Exhibit E
SLFS, SLGR and Health Care Reform

Minnesota's health care system has two undeniably terrible features:[1]

- Failure to cover all Minnesotans
- Cost

The coverage failure is a distressing failure of political will and systems design creativity. Millions of Minnesotans are potentially subject to financial ruin from a health care financial catastrophe. Those who have solid insurance coverage through their employer are at risk of losing it through job loss, employer business failure, or employer withdrawal from providing health insurance. Those who lack such coverage often cannot afford to cover themselves adequately. The need to maintain health care coverage can cause people to remain in jobs they would prefer to leave, creating both economic inefficiency and personal unhappiness. Government exists to prevent this kind of nonsense and Minnesota government is failing to do the job. It is no excuse that the federal government's responsibility arguably is more paramount and its failure certainly more gross. Minnesotans deserve better and can have better – for a price.

Relentless cost inflation combined with an aging population is generally conceded to be unsustainable. The BTSC found that rising health care costs will make it impossible to fund other essential services adequately if health care costs are not cut. If costs could be cut, the budget savings could be enormous, though probably not immediate.

Consistent with the budgetary importance of getting health care costs under control, two of the nine ideas developed by the Public Strategies Group and five foundations in Bridges to a Better Bottom Line deal with health care reform: Buying Health, Not Sickness; and Fundamentally Different Medical Assistance: Improve Public Health and Lower Public Costs. PSG recommends that the state use its market leverage to force replacement of the traditional fee-for-service payment system with a "total cost of care" payment system for a significant percentage of the Minnesota market, which, if it succeeded, could end up becoming the standard for the entire market. PSG also recommends that the state apply for a comprehensive waiver from the usual Medicaid rules and redesign its public health care programs for the poor and elderly.

Here, it is assumed that these PSG recommendations would work and reduce costs in the long run. Clearly, there is no more important fiscal problem to tackle than health care reform. Set forth here are three variations on PSG's recommendations that focus on the relationship between health care, the SLGR and the SLFS and also could achieve immediate coverage of all Minnesotans, a vital need that the PSG recommendations do not address.

[1] Quality also is widely expected by experts to be improvable, but both the quality problem and whether changes would improve it may be less than obvious to the public. Not so the risk of personal bankruptcy and the high and ever increasing cost to individuals and Minnesota governments.

Health Care Reform and Eliminating the Property Tax Relief Black Hole

The $2.4 billion in property tax aids and credits paid biennially to local governments ("PTACLG") is a black hole that should be a prime target for elimination because it produces no measurable results. One of the numerous[2] approaches to eliminating it is for the state to take over a portion (or all) of local governments' employee health care costs.

This could be done directly or by the state reimbursing local governments for employee health care costs. Pooling all public employees probably could enhance the state's market power and ability to achieve significant health care reform without mandating that all employers, residents or health care professionals follow its lead. Even if major reform is years off, pooling public employees could lead to immediate cost savings in negotiating health care coverage under the current system.

State payment or reimbursement of local governments' employee health care costs therefore could be a three way improvement: cutting costs immediately, enhancing the market power to achieve significant long term reform, and eliminating the PTACLG black hole. It should therefore be explored.

Covering All Minnesotans to End the Threat of Health Care Cost-Induced Personal Bankruptcy

Minnesotans, like other Americans, are being ripped off economically by the health care industry due to government's failure to require rational organization of the health care marketplace. As a people, we pay more to get worse results than the citizens of any other major Western industrialized nation. This means that those who are fortunate enough to have employer-provided coverage receive considerably lower salaries than would be the case if our health care system operated more efficiently. Those who have coverage generally receive excellent care[3], but not having, or losing, coverage, or exceeding coverage limits is increasingly common, and only liken to worsen in the current recession, and for many Minnesotans the threat of randomly caused personal financial ruin due to the misfortune of a health care crisis is very real. Health care costs are a leading, if not the leading, cause of personal bankruptcy filings.

The two health care reform ideas in Bridges to a Better Bottom Line promise to save billions of dollars in the long run, and perhaps to be the keys to getting health care spending in Minnesota under control. But they do not address the immediate, personal risk of every Minnesotan of randomly caused personal financial ruin from a health care crisis. This risk should be addressed up front, especially if transitioning to the savings promised by systemic improvements will cost money that comes out of Minnesota taxpayers' pockets.

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[2] See main text at 12-13

[3] The care in general is allegedly not cost effective for various reasons, but that is lost on the individual, who is interested primarily in his or her health, satisfied if the problem for which treatment was sought ends or diminishes, and oblivious to the lost salary.

