



FAQ's: Frequently Asked Questions about

The Minnesota Health Plan

What is the Minnesota Health Plan?

The Minnesota Health Plan is a single, state-wide health plan that covers all Minnesotans for all their medical needs – and costs LESS than we now are paying.

The Minnesota Health Plan (MHP) would be created by legislation under consideration by the Minnesota Senate and House. The MHP would provide comprehensive health care for **all** residents of Minnesota in the most economically, efficient means possible. It ensures that health care dollars are spent on health care, not on unnecessary administrative costs.

The Minnesota Health Plan can be thought of as a single health care plan that covers everyone, from the Governor and CEOs to average wage-earners. The financing of the Plan is based on what some people have described as a “single-payer” system, enabling us to control our run-away health care costs, while providing access to all needed medical care, including many types of care that are frequently not covered now, such as dental care and nursing home care.

Why do we need the Minnesota Health Plan?

Families, businesses, and government are being bankrupted by the high cost of health care and people are not getting the care they need. The MHP provides access to quality health care for everyone in an affordable, more efficient system.

- Healthcare expenses are the cause of more bankruptcies than all other causes combined.
- Everybody needs healthcare, yet many cannot afford it – 45,000 Americans die each year because of the lack of access to affordable healthcare.
- About 9% of Minnesotans have no health coverage at all.
- Perhaps 30% more have health insurance, but still cannot get the care they need, due to exclusions in their coverage (optical care, dental care, etc.) or co-payments and deductibles that they cannot afford.
- Many people cannot work because of untreated mental or physical health problems and many businesses cannot expand and grow because they cannot afford health care for more employees, creating a drag on our economy and productivity.

The health of our economy is dependent upon the health of our residents. We need to ensure that all residents have access to health care and that the financial costs of this care do not lead to bankruptcy.

We need to fix the health care mess by providing comprehensive health care to everyone while controlling costs. This can only be accomplished by a single plan that eliminates the insurance company administrative costs and includes price negotiation; a plan that ensures sufficient medical providers in every community; a plan that focuses on community and public health and wellness; a plan that covers everyone regardless of health condition or income; a plan that includes all needed medical care including prescriptions, nursing home care, etc.; a plan that allows people to focus their attention on their health and healing rather than worries about what is covered and whether they can afford to get care-- a plan like the Minnesota Health Plan.

What about the federal health care reform that was passed earlier this year?

The federal reforms are a positive step that will provide coverage to many of the uninsured, but they do little to control the costs for those who already have insurance, and the skyrocketing cost of health care must be addressed. By delivering health care in an efficient, common sense manner, the MHP will make health care affordable to all.

The recently enacted federal health reform legislation, the Patient Protection and Affordable Care Act (PPACA), is a first step; it affirms the principle of health care as a right and demonstrates that reform is possible. The law, signed by President Obama in March will expand insurance coverage to 32 million people who are currently uninsured. It will make a life-saving difference for many of them. Unfortunately after full enactment, there will still be 23 million Americans uninsured, and due to the PPACA's inability to control costs, there will be many people who *have* insurance but who still cannot afford needed health care.

Congress enacted insurance expansion but not true reform. The PPACA builds on fragmented, expensive system and adds administrative complexity with state-based insurance exchanges and compliance measures. It will cost more, not less. Because the U.S. pays almost twice as much per person for health care than other industrialized nations do, this plan is not sustainable and cost control is needed.

The federal bill went as far as our nation's polarized political climate allowed in 2010. Further change must come at the state level. The Minnesota Health Plan will create a sustainable health care system that guarantees every Minnesotan continuous affordable access to quality health care.

What is universal coverage?

*It's simple – "universal" means **everyone**. The Minnesota Health Plan is the only proposal under consideration in Minnesota that covers everyone.*

Coverage that includes everyone is considered "universal." When evaluating whether a plan is universal, one needs to consider whether truly 100% of the population is covered or whether there are gaps in coverage because of job transitions, lack of availability of affordable plans or barriers to enrollment. The term "universal" does not specify what health care services are covered, whether premiums, co-pays and deductibles are affordable, or what reform will be implemented to make this possible. Most advocates of universal coverage propose either a single-payer system, or an individual mandate system to reach universal coverage.

