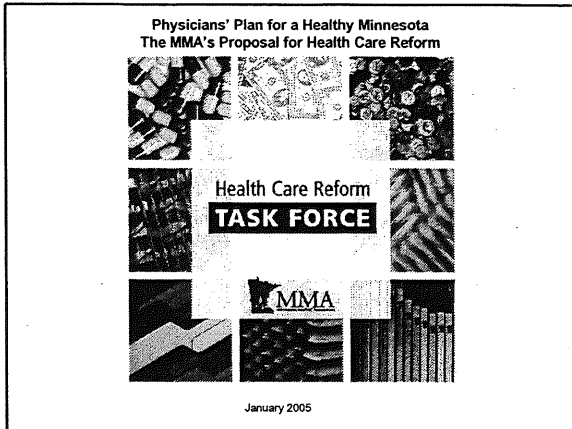


Dr. Shank



Health Care Reform & MMA

- Like many patients, physicians increasingly are frustrated by the inefficiencies in our current health care system.
- To meet its mission, physicians can and should provide greater leadership in trying to improve our health care system.
- A geographic, specialty, and politically diverse group of physicians worked throughout most of 2004 to create a vision and recommendations for reform.

Task Force Assumptions

- Bold ideas and fundamental reform is needed
- Most reform and cost control efforts don't focus on where the money is actually spent
- "Quality chasm" is real, even in MN, and must be addressed
- State reform alone has limitations, but can be productive
- A private, competitive market-based solution (with rules of engagement) is preferable to a government-controlled model

Health Care Reform Again? – Why?

- A Cost Crisis
 - Health care costs have increased at twice the rate of inflation for the last 40 years
 - 45 million uninsured (75 million at some point during the year)
 - 275,000 uninsured Minnesotans
- A Question of Value
 - U.S. ranking on life expectancy and infant mortality has fallen in the last 20 years; US #1 in life expectancy at age 80
 - Quality in MN is among the best nationally, but opportunity for improvement exists

A New Model for Minnesota:
4 Interconnected Features

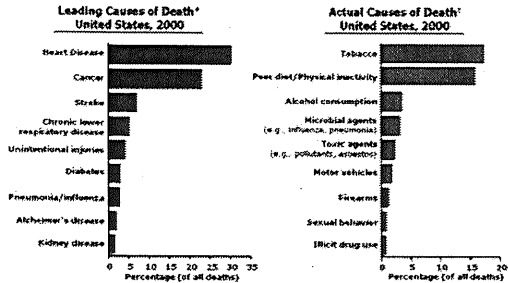
1. A Strong Public Health System
2. A Reformed Insurance Market that Delivers Universal Coverage
3. A Reformed Health Care Delivery Market that Creates Incentives for Improving Value
4. Systems that Fully Support Delivery of High Quality Care

1. A Strong Public Health System

- A strong public health system can:
 - Manage communitywide threats
 - Protect the capacity of the medical system by helping to reduce demand
 - Moderate long term health care costs
 - Improve population health status
- Public health policies must be considered an inseparable part of the health care system

Environment & Behavior Impacts Health

What we know... Leading causes of death compared to the actual/underlying causes of death in the United States, 2000



* Modified from: Arora E, Furlow J, D. Murphy S, Smith B. Deaths: final data for 2000. Statistical Reports. 2002; 13(15):1-22. † Modifiable Risk Factors: Impacts on Actual Causes of Death in the United States, 2000. 2004. 2004;9(15):1-12

A Strong Public Health System

- What can you do now?
 - Support a \$1.00 increase in the tobacco tax (reduce incidence of tobacco-related illnesses and lower youth consumption)
 - Create a healthier environment for all workers by prohibiting tobacco use in all workplaces in Minnesota

2. A Reformed Insurance Market that Delivers Universal Coverage

- The current insurance market
 - Rewards cost and risk avoidance by insurers
 - Insulates patients from the cost of care and the consequences of behaviors
- High costs and concentrated costs
 - To maximize affordability, all individuals need to financially participate in the system to create a broad risk base
 - A state mandate for all individuals to have health care coverage is achievable – the voluntary market doesn't work

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Elements of A Reformed Insurance Market

- **Require insurance coverage for "Essential Benefits"**
 - Community-developed (physician-led) process to define a single, standardized set of services as the "floor" of coverage for all
 - Behavioral health covered on same basis as other services
 - All plans/insurers implement same benefits – no variation due to employer or health plan
 - What's "in" depends on individual and community determinations of "affordability" – what are we willing to pay for ourselves and for others?
- **Subsidies for low-income**
- **Coverage for additional/supplemental services could be purchased**
 - Not required and not subsidized by tax system

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Elements of A Reformed Insurance Market

- **A "fairer" insurance system for spreading risk and cost**
 - Essential benefit package should be community rated (i.e., no age or demographic adjustments)
 - Guaranteed issuance of policies would be required to make the mandate for insurance work
 - Reinsurance mechanisms (i.e., pooling of high cost claims) should be explored to further spread the insurance risk of high cost cases

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A Reformed Insurance Market that Delivers Universal Coverage

- **What can you do now?**
 - Support the goal of insurance coverage for all Minnesotans
 - Maintain health care coverage for low-income Minnesotans
 - Work with MMA and others to explore individual mandate and other insurance reform proposals

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3. A Reformed Health Care Delivery Market that Creates Incentives for Improving Value

- Researchers have identified 3 categories of care to explain differences in health care use and cost:
 - Effective Care
 - Evidence-based, guideline driven
 - Preference-Sensitive Care
 - Driven by patient or physician preference
 - Supply-Sensitive Care
 - Driven by availability of resources

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Effective Care: Care based on solid evidence and guidelines

- Despite highly trained and skilled professionals, our current delivery systems too often fail to deliver effective, appropriate care
- On average, Americans receive about half the recommended medical care processes based on evidence-based guidelines
 - These deficiencies are found for preventive care, acute care, and chronic care (Source: McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. N Engl J Med 2003;348:2635-49).
- Example: For hypertension, adhering to evidence-based treatment guidelines for pharmaceuticals would save \$1.2 billion/year in the Medicare program alone (Source: Fischer MA and Avorn J. JAMA 2004;291:1850-1856).

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Preference-Sensitive and Supply-Sensitive Care:

- Preference-sensitive care:
 - Care based on personal preference (of patient OR MD/provider) rather than on specific evidence (e.g., ultrasounds in uncomplicated pregnancies – no evidence of improved outcome for mom or baby).
 - NOT always inappropriate
 - Reflects "art" of medicine, need to individualize care, and need to expand knowledge where evidence base may be weak
 - Opportunity for reducing utilization
 - More information, including real-time data access, is needed for both physicians and patients to make better care decisions
- Supply-sensitive care:
 - Care that is driven by the availability of services rather than by evidence or guidelines
 - Capacity is driven, in large part, by the financial incentives inherent in payment rates – particularly true for the artificial rates in Medicare (acute care payment model with rates too high for some services and too low for others)

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Reward Value Not Volume

- Current delivery system rewards volume, not value
 - Little discrimination between the services that are desirable because they improve health or quality of life (value-added), and those that are simply desired
 - Little reward for not doing a procedure or for avoiding future costs

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Incentives for Improving Value

- All stakeholders need incentives for quality & value
 - Purchasers need to demand quality not just discounts
 - Providers need more incentives to provide quality
 - Better payment or improved margins, such as payment for preventive services and disease management
 - Patients need information and incentives to demand quality and seek value – not just more services

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Barriers to Creation of A Reformed Health Care Delivery System

- Lack of information for consumers to determine quality and cost (i.e., value)
- Lack of incentives for consumers to pursue healthy behaviors
- Payment systems
 - “Administered pricing” especially by Medicare and Medicaid (i.e., payment below cost for many services and above cost for some services)
 - Cost shifting

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Recommendations to Achieve A Reformed Delivery System

- Engage patients more in medical decision-making
 - Patients need information on quality and costs
 - Patients need some financial exposure for value-based decisions (i.e., pay more for choosing more expensive physician/provider; for choosing brand name over generic)
 - We need a patient-centered system, rather than employers and health plans making decisions on behalf of patients
 - We need information available at point-of-care so that physicians and patients can choose appropriate care
- Need to end payment policies that shift costs
 - Especially true of Medicare and Medical Assistance

