additional nursing home and health care cuts.[182] Both houses of the legislature balked at these proposals but were unable to balance the state budget.[183] Following

173. *Id.*

174. Tom Scheck, *MinnesotaCare's Creators Say Pawlenty's Plan Hurts* (Minnesota Public Radio broadcast Mar. 10, 2005), *available at* http://news.minnesota.publicradio.org/features/2005/03/09_scheckt_mncare/.

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.*

179. Laura McCallum, *Health and Human Services Bill is Final Hurdle for Legislature* (Minnesota Public Radio broadcast May 28, 2003), *available at* http://news.minnesota.publicradio.org/features/2003/05/28_ap_sessionwrap/.

180. Laura McCallum, *Session Ends, Spin Begins* (Minnesota Public Radio broadcast May 30, 2003), *available at* http://news.minnesota.publicradio.org/features/2003/05/29_mccalluml_hhs/.

181. Minnesota Dept. of Human Svcs., Minnesota Health Care Programs: Eligibility Changes by Program, June 2003, *available at* http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs_id_005378.hcsp.

182. Michael Khoo, *Republicans, DFLers Reluctant to Give Pawlenty His Tax Cuts in Human Services* (Minnesota Public Radio broadcast Mar. 12, 2004), *available at* http://news.minnesota.publicradio.org/features/2004/03/12_khoom_budgettalk/.

183. *Id.*

adjournment, the Governor erased the projected $160 million deficit, largely by taking $110 million in reserves from the HealthCare Access Fund, which funds MinnesotaCare.[184] In 2005, the health care fights were even more divisive and were a large force behind the state's first-ever government shutdown.[185] An epic battle ensued between Democrats determined to "hold the line" against further cuts to health care programs and Republicans who saw limiting health expenditures as the best way to balance the budget without raising taxes.[186] Ultimately, an agreement largely based on imposition of a new tobacco-use fee (or tax)[187] resulted in legislation that preserved eligibility for MinnesotaCare and restored some benefits that had been reduced in 2003.[188]

The combination of increased health care costs, recession, and public battles over state funded health care left its mark—in 2001 5.7% of Minnesotans were uninsured, compared to 7.4% three years later.[189] In short, after this three-year period, 94,000 more Minnesotans were without health insurance.[190]

A look behind the increase from 5.7% to 7.4% tells a story both of the struggle of small business to afford health insurance and of the changing nature of Minnesota's workforce. While 68.4% of Minnesotans were covered by employer-based health insurance in 2001, that number dropped to 62.9% in 2004.[191] This decline was primarily due to both an increase in the number of unemployed and a decline in the number of employers offering health insurance.[192] Simultaneously, enrollees in the state's public health care program rose from 21.2% in 2001 to 25.1% in 2004.[193]

184. Tom Scheck, *Pawlenty Budget Solution Could Cost Some Minnesotans Their Health Care* (Minnesota Public Radio broadcast May 18, 2004), *available at* http://news.minnesota.publicradio.org/features/2004/05/18_scheckt_healthfund/.

185. Laura McCallum & Michael Khoo, *Behind the Scenes of State Budget Talks* (Minnesota Public Radio broadcast July 25, 2005), *available at* http://news.minnesota.publicradio.org/features/2005/07/21_mccalluml_behindthescenes/.

186. *Id.*

187. *Id.*

188. Minnesota Dept. of Human Svcs., Health Care Legislation, August 2005, http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs_id_051905.hcsp (last visited Nov. 12, 2006).

189. APRIL TODD-MALMLOV ET AL., MINN. DEP'T OF HEALTH, HEALTH INSURANCE COVERAGE IN MINNESOTA: TRENDS FROM 2001 TO 2004 5 (2006), *available at* http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/2006hhsrvrpt.pdf.

190. *Id.* at 1.

191. *Id.* at 1, 4.

192. *Id.* at 1.