The Minnesota Health Plan (MHP) is a universal single-payer, single-plan system that covers 100% of Minnesota residents for all their medical needs. The Minnesota Health Plan treats health care as a basic right, not something you need to "qualify" for. The only qualification for health care coverage under the MHP is that one is a Minnesota resident. Once enrolled, the coverage (all medically necessary care) continues for the duration of one's life as a Minnesota resident. A single-payer, single-plan system reforms our current system of health care.

In contrast, an individual mandate system requires every resident to "own" insurance, and is unlikely to result in truly universal coverage. Massachusetts implemented a universal coverage plan in 2006 remarkably similar to the federal plan enacted in 2010. Uninsurance rates decreased, but 4% of the population remains uninsured, 20% of the population has problems with medical debt and costs are exploding. Only a single-payer system results in 100% coverage.

What is single-payer health care?

"Single-payer" refers to the fact that doctors and hospitals are compensated by one health plan, rather than dealing with multiple insurance bureaucracies, as they now do.

Strictly speaking, "single-payer" refers only to the method of paying providers of health care. Single-payer describes the direct payment to providers from a single public fund rather than by the over 250 insurance companies and public plans we have now in Minnesota. It eliminates the "middleman"-- health insurance companies—and also the need for health care providers to bill different payers for every patients, thereby saving massive amounts of money. Revenues

for the single-payer fund come from government, businesses and individuals. Individual contributions to the fund (premiums) are based on ability to pay. Generally there are no co-pays or deductibles in a single-payer system.

Single-payer does not affect the delivery of health care. Ownership and management of physician groups, clinics and hospitals is unaffected. Providers in a single-payer system will continue to work in the same public and private clinics that they do now. A “single-payer” system is usually partnered with a “single plan.” Instead of the multitude of plans currently available, each with different networks of providers and different services covered, one comprehensive plan is available to all.

Who would be covered under the Minnesota Health Plan?

All Minnesotans are covered. We provide fire and police protection for everyone – why shouldn't we do that for health care?

All Minnesotans are covered. Under the MHP, there is no denial of care because of pre-existing conditions. There are no insurance company clerks telling your doctor how to practice medicine. The MHP provides coverage from birth until death, regardless of health, financial or employment status. Coverage follows you if you travel, retire or lose your job.

What services are covered under the Minnesota Health Plan?

All necessary medical care is covered, including prescription drugs, dental, mental health, chemical dependency treatment and nursing homes.

All necessary medical care is covered under the MHP. Equally important, it would reduce the need for costly medical care through public health, education, prevention and early intervention.

Under the Minnesota Health Plan, medically appropriate care is completely covered, including primary care, immunizations and preventive care, dental, mental health, hospitalization and prescription medication. Medical equipment and supplies like insulin, hospice, skilled nursing home care, home health care, substance abuse treatment, prescription glasses and hearing aids are also covered. Elective cosmetic procedures are not covered.

How does the Minnesota Health Plan control costs?

The Minnesota Health Plan eliminates layers of bureaucratic paperwork from multiple insurance companies and enables Minnesota to deliver health care efficiently, meeting the needs of the patients instead of the interests of insurance companies.

The MHP controls costs by cutting waste, not by denying care to patients.