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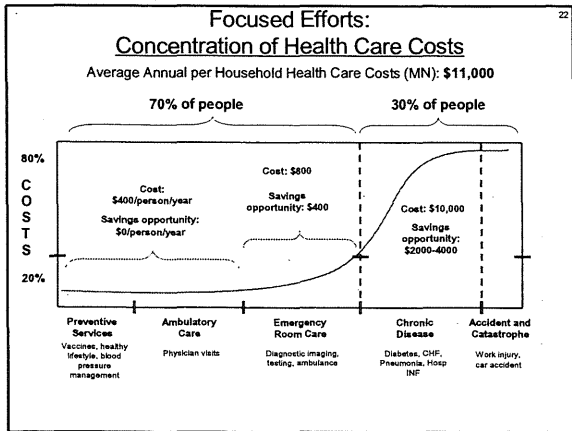
Recommendations to Achieve A Reformed Delivery System

- What can you do now?
 - Work with MMA and others to create valuable and appropriate quality and cost information
 - Support MA/GAMC/MNCare payment policies that reflect value of services – cost shifting complicates system and simply increases someone else's costs
 - Urge Congressional support for changes to Medicare payment policies – adequate payment levels and geographic fairness

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4. Systems that Fully Support the Delivery of High Quality Care

- Health care spending is highly concentrated in a small percentage of patients
 - 1% of patients generate almost 30% of costs, 30% of patients generate over 70% of costs
- Many of the current cost-control efforts focus on low-cost, limited users of system
 - Need to focus on \$\$\$ - especially chronic diseases



- Recommendations to Achieve High Quality Care**
- Promote physician-developed guidelines
 - Support expansion of an improved information infrastructure
 - Statewide implementation of electronic health records that communicate with one another
 - Systems that deliver information such as guidelines and quality data at point-of-service

- Recommendations to Achieve High Quality Care**
- A “medical home” for every Minnesotan
 - Having a personal physician improves quality, outcomes, and costs
 - Support chronic & complex care management programs that are linked to the medical home

25
**Recommendations to Achieve
High Quality Care**

- Support transparency in quality measurement & reporting
 - Selection of measures is key – must be statistically valid and appropriate measures (both of outcomes and processes)
 - Individual, physician-level measurement and reporting is not appropriate due to methodological limitations and complexity of health care encounters

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**Recommendations to Achieve
High Quality Care**

- Develop payment systems to support quality practice
 - Short-term, advocate for those systems that reward physician/provider actions to build capacity for quality (e.g., EMR installation, computerized pharmacy order entry, disease/case management programs, etc.); support models that reward process improvements

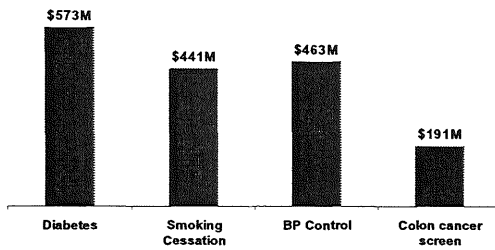
27
**Recommendations to Achieve
High Quality Care**

- What can you do now?
 - Work with MMA and others to create valuable and appropriate quality and cost information
 - Support government payment policies (i.e., Medicaid and State Employees) that reward physicians/providers actions to build capacity for quality (i.e., e.g., EMR installation, computerized pharmacy order entry, disease/case management programs, etc)
 - Support the "recommendations for government" in the MDH report, *Recommendations on Systems Improvements to Advance Evidenced-Based Health Care (January 2005)*.
 - Support efforts to create an effective information infrastructure in Minnesota
 - Support case and disease management programs for public program enrollees with complex, chronic illnesses that are linked to the medical home

Financing

- Generally, we believe there is enough money already in the system
- Additional up-front investments will be needed to build information infrastructure, directly finance medical education & research, and to create capacity for consumer education and support
- Any financing must be broad-based, stable, and adequate
- Among ideas offered for consideration: cap tax deductibility of health benefits beyond essential services

The Opportunity of High Quality Care: The Quality Gap – Avoidable Annual Medical Costs



Savings = Difference between top 10% of HMO performers and average - for patients in HMOs in 2003; 69 million Americans covered. Sources: NQDA.

A Summary: Current & New Market Dynamics

CURRENT	FUTURE
Insurance coverage not required; coverage levels variable depending on employer and health plan	Insurance required and all participate; community-wide agreement on set of essential services that are updated through a standard process and uniformly applied by all health plans; supplemental coverage available for purchase, but not subsidized or tax-preferred
Patients feel "entitled" to whatever plan covers; choose physicians or other providers based on referrals or word-of-mouth	Patients have more information, are more knowledgeable, and make decisions based on cost and quality and other value-based variables; choose providers based on information on cost and quality, may face cost differentials based on choices
Plans compete to enroll members in limited provider networks	Plans compete by helping consumers maximize the value of their dollars – information tools/resources, incentives for healthy behavior
Plans and purchasers reduce costs, in part, by shifting the costs elsewhere	Providers reduce costs for payers and patients by improving care processes; plans and purchasers save costs by helping consumers stay healthy and maximize value for dollars invested

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What Needs More Work?

- More Work:
 - Additional work is needed to clarify the new payment models (i.e., how will prices be set, how will payment rates be determined, what exposure will patients face, etc.)
 - Implications of the model on rural, underserved and vulnerable populations
 - Essential benefit set – what is “in” depends on what society is willing to spend
 - Long-term care
 - Medical transportation infrastructure
 - Financing medical education & research
 - Pharmaceutical costs (and other devices and technologies)
 - End-of-life care

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Next Steps

- Dissemination & Implementation
 - Communicating the MMA vision
 - Legislators, employers, health plans, patient/consumer groups, health care providers, hospitals, regulators, etc.
 - MMA will work with partners to begin implementing many elements as soon as possible

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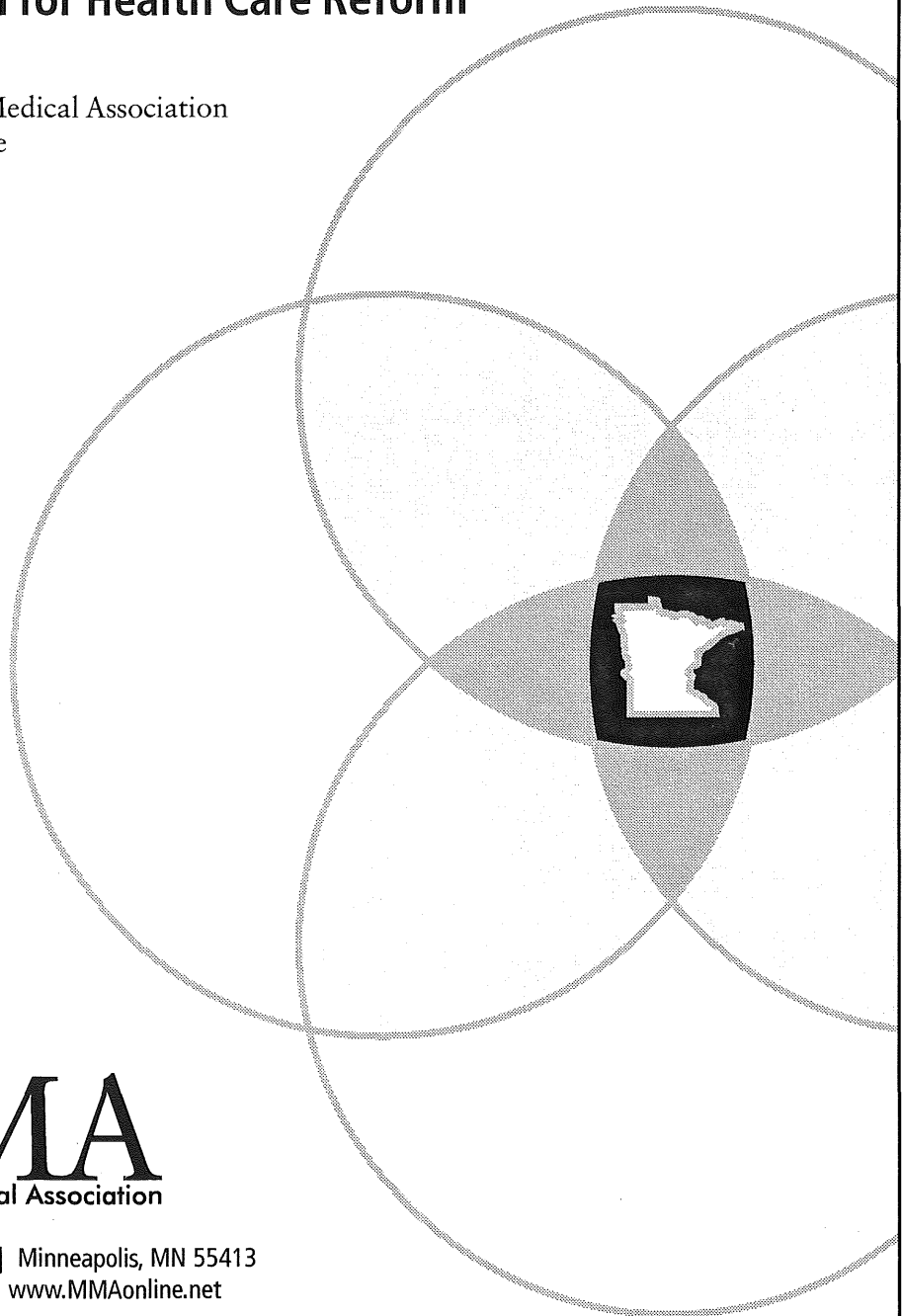
Thank You