Some other states have at least attempted to deal with this problem. Minnesota should try also. Here is one approach that might work, which could either be part of the change to a total cost of care approach, or an interim measure that solves the coverage problem and gets started on dealing with the cost problem:

- Require all Minnesotans to have health insurance
- Make Minnesota Care available to all, setting premiums high enough not to drive others out of the market
    - If a person lacks coverage, he or she would be automatically enrolled in Minnesota Care, with enrollment and payments administered through the tax system, like withholding and estimated tax payments
    - Premiums would be subsidized by the state for those who cannot afford the full price, so if the premium exceeds __% of the person's income, the state would pay the difference, with settling up administered through the annual income tax return
- Covering all Minnesotans in this or similar fashion would:
    - End or at least substantially diminish risk of personal financial catastrophe from paying for health care costs
    - Protect against swelling of ranks of uninsured, otherwise inevitable due to business failures, layoffs, and dropping of health care coverage
    - Reduce problems of emergency room medicine and uncompensated care
    - Add to state's market power to pursue total cost of care

Paying for Health Care Reform

Paying for health care reform would be no problem if the enormous promised savings began materializing immediately. But that is not likely to happen, and until it does, some new investment in health care is likely to be necessary.

In Buying Health, Not Sickness, PSG suggests that "Minnesota could eliminate the employee exclusion from income tax for the value of employer-provided health insurance premiums." The trouble with this, though, is that, unless the affected individuals (a majority of Minnesotans) get something in return, they would have to pay more tax while still being stuck in the existing system. This would simply increase the extent to which they are ripped off economically by the health care system. It would be far better if these people received something immediate, beyond the vague hope that health care, which has been pretty effective for most of them to date, will be better, cheaper, faster at some future time.

Immediate coverage of all Minnesotans could be the something immediate received for ending the employee income tax exclusion. All Minnesotans would receive in exchange the opportunity to have insurance against health care cost-induced personal financial ruin, and also less crowded emergency rooms as the practice of the uninsured using emergency rooms as clinics would end. The question for Minnesotans who get health insurance through their employers is: Would you be willing to pay Minnesota income tax on your health insurance cost if doing so bought:

- An immediate end to your and every other Minnesotan's risk of personal financial catastrophe from a health care cost catastrophe, and
- A solid start on a redesigned health care system that promises to cut costs dramatically and increase health care service quality in the future?

If Minnesota's political leaders and health care policy design experts will step up on this, there could be dramatic public support for both health care reform and the entire SLGR-SLFS redesign.

Two other points about health care "tax expenditures"[4] should be noted. First, ending the employee health care exclusion would pose administrative difficulties for many employers, which might make the business community resistant to this source of funding.

Second, there are numerous other health care tax expenditures, some of which might, upon analysis, be better systemically or politically than the employee income exclusion as a source for funding health care. Obvious possibilities include imposing the corporate income tax on health care firms and narrowing sales tax exemptions in an attempt to both raise the money to invest up front in reform and restrain the medical arms race, in which ever more expensive equipment is purchased, without regard to state wide demand and capacity.

The tax expenditures involving health care are shown in the following table:
(All numbers in millions of dollars and based on 2008 Tax Expenditure Budget, so current projections would differ)

	FY 2009	FY2010	FY2011
Direct Indiv. Income Tax:			
1.06 Employer contributions for medical insurance premiums and medical care	878.4	945.3	1,008.8
1.56 Self-employed health insurance	36.4	38.4	40.9
1.57 Health savings accounts	5.3	7.1	8.9
1.61 Itemized medical expenses	56.8	61.2	67.2
Total Direct Ind. Inc. Tax	976.9	1,052.0	1,125.8
Partially Implicated Indiv. Income Tax:			
1.10 Cafeteria plans – part is health care	251.9	275.9	302.1
1.07 Employer-paid accident & disability Insurance premiums	20.5	21.2	21.9
Indiv. Income Tax to Be Retained?			
1.78 Credit for long term care ins. prems.	7.4	7.5	7.7

[4] The starting point for determining whether an item is a "tax expenditure" is: "Tax expenditures are statutory provisions which reduce the amount of revenue that would otherwise be generated, including exemptions, deductions, credits and lower tax rates." Not all such items are considered tax expenditures, but there is no point in setting forth the criteria for making that determination here. See Tax Expenditure Budget pp. 1-2.

Corporate income tax:			
Should health care industry, now exempt, be taxed? Under corporate income? Insurance premiums? Both?	?	?	?
Sales tax:			
4.03 Drugs & medicines	243.2	261.0	280.5
4.04 Medical devices	10.3	10.6	11.0
4.05 Prescription eyeglasses	31.1	32.6	34.2
4.58 Hospitals & outpatient surgical centers	60.8	64.3	68.3
4.64 Certain purchases by ambulance svcs.	0.1	0.1	0.1
5.11 Private ambulance services	0.6	0.6	0.7
Health care services	?	?	?
Total Sales Tax	346.1+	369.2+	394.8+
Insurance premiums taxes:			
12.03 MN Comprehensive Health Assn Exemption	2.4	2.5	2.5
12.04 Lower rates for HMOs & Nonprofit Health Service Plan Corps	79.4	85.1	91.0
Total Insurance Premiums Taxes	81.8	87.6	93.5
Real property tax:			
Exemption for some health care orgs	?	?	?
Taxes that May Be Dedicated to Transport:			
6.03 Private ambulance service exemption From highway fuels excise taxes	0.2	0.2	0.2
15.09 Private ambulance service exemption From motor vehicle registration tax	0.2	0.2	0.2

The tax expenditures add up to roughly $1.5 billion per year in special treatment involving a health care system with major problems.