193. *Id.*

This growth was fueled by the growing number of residents with incomes below the federal poverty guidelines.[194] Three additional pieces of information about the uninsured Minnesotans are worth considering. First, these individuals were more likely to be Hispanic and lack a high school degree in 2004.[195] Second, an estimated 68,000 of those without health insurance are children.[196] Finally, an increasing majority of the uninsured, including three out of four uninsured children, is eligible for public health insurance.[197]

2. *Where Progress Occurred*

While the major health care debate in Minnesota over the last five years involved whether to reduce access or maintain the status quo, progress was made on other public health care fronts. The two most prominent Minnesota politicians during this period, Governor Tim Pawlenty and Attorney General Mike Hatch, both undertook significant health care initiatives, including the following efforts:

- In 2001, Minnesota's black children were three times more likely to be uninsured than white children, despite the fact that many appeared eligible for public health programs.[198] The Department of Human Services focused its outreach efforts, successfully enrolling children of color in public programs. By 2004, the health insurance disparity between white and black children was narrowed considerably.[199]

- Minnesota was the first state to pass an adverse health events reporting law in reaction to the 1999 Institute of Medicine (IOM) report, *To Err is Human*, which found that between 44,000 and 98,000 Americans die each year in

194. *Id.* at 13.
195. *Id.* at 27, 35.
196. CHILDREN'S DEF. FUND MINN., THE ROAD NOT TRAVELED: UNIVERSAL CHILDREN'S HEALTH CARE COVERAGE IN MINN. 1 (2006), http://www.cdf-mn.org/PDF/Road_Not_Traveled_06.pdf.
197. TODD-MALMLOV ET AL., *supra* note 189, at 58; CHILDREN'S DEF. FUND MINN, *supra* note 196, at 2.
198. MINNESOTA COVERAGE, *supra* note 49, at 61. In 2001, 3.6% of white children were uninsured, compared to 11.4% of black children. *Id.*
199. *Id.* In 2004, 4.3% of white children were uninsured, compared to 6.8% of black children. *Id.*

hospitals as a result of medical errors.[200] One key IOM recommendation was to establish a mandatory reporting system about adverse events that result in death or serious harm.[201] Minnesota's 2003 law, supported by the Department of Health and the Hospital Association, did just that.[202]

- An investigation into charity and debt collection practices at the Fairview Hospital System by the Minnesota Attorney General's Office led to an agreement by the majority of Minnesota's hospitals to provide discounted care to uninsured patients and to modify their medical debt collection practices.[203] Lower prices (which should be no more than the amount charged to a large insurer) will be charged to uninsured patients with incomes below $125,000.[204]

- Formation of the "Smart-Buy Alliance," which joins the state with private business and labor groups in a purchasers' alliance to drive quality improvements and efficiencies in health care.[205] Alliance members purchase separately, but agree to set uniform performance and cost/quality standards.[206] One of the first steps of the alliance was to set up a web site which connects consumers with information on the cost and quality of health care.[207] In 2006, an

200. INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 1999).

201. *Id.* at 86–108.

202. MINN. STAT. § 144.7067 (2004). The law identifies twenty-seven types of "never" incidents (such as wrong-site surgery, retention of a foreign object in a patient after surgery, and death or serious disability associated with medication error) and requires hospitals to disclose when any of these events occur. The Minnesota Department of Health publishes annual reports of the events by facility, along with an analysis of the events, the corrections implemented by facilities, and any recommendations for improvement in Minnesota. *Id.* at subdiv. 2.

203. Press Release, Minnesota Attorney General, Agreement Between Attorney General and Minnesota Hospitals Will Provide Fair Pricing to Uninsured Patients, Establish Code of Conduct for Debt Collection Practices (May 5, 2005), *available at* http://www.ag.state.mn.us/consumer/PR/PR_050505HospitalFairPricing.htm.

204. *Id.*

205. Smart Buy Alliance, http://www.maximumstrengthhealthcare.com/smartbuy/SBAmission.html (last visited Oct. 20, 2006).

206. *Id.* (follow "About the Smart Buy Alliance" hyperlink).