Physicians' Plan for a Healthy Minnesota

The MMA's Proposal for Health Care Reform

The Report of the Minnesota Medical Association
Health Care Reform Task Force

January 2005



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Executive Summary

The health care system in the United States, according to some, is on the verge of imploding. The rapidly rising cost of services is causing more and more Minnesotans to forego needed care. At the same time, the increasing costs are placing additional pressure on families, businesses, and state and local government budgets. The Minnesota Medical Association's (MMA) Health Care Reform Task Force has proposed a bold new approach that seeks to ensure affordable health care for all Minnesotans.

The proposal is a roadmap to provide all Minnesotans with affordable insurance for essential health care services. In creating this plan, the task force strove to achieve three common reform goals: expand access to care, improve quality, and control costs. To achieve those ends, it has proposed a model built on four key features:

1. A strong public health system,
2. A reformed insurance market that delivers universal coverage,
3. A reformed health care delivery market that creates incentives for increasing value,

4. Systems that fully support the delivery of high quality care.

The task force believes that these elements will provide the foundation for a system that serves everyone and allows Minnesotans to purchase better health care at a relatively lower price.

Why health care reform again?

The average annual cost of health care for an average Minnesota household is about \$11,000 – an amount that's projected to double by 2010, if current trends continue. Real wages are not growing fast enough to absorb such cost increases. If unabated, these trends portend a reduction in access to and quality of care, and a heavier economic burden on individuals, employers, and the government. Furthermore, Minnesota and the United States are not getting the best value for their health care dollars. The United States spends 50 percent more per capita than any other country on health care, but lags far behind other countries in the health measures of its population.

A new model for Minnesota: Four interconnected features

1. A strong public health system Health policy currently places far too little emphasis on population-wide prevention approaches that can help reduce risk factors for disease. Greater emphasis on communitywide public health measures that complement the work of the medical care system are needed.

Recommendations:

Provide leadership in making public health more prominent.

Supportive actions would include strengthening clean indoor air laws, increasing tobacco taxes, addressing the alarming trends in obesity rates, and providing immunization against preventable diseases. Such policy measures are powerful levers that can lead to healthier environments and healthier individuals.

Coordinate action to address modifiable risk factors. Although many organizations, including employers and health plans, have genuine interests in supporting prevention, activities across the state are currently fragmented. The MMA should urge the creation of a more coordinated and strategic action agenda to address the leading modifiable risk factors for all Minnesotans.

2. A reformed insurance market that delivers universal coverage Minnesota needs a system in which all residents have continuous coverage for services necessary for the preservation and restoration of health and function. The current system, which rewards cost avoidance on the part of insurers and insulates consumers from the cost of the care and the consequences of behaviors, cannot be maintained.

Recommendations:

Ensure universal coverage for essential benefits:

- *Require that all individuals have insurance coverage.*

The current voluntary health insurance system should be replaced by a system that requires continuous participation by all Minnesotans. Participation would be enforced through an individual mandate, which would be enforced in multiple ways and at multiple points (e.g., tax filings, drivers' license applications, school registration, etc.). The mandate would be for essential services only – a "floor" of coverage.

- *Identify an essential benefits package that is adequate to preserve health.*

A single, standardized set of health services, which are essential for the protection of individual and public health, should be developed. Behavioral health services would be covered on the same basis as any other clinical care. A physician-led, communitywide discussion that balances treatment expectations with affordability would be the basis for the development of the essential set of services. Unlike today, when covered benefits vary depending on one's employer or health plan, the single set of essential services would be applied consistently by all health plans in an open and transparent process.

Insurance coverage for services beyond the essential package could be purchased in the market, but those services would not be subsidized by the broader community.

- *Ensure affordability through subsidies and targeted tax incentives.*

In a mandated insurance system, financial subsidies will be necessary for persons of limited financial means. Cost sharing models should provide people with more information about cost and strive to motivate them to seek value and improve their health behaviors. Cost sharing should not, however, create barriers to preventive services or needed and effective care, especially for those with low incomes and/or high need.

The adoption of a communitywide essential benefit set should be used to trigger fundamental changes in health benefit tax policy such as limiting the tax deductibility of benefits to the essential benefit set. The savings from this policy could be used to help defray costs of any expanded tax incentives that might be provided to individuals and/or small businesses.

Build a fairer system of spreading risk and sharing cost:

- *Require statewide community rating, guaranteed issuance, and high-cost case reinsurance pool.*

In the current system, health plans compete to a significant degree by seeking to avoid insuring the groups of people that have the highest medical costs through their product designs, underwriting criteria, and rating policies. To create a more stable and fair system, the task force calls for a return to statewide community rating of

the essential benefits set. Plans would charge everyone the same premium for its essential benefit set regardless of their age or health status. The plan also calls for the creation of a mandatory reinsurance pool for all types of health plans and all products. Under the new model, policies would be available for purchase to all who wish to buy them – guaranteed issue.

Help employers make coverage options available.

Although an individual mandate is proposed, the task force recognizes that in the near-term, the employer-based system will remain the means by which most individuals obtain health insurance coverage. And employers likely will want to compete for workers as they now do by facilitating access to health insurance. The state should examine how models such as the Federal Employees Health Benefits Program could be made available to help employers efficiently offer multiple health plan choices. The state should also help employers make maximum use of worksite wellness programs.

3 • A reformed health care delivery market that creates incentives for improving value

Recommendations:

Engage patients through greater accountability for medical decision making.

Today, the cost and possibly marginal benefits of a service are not significant factors in a patient's perception of value. In a reformed system, "health literate" patients will select services based on their condition and risk factors; the strength of evidence indicating the effectiveness of the proposed intervention; and, the difference between the payment rate negotiated by that patient's insurance plan and the provider's price. The task force advocates a system in which patients, rather than purchasers and plans, make the choices.

A fundamentally different economic model for medical care services.

The current system creates powerful incentives for all parties to try to shift costs to someone else, which further distorts the economics of the system. Large purchasers need to be persuaded that a focus on real value will generate more savings than shifting costs to other players in the market. In the current system, large purchasers, such as businesses and governments, often receive discounts by controlling the flow of patients. Such discounts are often unrelated to the cost of providing services. That often shifts

costs to other buyers, especially individuals or small group purchasers.