The MHP controls costs through:

- Administrative efficiency and elimination of the vast bureaucracy devoted to denying care, billing and paying out claims for care at different rates and with different coverage for the same procedure, elimination of insurance marketing and administration.
- Increasing access to preventive services and early intervention for everyone, preventing costly emergency room and hospitalization expenses.
- Bulk purchasing of drugs and medical supplies at lower, negotiated prices
- Allocation of medical infrastructure and resources (like hospitals and surgical centers) based on a region's needs
- Annual budgets for health care facilities, rather than the current method of itemizing each pill dispensed, and each individual expense, and then billing them at different rates to different insurance companies for each patient treated.
- Negotiation of provider fees
- More efficient delivery of care (use of school nurses to administer flu shots instead of sending each student individually to an outside clinic, not sending patients by ambulances to more distant hospitals because closer hospitals are not in “network”)

This system would eliminate high CEO salaries, stock options, and bonuses based on profits, and save the money on advertising, marketing, and underwriting to compete for healthy enrollees (also avoiding the problem of people being rejected for medical coverage because they happen to be sick or in need of medical care.)

Who will run the health care system under the Minnesota Health Plan?

Publicly accountable officials will form the core of the Minnesota Health Plan's governance, unlike the current system where insurance companies control much of our care.

The MHP is governed by a public board appointed by locally elected county commissioners from every region of the state. The board will include health care providers and consumers.

The MHP Board runs the MHP and negotiates doctor fees and hospital budgets. It is responsible for health planning and the distribution of expensive technology, as well as working with the University, other higher education institutions, and local communities to ensure sufficient providers in every community. The budget for health care is set through a democratic and transparent process.

The MHP board would set the premiums (based on ability to pay) to fund the MN Health Plan.

How is the MHP paid for?

The Minnesota Health Plan would be funded by the same sources that currently pay for health care -- government, business and individuals – only they will pay less and get more.

Revenues for the MN Health Plan would come from the same sources they do now – government, businesses and individuals. Individual and business contributions to the fund (premiums) are based on ability to pay. There are no co-pays or deductibles.

Currently, government is the largest payer of health care services. Individuals are asked to pay an ever-increasing amount in the form of premiums, co-pays, and deductibles – if they have insurance. Those without insurance and those who are under-insured, face devastating medical bills. For most individuals and businesses the premium payment for the MN Health Plan would be less than they are paying in premiums and deductibles to insurance companies, co-pays at the clinic, and out of pocket costs for uncovered services.

Although the premiums would likely be collected by the Department of Revenue, they would go directly to the Minnesota Health Fund, not the state, and the Governor and Legislature would have no control over them. This is necessary to prevent the use of MHP premiums to balance the state budget, and would also prevent politicians from starving the Health Plan of needed funds, a problem that occurs in many of the countries where politicians are responsible for funding their national health plans.

Why are they called premiums instead of taxes?

Unlike taxes, MHP premiums do not go to the state treasury; they go directly to the MHP, where they can only be used for health care. They cannot be taken by the governor or legislature, and cannot be used to balance the state budget or pay for anything else.

Opponents will say that the MN Health Plan will drive up taxes. Aren't the premiums we would be paying actually taxes?

Unlike taxes, these premiums do not go to the state treasury; they go directly to the MN Health Plan, and can be spent only to pay for health care. They cannot be taken by the governor or legislature and cannot be used to balance the state budget or pay for anything else.

Keep in mind that health care is now one-sixth of the entire economy. Funding the MHP isn't like adding some additional taxes to pay for some new government program or service. We are talking about restructuring how we

finance one-sixth of our economy, most of which is and would remain in the private sector. We are simply shifting the premiums that people pay, from their current health plan, to the MN Health Plan. Likewise, employers would now be paying their share to the MN Health Plan. These premiums would replace all premiums, co-pays, deductibles and out of pocket expenses currently spent for health care.

Is the Minnesota Health Plan socialized medicine?

No. Under the MHP, doctors and hospitals that are now privately-owned would continue to be privately owned. They would compete for your business by providing superior care.

No. Socialized medicine is a system where the government employs all healthcare providers. In the MHP, like in Medicare, health care is publicly financed but delivered through existing doctors, clinics and hospitals. Under the Minnesota Health Plan, doctors and hospitals that are in the private sector remain in the private sector.

Some opponents erroneously claim that under a single plan, the government will make the medical decisions. In reality, under the *current* system medical decisions are made by insurance plans, But in the MHP, medical decisions are left to the patient and doctor as they should be.