207. *Id.*

additional initiative by the state and industry groups (including doctors) encourages patients to consult Consumer Reports for "best buy[s]" on the cheapest and most effective prescription drugs.[208]

- Audits of Minnesota HMOs by the Attorney General's office led to governance reforms and a renewed focus on executive compensation and travel expenses at these nonprofit institutions.[209] While subsequent investigations into Health Partners and Blue Cross were less noteworthy, the initial investigation by Attorney General Hatch's office into Allina's governance, travel, and spending practices contributed to structural changes at Allina, including the spin off of its one-million-plus member Medica health plan from its network of nineteen hospitals and forty-eight clinics.[210]

- Establishment of MinnesotaRxConnect in January 2004, which (under the leadership of Governor Pawlenty) made Minnesota the first state in the nation to establish a website so that citizens could purchase prescription medicine from pre-approved pharmacies in Canada.[211]

- Launch of Q-Care, a state program enacted by executive order which rewards health-care providers for providing better quality treatment for state-funded patients with certain chronic illnesses.[212] The program was developed by a bipartisan panel of state officials, physicians, insurers, and

208. Jeremy Olson, *Rx for Cheaper Drugs*, ST. PAUL PIONEER PRESS (Minn.), June 22, 2006, at 1A.

209. *See Charities and Charitable Giving: Proposals for Reform Before the Senate Finance Committee*, 109th Cong. 2–8 (2005) (statement of Mike Hatch, Att'y Gen. of Minnesota) (providing a concise overview of the Attorney General's nonprofit health system compliance reviews), *available at* http://www.senate.gov/~finance/hearings/testimony/2005test/mhtest040505.pdf.

210. Jim McCartney & Patrick Sweeney, *Allina, Medica to Split*, ST. PAUL PIONEER PRESS (Minn.), July 21, 2001, at A1.

211. *See generally* Kevin Goodno & Karen Janisch, *Minnesota: Leading the Way on Canadian Prescription Medicine Importation*, 31 WM. MITCHELL L. REV. 811 (2005) (discussing a state program for importing medicines from Canada).

212. Bill Salisbury, *Plan Seeks Better Health,* ST. PAUL PIONEER PRESS (Minn.), Aug. 1, 2006, at 1B.

other providers.[213]

3. A Road Not Taken

As former Governor Carlson noted in 2003, the conditions that year resembled those his administration faced in the early 1990s: the high cost of health insurance, the rising rate of uninsured and the need to get people back to work.[214] The response differed. Fierce partisanship replaced bipartisan efforts. Stalemate over whether to maintain the status quo left the ability to innovate behind.

The best effort to provide reform in the recent health care crisis came from a Citizen Forum appointed by Governor Pawlenty, headed by former Republican U.S. Senator David Durenberger.[215] Much like the Commission created in 1989, the Forum was asked to recommend innovations and reforms.[216] With broad representation from the business, academic, and health care communities, the bipartisan group issued a report with both short-term and long-term recommendations which ranged from more fully disclosing costs and quality to assuring universal participation in the health care system and reducing the cost of overhead administration.[217] The Forum urged a major overhaul of the health care system and stressed that to effectively control costs all the recommendations, including those on costs, quality, and access should be followed.[218]

While portions of the report provided the impetus for change in the State's role as purchaser, through, for example, the development of a united state health care purchasing strategy,[219]

213. *Id.*

214. Tom Scheck, *Minnesota Care's Creators Say Pawlenty's Plan Hurts* (Minnesota Public Radio broadcast Mar. 10, 2005), http://news.minnesota.publicradio.org/features/2005/03/09_scheckt_mncare.

215. Minnesota Citizens Forum on Health Care Cost, http://www.mncitizensforum.org (last visited Oct. 27, 2006).

216. Mark Brunswick, *Pawlenty Names Eighteen to Study Cost of Health Care,* STAR TRIB. (Minneapolis), Sept. 9, 2003, at 3B.

217. REPORT OF THE MINN. CITIZENS FORUM ON HEALTH CARE COSTS, LISTENING TO MINNESOTANS: TRANSFORMING MINNESOTA'S HEALTH CARE (2004), http://www.mncitizensforum.org/Meeting materials/CFHC Final Report.pdf.

218. *Id.* at 19, 24–27. The proposals were as follows: fully disclose costs and quality so that consumers can better understand where health care dollars are spent; allow Minnesotans to make decisions about health care, both individually and collectively; and reduce costs by eliminating ineffective and unnecessary care.