To help remedy the economic distortions, discriminatory pricing policy, particularly by government payers, must end. Currently, the government's payment policies for Medicare and Medicaid are often not fair, adequate, or aligned with the cost and value of services. Government should buy health care services on the same basis as the private market. The results of current government policy shift cost onto other payers, creating additional pressure in the system. For example, as prices rise for non-Medicare patients, companies provide fewer insurance options at greater costs and more people become uninsured or underinsured. By emphasizing value in its payment systems, government would be better able to manage the rising costs of care that are often volume- and supply-driven.

4 • Systems that fully support the delivery of high quality care

Recommendations:

Further increase the amount of effective care that is provided:

- *Support physician-developed guidelines.*
The appropriate use of evidence-based, clinical guidelines is an important tool for clinical and shared decision-making. Although numerous sources of guidelines exist, guidelines must be developed in an open, multi-specialty process. All guidelines should also be readily available for patient use so patients can understand how they should approach common health care problems and how to better understand what to expect from physicians and other health care providers.
- *Support expansion of an improved information infrastructure.*
Interconnected health information systems are needed to support more efficient care and to support a heightened commitment to measurement and improvement. To fully engage patients in making informed, value-based decisions, real-time benefit determination systems will be required. Building and sustaining such systems will require leadership by the federal and state governments and the active partnership of private-sector purchasers and health care providers.
- *Support a "medical home" for every adult and child in Minnesota anchored in a continuous*

relationship with a personal physician.

The relationship between patient and physician is the central leverage point for improving quality and value. If these relationships are allowed to continue long term without the disruption caused by health plan and network changes, the benefits of a medical home are further increased.

- *Place the emphasis for cost control where the greatest opportunity exists – chronic care.*
More than 70 percent of health care costs are incurred by about 30 percent of patients. In fact, only 5 percent of patients generate more than 50 percent of all costs. Today's system largely tries to save money by extracting deep discounts for most primary care. The task force believes that system is inefficient and counterproductive. It keeps physicians and other health professionals from investing the time and resources in prevention, health education, and care management, all of which can avert more expensive treatments in the future. The new system should focus cost-control efforts on chronically ill patients or those with complex diseases who generate the vast majority of the expenses.

Provide useful information about quality:

- *Support transparency and efficiency in quality measurement and reporting of system capability.*
In order to make more informed decisions and use their resources wisely, patients need to know what they are buying and what it costs. In order to improve the way they deliver care, physicians, hospitals, and other health professionals need to know how they are performing. This means all parties must commit to measuring and reporting on quality and cost. The reporting system, however, must capture relevant, appropriate, and valid performance information. There also must be an effort to streamline today's redundant systems that often do not produce valuable data.

Develop payment systems to support quality practice:

- *Support payment processes that financially reward the implementation of guidelines, registries, and other efforts to improve quality of care.*
In the future, patients will decide for themselves the value of health care services in both quality and cost. For now, new payment models should be developed that reward near-term provider actions that would build their capacity and sys-

tems for efficient, effective care – the installation of electronic medical records, computerized pharmacy-order entry systems, clinical decision-support systems, disease and case management, team-based care, etc. It is also reasonable, in the interim, to support models that appropriately reward process improvements (e.g., documentation of appropriate recommendations made to patients). Given current methodological limitations, the task force does not support pay-for-performance models that link payment with patient outcomes.

Ensure the safety and quality of health care:

- *Leverage existing quality improvement work.*
There is a tremendous amount of quality improvement activity already underway in Minnesota. Enough money is being spent already to fund an aggressive quality improvement agenda for the state. Much more could be accomplished if the activities were more efficiently organized and connected and duplicative efforts were reduced.
- *Ensure the competency of health care professionals and institutions.*
Current limitations in methods preclude the use of statistical quality measures at the individual physician level. Instead, physician competency is assessed by methods such as state licensure and board certification. Board certification, in particular, is undergoing significant transformation. More emphasis is being placed on ongoing demonstration of performance rather than knowledge alone. As the new market system evolves, the role of various stakeholders in assuring competency will need to be reevaluated.

Financing the health care system

The task force found that generally there is enough money in the system to insure everyone and provide them with high-quality care. However, members also identified recommendations for improving the way health care is financed.

Pursue broad-based financing.

Given the fundamental public interest in improving health, financing for public health and health care services should be broad-based. The current approaches of indirect and selective taxation are not sustainable.

Achieve efficiencies and redirect expenditures.

Much of the money spent on health care now is wasted. Capturing those lost dollars will require administrative simplification in the insurance, billing, and claims adjudi-

cation processes. It will also require the elimination of the waste and extra expense created by overuse of resources and current variations in quality.

Invest where needed to build the system of the future.

Additional investments will be needed in order to build the required information infrastructure, enhance prevention efforts, and increase the amount of effective care delivered. To guarantee access and quality in the future, it is critical to find separate and sustainable funding sources for medical education and research. The task force recommends that the costs of medical education and research be separated from the costs of patient care.

Moving reform forward

The task force recommends a mix of strategies for advancing various ideas in this report. Some elements of the proposed model for reform are relatively developed and focus on areas where the MMA can lead through its own actions. These include controlling costs through quality improvement. In some areas, the task force recommends that the MMA advance ideas for discussion at a more conceptual level to increase the chances for broader consensus. These include ideas for a very different approach to benefit design and transformation of the economic incentives in the system.

The task force is recommending a set of bold ideas that are certain to generate controversy, as they would create fundamental changes affecting virtually all stakeholders in the health care system. The task force has provided a new vision for a reformed health care system; it is hoped that these ideas will help to stimulate a productive discussion and change the terms and boundaries of the debate.

According to a 2003 survey conducted by the Minnesota Citizens Forum on Health Care Costs, Minnesotans want a bold new approach to health care reform. The task force believes that the proposals in this report provide the foundation for such a system.

Task Force Charge and Process

Health care reform is back on the front burner of state policy. Although the issues of health care costs and access never really went away, the urgency and the scope of discussions about them did fade for a time. After the piecemeal dismantling of the MinnesotaCare reforms of the early 1990s, most of the legislative action has addressed parts of the problem rather than the whole problem, and changes have been incremental. Often one step cancels another made previously. Momentum is now building for a broader and more fundamental debate about the future of the entire health system.

The MMA recognized that a new framework for debate about health care reform was needed, given changes in the environment and evolution of the issues over the years, and that it had an opportunity to step up its involvement and assume a more proactive role in shaping current health reform discussions. To inform its deliberations, the MMA Board of Trustees chartered the Health Care Reform Task Force to develop a new set of principles and recommend future directions for the MMA's work in health care reform (a copy of the charter can be found in Appendix A).

More than 50 physicians responded to the member-wide call for volunteers to serve on the task force. G. Richard Geier, M.D., MMA board chair, selected members from diverse

specialties and from various parts of the state. Former MMA President Judith Shank, M.D., was asked to chair the group. The task force met 11 times over the course of nine months.

The task force explored issues in depth and let its conclusions evolve during a number of discussions. From the beginning, members made it clear that they had no desire to reinvent the wheel, but sought to be informed by and build from good work that had previously been done in Minnesota and nationally, notably the recent report from the Minnesota Citizens Forum on Health Care Costs and several recent reports by the Institute of Medicine. Appendix B illustrates how the task force's primary recommendations relate to some of these reports.

Throughout the discussions, task force members tried to put patients and the community first, believing that the health of the profession will follow from policies that improve the system for those it serves. Of critical importance to every task force member was simultaneously achieving consensus among different points of view and defining a set of recommendations that would result in bold and fundamental change. The task force hoped that its report would create a vision for reform around which the physicians of Minnesota could unite in order to provide the necessary leadership for change in their communities and statewide.

Key Assumptions

Over the course of its deliberations, the task force developed a number of assumptions that created the foundation for the specific recommendations it ultimately endorsed.