Won't there be "waiting lines" for health care services?

*Under the MHP, waiting lines would be shorter than they are under our current dysfunctional health care system, because the plan is required to ensure that there are an adequate number of health professionals to guarantee timely access to care. And, we will no longer have the problem where one in ten Minnesotans can't even get **into** a waiting line because they have no coverage.*

Waiting lines are an indication of inadequate capacity in the health care system. The MN Health Plan would increase the capacity of Minnesota's health care system, while still lowering costs through administrative savings. In fact, one of the founding principles of the MHP is a requirement that the plan ensure that there are an adequate number of health care professionals to guarantee timely access to care.

We currently have "waiting lines" for those seeking certain non-emergency specialized care. For example, anyone who has tried to see a dermatologist, a psychiatrist or certain other specialists, it can easily take 3 months to get an appointment. Remember that many middle and moderate income Minnesotans have no line to wait in because they cannot afford the care at all.

The "wait list" issue often is brought up in reference to Canada, which has a very popular single health plan that covers everyone, despite spending about half as much as the U.S.. Although there have been problems with waiting times for some non-emergency procedures in Canada, the problem is smaller than portrayed by American health insurance companies, and the Canadian provinces are addressing the problem.

What about consumer choice under the Minnesota Health Plan?

Patients will have complete choice in picking doctors, clinics and hospitals. There will be no more worry about whether a doctor is "out of network."

You will have more choice under the MHP than you do now.

People will be able to choose their medical providers under the MHP. In contrast, under our current system, many consumers must choose providers within their health plan network. Under the MHP, you can choose any licensed provider – there are no "networks" to worry about.

Won't health care be "rationed"?

No. Health care should not be rationed by either government or insurance companies. The MHP is required to meet all reasonable medical needs so decisions about appropriate care are made by doctors and their patients.

Health care should not be rationed by either government or insurance companies. Decisions about appropriate care should be made within the doctor/patient relationship.

In fact, people tend to be very good at “rationing” their own health care – when given an option, through a living will (advance directive), most people will choose not to be resuscitated when they are terminally ill and in pain. When spine doctors and their patients discuss options thoroughly, many choose not to have costly surgery, selecting alternative treatment instead.

Minnesotans’ health care is *currently* rationed:

- by insurance plans excluding care because of pre-existing conditions, or even refusing to cover people with chronic health problems -- the sicker you are and the more you need care, the more likely they will deny you coverage and care
- by insurance plans overruling doctors’ treatment plans
- by cost, when people cannot afford insurance or out of pocket expenses
- by lack of providers – there is a serious shortage of dental care providers, especially in many small rural communities

Under the MHP, care would **not** be rationed by government or insurance companies. It would **not** be rationed because you are sick or unable to pay. And, the MHP is required to work with higher education institutions and provide incentives to train and recruit enough medical professionals to meet the need, so it would **not** be rationed by a lack of providers.

Don’t people need “skin in the game” in order to control health care costs?

High deductible plans and co-pays can discourage people from seeking needed care. The Minnesota Health Plan controls costs through efficiencies not by erecting barriers to care.

When people pay first dollar, they delay or avoid getting care and this ultimately leads to increased overall costs and worse outcomes. A recent study demonstrated that even a modest increase in co-payments (average increase \$7.00) among elderly Medicare recipients led to a decrease in out-patient clinic visits but an increase in number and length of hospitalizations with an overall increase in cost. The study also concluded that increasing copayments may have adverse health consequences. The results were more pronounced for people with chronic medical conditions where deferring effective outpatient care is likely to have both adverse health consequences and lead to increased costs. Underuse is a bigger problem in this country- people self ration care because they can’t afford it and health problems get worse.

Bear in mind a couple other points- primary care visits are not the cost driver in health care. Primary care actually offers a return on investment: care coordination, fewer hospitalizations and emergency room visits, better outcomes of chronic conditions, fewer malpractice claims and even lower rates of obesity.

Won’t people from out of state move here just to get health care?