219. Governor Pawlenty appointed a Health Cabinet (made up of several state agency commissioners) to evaluate the Forum's recommendations. Several

the recommendations as a whole were not embraced by the Governor who tasked the Forum. For example, the report's recognition of the relationship between access and costs,[220] and its corresponding recommendations to achieve a goal of universal participation in the health care system,[221] did not stir bipartisan efforts for reform. Nor did the report's proposal that this universal participation start with covering Minnesota's children.[222]

4. Why Was This Road Not Taken?

In 1997, Thomas Oliver and Pamela Paul-Shaheen analyzed six states (including Minnesota) identified as health care innovators in the preceding decade.[223] Based on their research they isolated the key traits common to these reform efforts: committed, high-level leadership (governors and key legislators) who were "policy entrepreneurs" and "prominent investors."[224] Of these traits one stood out: skilled leadership from senior politicians—those described as "'policy entrepreneurs.'"[225] While skilled leadership did not guarantee success, reform efforts failed without it. Entrepreneurship, typically associated with the private sector, applies to the public sector as well. In defining the "essence" of public sector entrepreneurship, Oliver and Paul-Shaheen state that, like their private sector counterparts, public entrepreneurs introduce innovations to society.[226] They do this by identifying the target problems, marketing a reform agenda, and building coalitions to support and make the plan reality.[227] Policy entrepreneurs seldom act alone.

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initiatives followed. For example, the Citizens Forum found that health care consumers are too often left in the dark about the quality and costs of health care. *Id.* In response to that finding, a sub-group of the Governor's Health Cabinet created Minnesotahealthinfo.org.

220. *Id.* at 33–34.

221. *Id.* at 33–37.

222. CHILDREN'S DEF. FUND MINN., *supra* note 196, at 14 (referring to a statewide shared goal of children's health care coverage). In the 1980s and 1990s, there existed a bipartisan priority of providing health care to children. *Id.* at 4.

223. *See* Thomas R. Oliver & Pamela Paul-Shaheen, *Translating Ideas into Actions: Entrepreneurial Leadership in State Health Care Reforms,* 22 J. HEALTH POL. POL'Y & L., 721, 742–88 (1997). The other five states examined were Florida, Massachusetts, Oregon, Vermont, and Washington.

224. *Id.* at 721.

225. *Id.* at 724.

226. *Id.*

227. *Id.*

In addition to prominent entrepreneurs and investors, other key factors for health reform success included (1) commissions or other ad hoc arenas created to study health care issues and formulate technically sophisticated proposals; (2) relative wealth; (3) a "try and try again" philosophy, where larger goals were met based on incremental steps; and (4) collaboration between high-level executive branch and legislative leaders.[228]

At that time, Minnesota met each of these criteria. The MinnesotaCare agenda was built on the incremental progress made through expanded Medicaid eligibility and unique state programs for both children and childless low-income adults.[229] After his veto of the initial legislation in 1991, Governor Carlson made it his goal to enact health care reform.[230] He also worked with a knowledgeable, bipartisan group of legislators to create and pass comprehensive reforms.[231] Following its initial passage, this bipartisan commitment to both cost containment and access remained, even as the state took steps different from the original MinnesotaCare roadmap.[232] Finally, Minnesota had interested, engaged investors: health care professionals, consumer advocates, providers, unions, and business leaders.[233]

Flash forward to the decade following 1997. In Minnesota, during the late 1990s and early years of the new century, no statewide leader held both the passion for further health care reform and the willingness to build bipartisan coalitions to support it. Governor Ventura had, perhaps, the best economic opportunity to undertake reform efforts—if his goals had focused more on insuring children and less on property tax reform and vehicle registration taxes. In 2001, Minnesota's rate of uninsured children reached a historic low: fewer than 5% of Minnesota children lacked health insurance.[234] There are two ways to look at that gap. On one hand, leaders could acknowledge that the state leads the country in children's health, but resign themselves to the fact that complete success was simply not feasible. On the other hand, leaders could view bridging the gap as distinctly possible,

228. *Id.* at 737–46.
229. *See* discussion *supra* Part III.B.
230. *See* discussion *supra* Part III.B.
231. *See* discussion *supra* Part III.B.
232. *See* discussion *supra* Part III.B–C.
233. *See supra* Part III.B.
234. CHILDREN'S DEF. FUND MINN., *supra* note 196, at 5.

particularly considering that the majority of those uninsured 5% probably were eligible for one of the state's public health programs. Minnesota political leaders at the time chose the former view.