1. Regardless of the mechanism of financing (whether a competitive market model or a government-funded and regulated model), it is critical that the delivery of effective health care be improved, including reducing the utilization of services that are driven more by the preference of the patient and/or physician (preference sensitive care), as well as those that are driven more by availability (supply sensitive care), rather than by evidence of appropriateness.
2. The task force recognized that the current system of health care financing creates severe economic distortions for all users and that federal payment policy is a significant contributing factor. The current system of "administered pricing" by Medicare and Medicaid shifts costs to other users, thereby increasing costs for other consumers. Complete reform will require federal action, but it is possible for Minnesota, and neighboring states working with Minnesota, to make changes that will improve health care quality and value and slow the rate of increase in health care spending. The Institute of Medicine in its Leadership by Example report has suggested that there is a greater likelihood for reform when whole states or regions undertake efforts to improve health care quality and value. Minnesota has an opportunity to lead the nation in such efforts. The recommendations outlined in this report should serve as a blueprint for the combined efforts of physicians, other health care providers, consumers, payers, and government to move forward in a coordinated and effective manner.
3. The task force recognized that Minnesota is not an island and could not, even if we wished to, make fundamental changes in the nature of the current employer-based private insurance system absent federal policy changes. The task force did look briefly at other international models of health care financing and wondered whether, especially

given global economics, the role of employers might be changed in the future. Such questions ought to be considered at the national level and, possibly, studied by a group such as the Institute of Medicine.

4. The vast majority of task force members concluded that a private, competitive market model is preferable to a government-controlled model, primarily because of its superior ability to promote innovation and advance-

ment. Many task force members did, however, place a high value on the equity and potential administrative simplicity of a more centrally financed and managed system. Members generally agreed that appropriate health policy should strive to find the optimal mix of competitive and regulatory approaches, and the recommendations in this report do propose a balance of both.

The Case for Change

The health care system in America may be on the verge of implosion. Health care costs have risen more than twice as fast as general inflation for the last 40 years. Greater rates of increase in recent years have strained the economy at both the macroeconomic and microeconomic levels. As a result, health care costs are now seen by many economists as the greatest threat to both private-sector economic growth and government budgets. Rising health care costs constrain job creation and real wage growth. Increases in publicly funded health care costs are straining budgets at the federal, state and local levels of government. At a micro level, the costs of health care for individuals are rising so fast that people are making choices to forego treatment recommended by physicians. Access to needed care is uneven and falling. Ensuring a uniformly high level of quality of care is a greater challenge than previously realized. The health care system is not creating value for those who use it or pay for it. And when it comes to the most basic bottom line, it turns out we aren't buying nearly as much health for the money we are investing as we should or could be.

Minnesota has achieved distinction by providing insurance and health care for more of its citizens than other states. The state's health system generally provides better quality at a lower per capita cost and produces better health outcomes (e.g., longer life span, better immunization rates, and lower mortality rates) than almost any other state in the nation. Nonetheless, as the recent report from the Citizens Forum on Health Care Costs documented, Minnesota is not immune to the larger pressures bearing down on the system. Minnesota is facing staggering increases in costs, pervasive patterns of disparity in the health of various populations, and threats to quality.¹

Cost

Per capita health care costs have increased at an average of 3.6 percent per year since 1960, versus GDP growth of only 1.4 percent per year. The share of the national economy spent on health care, education, and defense was 6 percent

for each in 1960. By 2003, education was still at 6 percent, defense had fallen to 4 percent, and health care was at 16 percent of all spending. The imbedded cost of health care in the goods and services produced by American companies creates a growing competitive disadvantage with global competitors.² The average annual health care cost for a family in Minnesota is about \$11,000, and this is projected to double by 2010 if current trends continue.³ Real wages are not growing fast enough to absorb this cost increase. If unabated, these trends portend a reduction in access to and quality of care, and adverse economic effects for individuals, companies, and government.

Thanks to improvements in databases and analytic methods, we now are able to understand much more clearly what is driving health care cost increases. We can begin to answer questions such as how much of the increase is attributable to increases in the price of services, and how much is volume? How much is due to increases in technological capability, to sheer demographics, and to changes in the profile of diseases, especially those caused by lifestyle choices and environmental factors?

A recent study by Thorpe et al. in *Health Affairs* broke down the component parts of the cost increase for the 15 health conditions that account for the majority of the health spending increase from 1987 to 2000. The researchers found that for about half the conditions, total cost increases were driven principally by increases in the cost per case (i.e., the increased intensity of care), which were driven in turn by new technologies and new treatment approaches. For the other half of conditions, an increase in the numbers of people being treated was the main factor. Notably, two of the top cost drivers in this analysis are diabetes and pulmonary diseases, the causes of which are environmental or related to personal health behaviors (especially smoking and obesity) and almost entirely preventable.⁴

The task force concluded that it is critical to look more deeply at the separate drivers of cost increases because different parts of the problem need different kinds of solutions.

Access

The United States is alone among developed nations in failing to guarantee universal health care coverage to its people. During the booming economy and tight labor markets of the 1990s, employer-provided coverage grew, though even then about 15 percent of people were left without coverage (most of whom were employed). After a decade of fairly steady progress toward insuring more people, coverage levels are falling in the nation and in Minnesota, as employers have a harder time offering coverage, employees have a harder time affording it even when offered, and government programs tighten eligibility requirements as budgets are cut. Forty-five million Americans are uninsured on any given day of the year, and 82 million are uninsured at some point in the year.⁵ The last official estimate for the number of uninsured Minnesotans was 275,000, although new data are expected soon that will likely show an increase.⁶ Given cost trends and projected budget deficits, the number of uninsured is likely to increase more absent policy changes. For many thousands of other Minnesotans, high deductible policies or limited coverage options may limit access to necessary and appropriate medical care.

Given that health care providers work hard to provide charity care, and that public policy requires that people not be refused care for inability to pay, public opinion hasn't always equated lack of insurance to lack of needed care. The evidence is now clear, however, that coverage correlates strongly to health, productivity, and even mortality. Approximately 18,000 people die each year in the United States because they are uninsured, according to the Institute of Medicine (IOM). Others suffer unnecessary consequences of their disease and lack of treatment, and the indirect costs to the economy in lost productivity (including both absenteeism and impaired performance of people who continue to work despite their illness and limitations) are increasing.⁷

Besides barriers to access imposed by inadequate insurance coverage, limitations in public health resources, and other infrastructure problems contribute to unequal access to health care.

Quality

Quality of health care is now understood to be highly variable. An estimated 30 percent of all health care spending nationally goes for care that is either not indicated, not effective, or not up to current community standards. A 2003 study by McGlynn et al. published in the *New England Journal of Medicine* constitutes the most thorough review to date of actual care received against well-accepted clinical standards. The researchers reached the startling conclusion that Americans receive effective care (defined as ap-

propriate care based on medical evidence and practice guidelines) for acute and chronic conditions only about half the time.⁸ Dartmouth researchers (Fisher et al.) reported in the *Annals of Internal Medicine* that for the Medicare program, the highest quality of care is actually delivered in the lowest-cost regions of the country.⁹ Medicare data show Minnesota to be a low-cost, high-quality state. But current Medicare payment policy essentially penalizes rather than rewards this.

The evidence is mounting that “more care is not always better care” and that sometimes, in fact, more care is downright dangerous. The seminal “Quality Chasm” series from the Institute of Medicine not only documents the impact of suboptimal care on the public’s health but suggests a blueprint for solutions.¹⁰ Although many analyses suggest that Minnesota performs significantly better than national averages, there are also clear indications that quality variation is an issue and an opportunity here as well. These sources include the Institute for Clinical Systems Improvement, Stratis Health (the Medicare Quality Improvement Organization), and the recent results from the Council of Health Plans’ Community Measurement Project. The task force is convinced that the IOM and the Citizens Forum had it right. Higher quality care need not always cost more; in fact, when it comes to cost containment, quality improvement is a big part of the answer.