Businesses and people will be attracted to Minnesota because of the lower costs and better care provided by the MHP. While attracting business will create additional jobs, Minnesota should not be responsible for paying the costs of people coming here for health care. The MHP Board is responsible for working with the federal government to ensure that Minnesotans do not pay for people moving here to get healthcare.

The Minnesota Health Plan, with its lower costs and comprehensive coverage will attract businesses and individuals from other states.

The MHP Board is required to work with the federal government to create standards to prevent an influx of people from other states and to get reimbursement from the other states or the federal government for people that do move here for health care. Minnesota is responsible for the health care of its own residents, and other states should be responsible for their own. If people from other states move here to get health care, those states should be held responsible for reimbursing those costs.

Like every other major health reform proposal, the MHP would require waivers and authorization from the federal government to address this issue. (This issue is one of the reasons that national reform would be preferable to state-by-state reforms).

The MHP would attract *businesses* from other states because it would be less expensive to expand and grow here without the worry of finding health care coverage for employees. But this is *not* a problem, it's an answer to a problem!

Will the Minnesota Health Plan cover undocumented immigrants?

The immigration issue is a federal issue and must be resolved by Congress. Undocumented people currently receive health care in Minnesota and other states, but in the most expensive settings -- emergency rooms and hospitals. The MHP would provide care at an earlier, less costly stage.

The issue of undocumented immigrants needs to be addressed, but will not be solved until the federal government provides comprehensive immigration reform. Immigrants currently living in Minnesota already receive healthcare. Unfortunately, we give them health care at the most expensive stage – in emergency rooms and hospitals. Under the MHP, they would get health care at an earlier, less costly stage.

The Minnesota Health Plan does not treat undocumented workers differently from anyone else. If the undocumented worker meets the eligibility requirements for residency, he or she will enroll in the MHP, pay the premiums, and receive care as needed. If the undocumented worker is not a resident, he or she will not be given a card and will be billed if he or she needs medical care, just as visitors from other states will be billed.

Neither the Health Board, nor any health care institution, nor any individual health care provider will be responsible for seeking identification beyond enrollment in the Minnesota Health Plan. The alternative is to require the Minnesota Health Board to become a law enforcement agency that enforces our immigration laws. That is not a good idea. Requiring the board to act like police will create high administrative costs, and it could threaten the health of bona fide residents.

As a society, we share an interest in ensuring that all who live in our state are as healthy as possible. Having all residents have coverage improves public health. We don't want the person at the check-out counter, in church or in the classroom to be spreading infections because they don't have access to health care. When everyone has access to preventive and acute health care the costs in terms of health and money are lower for all of us.

Why should my hard-earned money go to pay for health care for people who don't work or don't take care of their health?

Everyone pays their fair share into the MN Health Plan and everyone has access to the care they need to get health and stay healthy. It's not just the fairest way to provide health care, a single-system is also the least expensive.

It is not true that the uninsured don't work. 71% of uninsured Minnesotans have jobs, and 80% of these are working 31 hours/week or more. Our taxes and our health insurance premiums are already going to pay for health care for the uninsured. When those without coverage use expensive sources of care, such as emergency rooms, and can't pay their bills, those costs get absorbed by government and the insured by way of higher premiums. All of these costs are higher in our fragmented multi-payer system. Single-payer financing is a fairer and more efficient way for us all to contribute.

Poor health habits are just as much a problem among those who work and those who have insurance as they are among those who don't. The best way to get people to take care of their own health is to get them in the health care system and then give them the knowledge and tools to take care of their selves. If we shut them out of the system it will be harder for them to make those changes.

Don't people oppose government involvement in health care?

Polls can vary widely, depending on wording, but the vast majority of people think government has a responsibility to assure health care coverage for everyone.

Americans favor a government solution to our health care crisis. A January, 2008 AP-Yahoo poll revealed that 65% of Americans said yes to the statement: "The United States should adopt a universal health insurance program in which everyone is covered under a program like Medicare that is run by the government and financed by taxpayers."