More recently, two statewide leaders, Governor Pawlenty and Attorney General Hatch, both trumpeted their commitment to health care reform. Neither has donned the role of a policy entrepreneur. Rather, each has taken incremental steps within their realm of authority in health care.[235] Smart Buy, the Canadian Drug Program, HMO audits, and the agreement with Minnesota Hospitals on charges to the uninsured are examples of reform steps, albeit limited ones.[236] However, none of these efforts attempt to control the trifecta of costs, access, and quality. Addressing costs alone hurts the quality that long differentiated Minnesota healthcare. Quality improvements, however laudable, do not create access for the growing number of uninsured Minnesotans. Addressing access in a vacuum does little to address costs. Approaching reform in a way that addresses all three of these areas (costs, access, and quality) requires long term commitment. It requires working with other branches of government and the private sector. It also requires sharing the limelight, and sometimes sharing the headlines. In the current political paradigm, Minnesota's political leaders have yet to do so.

This leadership gap explains much about the road not taken. Today, Minnesota has institutional investors ready to participate in a broader health reform discussion. A survey by the Minnesota Chamber of Commerce found "access to affordable health care" to be one of the most important issues to 65% of businesses.[237] In 2005, the Minnesota Medical Association (MMA) introduced "Physicians' Plan for a Healthy Minnesota," a roadmap for providing all Minnesota citizens with affordable insurance for essential health care services and improving the quality of care—

235. Governor Pawlenty's proposed cutbacks in MinnesotaCare and GAMC do not fall into the category of "incremental steps" forward. *See supra* Part IV.B.2. (discussing steps taken by Governor Tim Pawlenty and Attorney General Mike Hatch to reform health care in Minnesota).

236. *See supra id.*

237. MINN. CHAMBER OF COMMERCE, 2005 MINNESOTA BUSINESS BAROMETER SURVEY, http://mnchamber.com/news/Archived/Himle_presentation.pdf. Forty-six percent of business leaders identified affordable health care as the top issue facing Minnesota businesses. *Id.* An additional 19% cited it as the second-most critical issue. *Id.*

while at the same time holding down rising health care costs.[238] The MMA subsequently reached out to others in the legislature and health care community to create a "Healthy Minnesota Partnership" which hopes to propose a broad set of reforms in 2007.[239] Minnesota also benefits from deep institutional knowledge within the legislature[240] and a health care community long noted for its collaboration and innovation. Finally, Minnesota's past strides make the health care gap here—while growing—smaller and easier to bridge than the access, cost, and quality gaps faced by other states. But the political leadership for health reform seen in Massachusetts, Illinois, and Maine is missing here. Without it, expertise, industry support, and one of the most progressive health care systems in the country remain waiting.

V. CONCLUSION

On the eve of the First World War, almost every European country had adopted a national system of health insurance.[241] It was 1912 and the height of the Progressive Movement. Social Progressives left both the Republican and Democratic parties to nominate Theodore Roosevelt, who backed a national health insurance system, as their "Bull Moose" candidate. Roosevelt's defeat, World War I, the election of a candidate who declined to back compulsory health insurance, and the demise of the Progressive Party left this issue on the back burner. When it was

238. MINN. MED. ASS'N, PHYSICIANS' PLAN FOR A HEALTHY MINN. (2005), http://www.mmaonline.net/taskforce/report.pdf. The key features envisioned in the MMA plan were health insurance for all Minnesotans, a strong public health system with an emphasis on disease prevention, systems that support high-quality health care, and a health care delivery market focused on value. *Id.* Since proposing their reform plan, MMA physician leaders have met with more than seventy groups representing government, health plans, labor, employers, consumers, and others to gauge interest in using the physicians' plan as the basis for a broader reform effort.

239. *See* Press Release, Minn. Med. Ass'n, Physicians Launch Health Care Reform P'ship, (Mar. 7, 2006), http://www.mmaonline.net/media/06.03.07.HCR.cfm (outlining the membership and mission of the Minnesota Healthy Partnership).

240. Senator Linda Berglin, one of the "Gang of Seven" that pushed through MinnesotaCare, remains a legislative innovator. In 2005, she was the key Senate Democrat intent on maintaining the integrity of MinnesotaCare eligibility and benefits. *Berglin, Key Senator, Underestimated at Opponents' Peril* (Minnesota Public Radio broadcast June 12, 2005), *available at* http://news.minnesota.publicradio.org/features/2005/06/11_ap_berglin/.