Health Status

It is increasingly clear that despite spending twice as much or more per capita than most other countries on health care, the United States lags far behind them on broad measures of the health of our population. The World Health Organization ranks the United States at number 29 in life expectancy. The United States has fallen in the rankings on such basic measures as both male and female life expectancy and infant mortality in the last 20 years.¹¹ The reasons for the disparity in spending and outcome are complex. Indeed, researchers believe that differences in access to medical services per se account for perhaps 10 percent of those gaps. The most powerful determinants of population health are personal health behaviors and the physical, economic, and social conditions of the communities in which people live.¹²

For example, Costa Rica spends less than 10 percent per capita of what the United States does for medical care. Yet, life expectancy in both countries is virtually identical. Some of the reasons: Costa Rica has one-half the rate of tobacco use, and a four-times lower lung cancer death rate than the United States; a fraction of the car ownership rate, which results in lower accidents and higher exercise rates; dramatically different dietary patterns; and, much less obesity,

diabetes, and heart disease. Stress levels and the attendant ailments are quite different in that society as well.¹³ Some might suggest that this comparison is much too simplistic. But it does raise a provocative challenge: Shouldn't the health we are producing for our population for the dollars we invest be the truest measure of our health policy?

From a state standpoint, part of Minnesota's past performance on measures of health care cost and quality come from its historically strong public health system and the relatively healthier habits of the population. More recently, however, local health behavior trends should give us cause for alarm. Smoking rates, for example, have not fallen in Minnesota as rapidly as in the nation as a whole. Youth smoking rates increased more rapidly during the years we were not funding aggressive prevention efforts, and obesity rates are increasing faster in Minnesota than in some areas. Despite the high health status rankings of the majority population, some key health status measures among African Americans and American Indians are worse than their counterparts in other states.¹⁴ Public health research suggests that the causes of these disparities have a great deal to do with social and economic conditions in the communities in which minority populations are concentrated. Given the forecasted growth of these populations in coming decades, these disparities are even more significant.

Broad solutions across all sectors are needed

The medical profession should step up and acknowledge that it can and will make improvements in the areas it can influence. However, addressing the root causes of these deep challenges lies far outside the capability of individual

physicians, hospitals, or health care delivery systems. Health care costs and quality are determined by the financing systems and market conditions in which health professionals do their work. The determinants of public health have everything to do with public policy choices in the spheres of economics, community design, and the like. Policy solutions are needed across a broad range of issues if we want to see results.

Although the U.S. health care system has been predicted to be on the brink of collapse more than once over the last several decades, the health system has found ways to respond to the political pressures of the moment and avoid fundamental change. For instance, "the Hillary Effect," was coined by some health economists to explain the rather significant slowdown in cost growth in the mid-1990s.¹ Many health policy experts decry the current state of affairs; they say the nation, and the state, have already tried the major alternatives – government control, market competition, and voluntary efforts from the health sector itself (although the rigor of the attempts can be debated). Many experts believe that the policy discussion is bereft of big new ideas and, therefore, they expect continued tinkering at the margins and lack of fundamental progress.

This task force, however, has looked at the factors and trends in health care and sees reason for hope. The system clearly can do better – if we can build a system that supports, rather than undermines, doing what we already know works.

Note: The task force reviewed a large number of articles and reports in the course of its deliberations, the majority of which are cited in the bibliography (see Appendix D).

¹ The term is a reference to then-First Lady Hillary Clinton's efforts to reform health care at the national level.

Vision for a New Health System

The task force began its deliberations with each member articulating his or her own views of the most essential features of a new system. The resulting attributes were ranked by the group and the following statements, written as a proposed vision to guide the MMA's future efforts, express the most central issues prioritized in that process.

- *The MMA envisions a system in which all Minnesotans have affordable coverage for essential health benefits that allows them to get needed care and preventive services in a timely and effective manner.*
- *Strong patient/physician relationships, unimpeded by third parties, will restore citizen trust in the system and professional satisfaction with the practice of medicine.*
- *Affordability for individuals, employers, and society will be improved by a renewed commitment by physicians to deliver high-quality effective and efficient care, patient responsibility for personal health behaviors and cost conscious choices, and incentives that reward all parties for a greater focus on prevention and enhanced health.*
- *The ideal health system will deliver significantly greater returns in improved health status for the dollars invested and will deliver equity for all in access, treatment quality, and outcomes.*
- *Whatever the design of the system, the funding provided to the public health and health care delivery systems must be broad-based, stable, and adequate to meet the health needs of the state.*
- *In order to achieve this higher-performing system, we need a fundamental change in the financing approach and market dynamics of health care. The MMA believes that the uncontrolled growth in health care costs can best be mitigated by replacing the current price and volume incentives that result from a system in which payers artificially control prices, with a patient-centered market in which incentives are aligned to encourage the use of preventive services and effective care without subsidizing the consumption of services of minimal clinical value. In the current system, large purchasers and health plans have the ability to impose prices and shift costs to smaller purchasers or individuals because they control the flow of patients. In the new system, the price of care will be determined by patients' determination of the value they receive from the services provided.*

Principles for Reform

Health policy debates are often framed in terms of competing claims of "rights." The task force believed that the discussion can be more productively focused around an interconnected set of mutual responsibilities. The task force suggests that as members of the community of all Minnesotans, we all have a set of critical responsibilities to each other.

A. The community has a responsibility

1. *To ensure affordable access to basic care.*
2. *To broadly share the risk and cost of medical needs.*
3. *To assist the population in using health care resources wisely.*
4. *To provide the conditions and environment in which people can be healthy and make healthy choices.*
5. *To maximize the proportion of health spending that goes to effective care for all who need it.*

6. *To secure the future capacity of the health care system to provide sustained high quality and affordable health care, through investments in prevention, medical education, medical research, and improvements in the system's infrastructure.*

B. Individuals have a responsibility to the community

1. *To participate financially in sharing the cost of the system that benefits all.*
2. *To use the system wisely and draw on collective resources judiciously.*
3. *To take personal responsibility for their own health behaviors and reduce their own health risks.*
4. *To become more health literate (e.g., educated about prevention, selection of plans/providers, wise use of resources, and the clinical decision making process).*

C. Physicians and other clinicians have responsibilities to individual patients and to the broader community

1. To accurately assess patient needs and recommend appropriate and effective care.
2. To advocate honestly for needed and effective care for their patients.
3. To help individuals achieve measurable improvements in health.
4. To exercise stewardship over collective health care resources.
5. To participate in care management as members of an effective multidisciplinary health care team.
6. To foster health literacy among patients and the broader population.
7. To create and foster continuous learning environments in the organizations in which they practice.

D. Group purchasers (private-sector employers and government) have responsibilities as members of the community

1. To set expectations for health plans to focus on the delivery of efficient care and health improvement by engaging patients and supporting providers.
2. To emphasize prevention strategies (including those with longer-term payoff) in benefits design.
3. To share in the needed investments in improvements to the infrastructure of the health system.
4. To move the health care system toward affordable, universal coverage for all, not just people employed by large companies or covered through publicly sponsored health care funds.

E. Health plans/insurers have responsibilities as members of the community

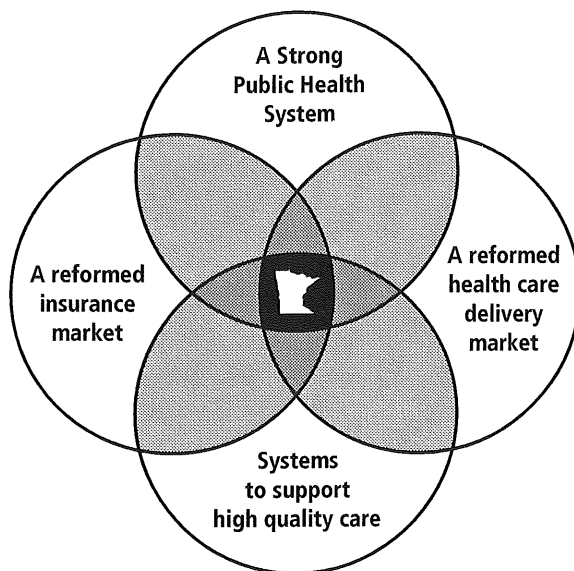
1. To create payment systems that foster care efficiency and health improvement.
2. To coordinate care management systems with physicians and care teams and to provide the needed information and infrastructure supports for high-quality programs.