That being said, the issue of distrust of government is played up by the opposition. People worry that government intervention will worsen quality of care. However, the Veteran's Administration is considered to provide the highest quality and most cost effective care in the country. No one criticizing "government run" health care ever suggests privatizing the Veteran's Administration. Medicare, a single-payer system is rated very favorably by enrollees and suggestions about changing Medicare are met with vigorous opposition.

It is also helpful to understand that the governance structure of the MHP begins at the regional level. An elected regional board identifies the regional health care needs and presents them to the state board. Each region has a representative on the state board. This is a "bottom up", open and public style of creating a health care system, not a "top down", closed or private system. The Minnesota Health Plan will return medical decision making to the doctor-patient relationship, where it belongs.

Once the Minnesota Health Plan goes into effect, will private insurance still be available in MN? How? What for?

When the MN Health Plan is passed, private insurance can only be sold for situations not covered by the MN health Plan.

On and after the day the MHP becomes operational, a health plan, as defined in Minnesota Statutes, section 62Q.01, subd. 3, may not be sold in Minnesota for services provided by the Minnesota Health Plan." Practically, this would mean that private insurance could only be sold for services excluded from the MHP – those of convenience, not of medical necessity (such as purely cosmetic surgery).

Will the people working for insurance companies lose their jobs?

By delivering health care in a common sense, efficient manner, the MHP will stimulate the economy and create jobs. However, there will be some who lose jobs in the transition, so the MHP contains provisions to assist those dislocated workers.

Regrettably, as with any economic change there is some job displacement but the MHP has provisions to retrain and assist those displaced into other jobs.

Keep in mind however, that our current health care system's high costs and limited access inhibits economic growth. As a result, enactment of the MHP would stimulate the economy and create new jobs. It would free businesses to expand without worrying about finding, negotiating, and paying for health care benefits for their employees. Entrepreneurs and self-employed individuals would be able to spend full-time on their business ventures rather than seeking another job which would provide benefits. The MHP would be a strong jobs magnet for businesses in other states looking to expand, and this would create new job opportunities for laid-off health workers.

Minnesota has a responsibility to assist those facing job transition and the MHP contains provisions to help retrain displaced workers as a result of the new plan. Because there is a shortage of many medical professionals such as medical technologists, RNs etc., it would be easy to help insurance workers transition to positions in the medical profession. In fact, many insurance company employees already have medical training and could quickly return to fill much-needed medical positions. The billing clerks in doctors' offices and hospitals could contribute to the capacity and quality of the health care system by being retrained and moved from bureaucratic positions to medical ones. Also,

the MHP has the authority to contract out the processing of medical claims, and it would be logical for them to select one of the large health plans, keeping a portion of their administrative personnel in place.

Finally, it is worth pointing out that the people who lose their jobs because of the MHP will have one thing going for them that Minnesotans who have lost their jobs during the current recession did not -- they would have health care! The loss of health coverage for laid off workers is one of the most expensive and dangerous problems they face. Not having to worry about having health care after a lay off is an incredible help.

Why is the MN Health Plan better than an insurance mandate?

Forcing people to buy insurance when they cannot afford it, is not fair and doesn't work. And, because the mandated insurance plans often exclude dental and other types of care, it is misguided to require a person with dental problems to spend their last dollars on a plan that won't help them.

The fundamental problem that has prompted reform is the rapidly rising cost of our current insurance-based system. "Universal" care through the mandated purchase of insurance does nothing to reduce costs, rather it bloats the system with more dollars to provide coverage to everyone.

Proponents of an insurance-based system with mandated purchase propose to keep insurance plans affordable by using a basic "benefits set."

The MHP would provide comprehensive coverage for all, using the administrative savings inherent in the single system. Medicare, which is somewhat comparable in that it is a single plan for seniors, has administrative costs of under 3% of revenues, compared to insurance plans which typically have administrative costs of at least 15%.