241. STARR, *supra* note 15, at 236.

raised again, physicians opposed it and "buried it in an avalanche of anticommunist rhetoric."[242]

Recently, politicians (some running from the liberal label) again refer to themselves as progressive—and for good reason. The word progressive resonates here. The "Progressive Era," which grew from the early Grange and Populist movements, found its center in Minnesota and Wisconsin, in the midst of agrarian discontent.[243] It spread and reached its zenith in the early twentieth century with the 1912 election.[244] Wisconsin Senator Robert "Fighting Bob" La Follette was its champion.[245] Progressives count both Theodore Roosevelt and Woodrow Wilson among their members, but the term refers to a movement beyond either of their philosophies. Progressives, from a historical perspective, are not liberals.[246] Progressives in the early twentieth century took the populist, evangelical movement heralded by William Jennings Bryan and melded it with the middle class push to reform.[247] Progressives were individualists—they railed against social distinctions and monopolies. They promoted individualism and self advancement, and they believed in social justice.[248]

Minnesota is a progressive state when it comes to health care. It is a progressive state because of its employers, who provide health

242. *Id.* at 254.

243. *See generally* RICHARD HOFSTADTER, THE AMERICAN POLITICAL TRADITION (Knopf 1973) (1948).

244. *Id.* at 229–30.

245. *Id.* at 230. Roosevelt praised La Follette for having made his home state "an experimental laboratory of wise governmental action in aid of social and economic justice." That was in 1910. In 1908, Roosevelt wrote of "the La Follette type of fool radicalism." *Id.*

246. Franklin Roosevelt, with his tendencies toward distributive justice, was a liberal using the political definitions of the first half of the twentieth century. HOFSTADTER, *supra* note 243, at 203–33 (discussing Roosevelt's evolution as a political leader).

247. *See id.* at 183–202.

248. As Richard Hofstadter wrote in his Pulitzer Prize winning text on the progressive movement, progressivism was not a movement by or against any social class, but rather, a "widespread and remarkably good-natured effort of the greater part of society to achieve some not very clearly specified self-reformation. Its general theme was the effort to restore a type of economic individualism and political democracy that was widely believed to have existed earlier in America and to have been destroyed by the great corporation and the corrupt political machine; and to bring back a kind of morality and civic purity that was also believed to have been lost." RICHARD HOFSTADTER, THE AGE OF REFORM: FROM BRYAN TO F.D.R. 5–6 (Knopf 1972) (1955).

insurance at a rate 10% above the national average.[249] It is a progressive state because of the quality health care provided by its nationally renowned providers and its largely non-profit health care system. It is a progressive state because of the bipartisan efforts, across the decades, to enact the incremental changes that led to insurance reforms and broad coverage for working families. It is a progressive state because the historical "progressive" label fits the Minnesota electorate—an electorate that values individual responsibility and independence. Hence, its embrace of MinnesotaCare, which, with its sliding scale premiums and structure is truly a leg up, not a hand out, for the working poor. Minnesota is progressive in its distrust of large health care institutions (as opposed to its physicians and other health providers) as evidenced by the embrace of Attorney General Hatch's investigations of health insurers. Finally, Minnesota is progressive in its willingness to embrace reform and to try something new—because perhaps it will lead to something better.

Yet, it is a progressive state at a standstill on health care reform. In the public sector, as in the private arena, successful entrepreneurs act less like "mountain men" and more like leaders of a wagon train in their pioneering activities.[250] They assemble and coordinate teams.[251] They prepare for the long road across the mountains. Minnesota's reform efforts await political leadership for the assembled wagon train.

249. KAISER FAMILY FOUND., http://www.statehealthfacts.org (click on "Minnesota" then follow "Health Coverage & Uninsured" hyperlink then follow "Total Population" hyperlink) (last visited Oct. 27, 2006). Minnesota employers cover 3.2 million people or 63% of the state population. *Id.* Employers cover 53% of the total U.S. population. *Id.*

250. JOHN E. TROPMAN & GERSH MORNINGSTAR, ENTREPRENEURIAL SYSTEMS FOR THE 1990S: THEIR CREATION, STRUCTURE, AND MANAGEMENT 54–56 (1989).

251. Oliver & Paul-Shaheen, *supra* note 223, at 760.