3. To correct business practices that lead to health care fragmentation, such as carved-out behavioral health benefits.
4. To minimize the complexity of the system and the costs of administration, and to assist patients/members in navigating the system.
5. To share in the needed investments in prevention strategies and infrastructure improvement.
6. To provide tools and resources and foster an environment to help beneficiaries achieve and physicians deliver desirable results.
7. To create and foster continuous learning environments for the improvement of health care administration and delivery.

The task force believes that these principles could engender agreement among all stakeholders. At first glance, they may seem noncontroversial and perhaps not terribly new or noteworthy. A closer look at and comparison to how each stakeholder currently acts in today's system, however, shows a very different picture. For instance, today most purchasers and plans feel little responsibility for funding the needed infrastructure improvements in the delivery system or for funding prevention programs with long-term benefits to the community as a whole rather than their own bottom lines. Most patients do not think about health care resources as something to be conserved and shared. Most physicians do not yet practice in the kind of interdisciplinary care teams that are needed to manage complex and chronic conditions.

The task force believes that health reform debates usually skip too quickly past this first step of articulating and agreeing on parties' fundamental underlying assumptions and beliefs. Mutual understanding and agreement at this level helps to shape expectations for a positive outcome in a policy debate. It also can provide a common place for all parties to return to when negotiations break down. Therefore, the task force recommends that the MMA invest time and effort in conversations with leaders from key stakeholder groups using this "mutual responsibilities" framework. This discussion about underlying values should guide reform and identify where common ground can be forged.

A Model for a New System



This model depicts four key, interconnected features. These features taken together would address the fundamental challenge of producing greater value in the health system – i.e., better health for all Minnesotans for the dollars invested. All four components are critical; no one part alone is the “silver bullet” for reform. The narrative describes each part of the model in turn:

1. *A strong public health system*
2. *A reformed insurance market that delivers universal coverage*
3. *A reformed health care delivery market that creates incentives for increasing value*
4. *Systems that fully support the delivery of high quality care*

1 ● A Strong Public Health System

Despite the overwhelming influence of environmental factors and behavioral choices on personal and population health status, the nation and the state spend only about 5 percent of their total health budgets addressing these issues.¹⁵ The vast majority of the health budgets are devoted to individual, patient-level clinical interventions, which often occur after illness is already present. The state and nation need to invest much more heavily in primary and secondary prevention efforts both to intervene in the process of disease and reduce costs. Primary prevention, those efforts undertaken long before there is any clinical evidence of disease, can provide long-term benefits that

are difficult to measure in short economic horizons. Intervention to prevent the worsening of a condition undertaken after disease is present (secondary prevention) can show more dramatic results in the short term and more quantifiable economic results. For example it is known that individuals who are overweight or who have hypertension use about 30 percent more resources each year than people with normal weights and blood pressure levels. Lifestyle modifications to eliminate tobacco use and effective use of drugs to prevent recurrent heart attack and heart failure can reduce the need for hospitalizations and expensive interventions such as angioplasty and stenting. Limiting smoking in public places and reducing tobacco use can curb the incidence of asthma and cardiovascular disease, even in the very short term for patients with existing disease.

The primary prevention efforts of the public health system aim to prevent illness and injury before it ever happens by systematically reducing risk factors in the environment (e.g., through protection of the food and water supply, highway and workplace safety), and by promoting changes in social norms and behaviors (e.g., reducing tobacco use). The clinical and public health systems share responsibility for containing infectious diseases through strategies such as immunization and outbreak control. They also must respond to other public health emergencies such as natural and man-made disasters. Though harder to quantify in cost/benefit terms (especially over the short term of most public- and private-sector decision making), primary prevention strategies are largely responsible for the majority

of the phenomenal gains in lifespan over the past century.

A stronger public health system can help do several critical things:

1. *Manage communitywide threats to health from a variety of sources;*
2. *Protect the capacity of the medical system by helping to reduce demand, which will be especially critical given the growing needs of an aging population;*
3. *Moderate long term health care costs; and,*
4. *Improve population health status.*

None of these can be accomplished without stronger public health efforts to address communitywide conditions and reduce the risk factors that cause so much preventable disease. Without a strong public health system as its complement, the medical care system cannot succeed in controlling health care costs or improving health outcomes. Unfortunately, attention to and investments in public health have been short term and episodic. In a sense, public health is the victim of its own success; when it works well, it is largely invisible and quickly forgotten.

Recommendations:

Lead in making public health more prominent.

Prevention generally fails to generate the advocacy support that groups dealing with more visible and current problems can muster. As a professional association, the MMA is in a unique position to provide leadership in the area of public health. The MMA can and should tie its positions on public health issues such as the tobacco tax, clean indoor air laws, and obesity prevention to broader health care cost and access proposals and legislative strategy. Policymakers have an obligation to use the policy tools that they uniquely control, just as providers and other stakeholders are expected to do their parts to control costs and improve quality. The public health system and public health policies ought not to be considered as separate from the health care cost and system reform debate.

Coordinate action to address modifiable risk factors.

Although many organizations, including employers and health plans, have genuine interests in supporting prevention, activities across the state are currently fragmented. The MMA should urge the creation of a more coordinated and strategic action agenda to address the leading modifiable risk factors for all Minnesotans.

2 • A Reformed Health Insurance Market

For most of the last decade or more, policymakers have tried to ensure universal “access” to care – meaning insurance is available for those who can afford it, and emergency care is available even if you don’t have insurance. Federal and state health policy has become increasingly complex as a variety of voluntary coverage plans and a range of cross-subsidization schemes have been developed, overlaying inconsistent laws that require some provision of emergency and other charity care. The resulting patchwork quilt of coverage creates a host of problems: unnecessary administrative complexity; poor care coordination for most people; too many uninsured and under-insured people; and, unnecessarily high costs for intensive care due to lack of basic preventive and primary care. Most importantly it produces unnecessary illness, disability, and death.

Employers who voluntarily elect to pay for health insurance are saddled with often unmanageable cost increases and are at a growing competitive disadvantage in both domestic and international markets. Today’s insurance marketplace is characterized by more and more segmented risk pools and selective marketing of experience-rated products with varying benefit levels to compete in specific desirable market segments. In such a market, health plans economically prosper by attracting those who need and consume the least amount of care, not by best serving those who need the most.

The task force concluded that universal access will never get us to a fundamentally more effective and efficient system. The task force advocates a return to what was once law in Minnesota, but was regrettably repealed – a commitment to achieve universal coverage. Minnesota needs a system in which all residents have continuous coverage for services necessary for the preservation and restoration of health and function. The current system, which rewards cost avoidance on the part of insurers and insulates consumers from the cost of the care and the consequences of behaviors, cannot be maintained.

The task force’s recommended new model is fundamentally different. It would not guarantee anyone full coverage of everything possible, but rather would ensure for everyone coverage of all needed and effective care. The task force advocates moving away from a market in which consumers respond to the system that is designed for them, and toward a market in which consumers have more direct control over their choices. In this system, consumers also have more responsibility, including the responsibility to participate in the system by purchasing at least the minimum level of coverage. The task force also advocates fundamental insur-

ance reform to end cost shifting and more equitably distribute the high cost of care for the sickest people.

An important design feature of this reform model is that the market would still offer supplemental coverage. It would allow consumers to choose products that further limit their out-of-pocket expenses to or add coverage for services broader than the core set of services. But such coverage would not be mandated, subsidized, or tax-preferred. The task force does not expect that the essential benefit set would be a “bare bones” kind of package. The goal would be coverage for those things that are the most essential to protecting individual and population health. However, the task force also recognizes an essential dilemma – it is not possible to precisely determine “what’s in and what’s out” until there is a greater degree of societal consensus on what we are individually and collectively willing to pay for health care. While the task force does not advise that the MMA seek legislation to promote these changes on its own, the specificity of the recommendations will allow the MMA to lead discussions and to challenge others to respond accordingly. The recommendations to reform the insurance market are detailed below.

Recommendations:

Ensure universal coverage for essential benefits:

- *Require that all individuals have insurance coverage.*

The task force believes that in order to maximize the health of individuals and the entire population, as well as to create a more functional health insurance system, the current voluntary health insurance system should be replaced by a system that requires continuous participation by all Minnesota residents (an individual mandate). The mandate would be enforced in multiple ways and at multiple points (e.g., tax filings, drivers’ license applications, school registrations, etc.). The mandate would be for essential services only – a “floor” of coverage. Additional supplemental coverage should be available in the market.