Because the insurance-based system offers plans that do *not* have comprehensive benefits, they cannot accurately claim to cover people whose medical needs are not in the benefit set. For example if your medical needs are for dental work and your insurance plan excludes dental, or if the co-pays or deductibles are unaffordable, you do not have the health care that you need, despite having health insurance.

Also, as with Minnesota's auto insurance mandate, there are still many drivers who do not buy it because they cannot afford it – it is not universal despite the law mandating it.

Finally, when there are multiple health plans, there will always be gaps in coverage during transitions between plans. If an employee with benefits loses the job and cannot afford COBRA, or the COBRA coverage runs out, or they lose coverage through divorce or aging out of their parents plan, there is a gap. And in a state of five million people, there will be thousands of people who get sick or injured during these gaps in coverage. Even if the state mandates that everyone buy insurance, they will not achieve universal coverage.

Why not use tax subsidies to help the uninsured buy health insurance?

Our health care system is wasteful and inefficient. Rather than propping it up with more subsidies, it's time to fix the system. Tax subsidies, a feature of the federal reform package, provide short term relief for some but leave the basic problems unresolved.

Tax subsidies do not fix any of the causes of the health care mess. They do not reduce costs or address the inefficiencies or administrative waste that takes dollars away from patient care. They simply shift the costs of the system.

Even with tax subsidies for a "basic benefit-set," moderate- and lower-income individuals would be unable to afford good coverage, leaving them with modest benefits and high deductibles making health care unaffordable. The costs of unpaid medical bills due to inadequate coverage would continue to be transferred to those with adequate coverage.

Why not Health Savings Accounts?

HSA's have lost credibility because they fail to treat the underlying cause of our health care problems and actually discourage people from accessing health care until symptoms have turned serious.

Like the tax subsidies mentioned above, Health Savings Accounts do not fix any of the causes of the health care mess. They do not reduce costs or address the inefficiencies or administrative waste that takes dollars away from patient care. If anything, they exacerbate the problem by taking affluent and healthy people out of the insurance pool and leaving the sick, elderly and low income people, thus driving up the price of insurance.

HSAs are individually owned pre-tax accounts used to pay medical expenses. Once the HSA account is depleted and a deductible is met, medical expenses are covered by a “catastrophic” insurance plan (also known as low-cost, high-deductible plans). Healthy individuals tend to be attracted to HSAs, while older, less healthy individuals need more complete benefits. When sicker people are concentrated in the traditional plans because healthier ones opt for HSAs, the cost of premiums rises dramatically. An obvious example of the inequality of HSAs is that they shift more of the burden to women, whose health care costs average about \$1000 more than men. In effect, HSAs move healthier people out of the insurance pool, driving up the cost of health insurance for everyone else, causing a sharp increase in the number of people without any insurance.

Finally, HSAs discourage preventive care – people avoid seeking needed care if they have to pay for it out of a limited account. They defer care that isn't urgent.

Don't we need tort reform; malpractice is driving up the cost of care?

Malpractice costs and defensive medicine are minor costs to our overall system. Because malpractice awards typically go to pay medical costs, the Minnesota Health Plan will lower malpractice costs because everyone will have continuous coverage.

Malpractice reform isn't the magic bullet that proponents claim. The Congressional Budget Office concludes that limiting malpractice liability would only lower total health care spending by 0.5%. That figure includes a 0.2 percent reduction from lower premiums for malpractice insurance paid by medical professionals, and it includes an additional 0.3 percent in reduced costs of medical tests, imaging and other medical services for the practice of “defensive medicine”.

About half of all malpractice awards go to pay present and future medical costs. If everyone had continuous, comprehensive coverage, the incidence of malpractice suits would go down. Second, many claims stem from a lack of communication between doctor and patient (for example in the Emergency Department). Miscommunication and mistakes are increased in our current system because physicians don't have continuity of care with their patients. They are less likely to know a patient's medical history or to establish therapeutic trust because of changes in insurance coverage and choice-limiting provider networks. Under a single-payer system all providers are in the “network”, patients can stay with the providers they know and trust and who know their medical history.