- *Identify an essential benefits package that is adequate to protect health.*

A single, standardized set of health services, which are essential for the protection of individual and public health, should be identified and established as the required floor of coverage for all individuals (the required level of coverage for the individual mandate). Services beyond the standardized set should be available in a competitive market, but would not be subsidized by

the broader community (either directly or through tax policy). The design of the benefits floor should not be based on either a catastrophic policy with a high deductible or on first-dollar coverage with a simple dollar cap for coverage. Essential benefits should be based on health status impact and evidence of effective interventions. Age-appropriate health risk assessment should be provided for all patients. Behavioral health services should be covered on the same basis as any other clinical service.

- *Ensure affordability through subsidies and targeted tax incentives.*

In a mandated insurance system, financial subsidies will be necessary for persons with limited financial means. The task force supported the basic principle that “everyone pays something.” Economists and advocates will need to address what constitutes “realistic” affordability for low-income populations. Cost-sharing models should strive to make people more motivated to seek value and improve their health behaviors. Cost sharing should not, however, create barriers to preventive services or needed and effective care, especially for those with low incomes and/or high need.

The adoption of a communitywide essential benefit set should be used to trigger fundamental changes in health benefit tax policy. The task force believed that a cap on the tax deductibility of benefits should be imposed and limited to the essential benefit set. The savings from this policy could be used to help defray costs of any expanded tax incentives that might be provided to individuals and/or small businesses.

Build a fairer system of spreading risk and sharing cost:

- *Require statewide community rating and guaranteed issuance for the essential benefits package.*

In the current system, health plans compete to a significant degree not over their ability to manage costs or improve health but by seeking to avoid the highest cost groups of people through their product designs, underwriting criteria, and rating policies. To create a more stable and fair system, each insurer or health plan should set one statewide community rate for the benefit package. The community rate set by each plan would not vary from one market segment to another (the rate for the benefit package would

not vary whether sold to a large employer, a small employer, or an individual). There should be no adjustments for age or other factors to the community rate. The only allowed variation should be for health improvement incentives (e.g., discounts for positive behaviors). In a mandatory universal coverage system, all insurance products must be available to all who wish to buy them – guaranteed issuance of policies.

- *Reinsure high-cost claims.*

Because costs are so highly concentrated in a relatively few number of cases, all insurance plans (and all products sold by those plans) should be required to participate in a single reinsurance pool. There will likely be a need for further risk adjustments beyond the reinsurance mechanism to protect plans from adverse selection.

Help employers make coverage options available.

Under the model envisioned by the task force, employers would not be required to offer coverage or contribute any set portion to the cost. Employers, however, likely will want to compete for workers as they now do by facilitating access to health insurance. The state should examine how models such as the Federal Employees Health Benefits Program could be made available to help employers efficiently offer multiple health plan choices. The state should also help employers make maximum use of worksite wellness programs.

3 • A Reformed Health Care Delivery Market

The dominant payment methods in the current health care system offer health systems, hospitals, physicians, and other clinicians a higher profit for some services and limited payment for others, without clear regard for the overall effectiveness or importance of the service in terms of health impact. Unfettered utilization of health care services, new drugs, and technology are encouraged by the prevailing incentives, with no incentive for patients to be cost-conscious or for providers to encourage cost-effective alternatives. The ideal future system should, instead, reward cost-effective care and evidence-based treatment. The system should not reward or subsidize ineffective services or inefficient delivery.

Effective care, defined as care that is based on solid evidence and guidelines, is not now delivered as often as it should be. If more effective care were delivered, it is reasonable to expect that at least some costs would initially rise as more services are provided to those who currently are underserved. In the long run, though, future costs will be avoided.

Researchers have described two distinct categories of care that contribute significantly to the variation in rates of service use and cost across the country and within market regions: preference-sensitive and supply-sensitive care.¹⁶

Preference sensitive care, defined as care obtained by patients or ordered by physicians on the basis of personal preference rather than on the basis of available evidence or guidelines, contributes to increased health care costs. For example, use of frequent ultrasound examinations in uncomplicated pregnancy or repeated complex imaging procedures for evaluation of common conditions increase overall costs without providing specific clinical value. Sometimes, preference-sensitive care decisions are based on legitimate concerns or may be made where there is not yet good evidence to guide practice. Providing such care may yield important information and inform future choices. For example, rigorous use of clinical trials or analysis of large claims databases to which all physicians and hospitals would submit data as a condition of payment for the service. The task force recommends the development of new tools and strategies to provide patients with the information and, ultimately, the incentives to make choices that will reduce the overall utilization of unneeded preference-sensitive care.

Supply sensitive care is care that is driven by the availability of services rather than by scientific evidence or guidelines. It also increases overall costs. Fisher et al. have demonstrated that the difference in Medicare costs between Minneapolis-St. Paul and Miami is related to the greater supply of intensive care and medical specialty resources in the latter, without difference in patient need or outcomes.¹⁷ From a patient care standpoint, it is not necessary that every hospital in a relatively small geographic area have a cardiac surgical program, an orthopedic program, a high-risk obstetrical program, and a comprehensive cancer program, each with marginal patient volumes. Such a diffusion of capacity is economically inefficient and undermines quality as well. The current situation is driven in large part, the task force believes, by the artificial payment system now used by Medicare and others in which the price for services is often unrelated to the clinical value delivered and to the cost of providing the service. Government program payments now are vastly below cost for many clinical services but also significantly higher than cost for others. The task force believes that the recommendations for a reformed health care delivery market that are proposed below would lead hospitals, physicians, clinics, and health systems to better allocate capital and resources.

In the current system, large purchasers or health plans control the ability of patients to select their physicians and other providers. In return for the ability to restrict patient

choice only to the plan's network, plans (on behalf of purchasers) effectively set prices and demand discounts unrelated to either the cost of delivering care or the value that care represents to the ultimate customer – the patient. Health plan enrollees generally feel entitled to receive all possible services without much regard to cost. Many presume that having paid a premium for an insurance package ensures coverage (sometimes after a deductible and/or co-payment) for virtually all the care that is available as long as it is “medically necessary,” although the decision processes that determine medical necessity are controlled by health plans and are usually far from transparent.

Under the task force model of universal coverage, a standard definition of the core services would be set and kept up to date by a physician-led process and would not vary from plan to plan. The services would include evidence-based preventive and treatment services but generally would exclude coverage for services classified by guidelines as not indicated.

Health plans would no longer control patient access via predetermined networks, nor would they determine the price charged by the care system, hospital, physician, or other health professionals. While health plans would still negotiate payment arrangements and patients could still keep their out-of-pocket costs lower by using those providers with the most preferential contracts, plans would no longer dictate total provider prices. It would be up to patients to decide whether additional services or the use of higher-cost providers are worth the added cost to them. Patients could pay extra to receive care from higher-cost providers, use a brand name drug rather than a generic, or otherwise opt for a more expensive alternative when multiple choices exist. The choice is the patient's. This model moves the consumer away from simply asking, What is covered? to a more balanced set of questions such as What are my options? How much does each cost? What is the value to me? The model also shifts the nature of health plan competition. Plans will help consumers maximize the value for their dollars and make the best choices among providers, treatment options, and health improvement strategies.

Recommendations:

Engage patients through greater accountability for medical decision making.

Today, the cost of a service and the possible incremental or marginal benefit of a service are not significant factors in determining patients' perception of value. In a reformed system in which patients have access to information and are more health literate, patients will select health care services of value based on three things: 1) the patient's condition and risk factors; 2) the strength of the evidence on the effec-

tiveness of the proposed intervention; and, 3) any difference between the payment rate negotiated by that patient's insurance plan and the provider's price.

A fundamentally different economic model for medical care services.

In the current system, large purchasers (businesses and government, directly and via health plans) essentially set prices by controlling the flow of patients and commanding discounts often unrelated to the cost of providing services. These actions shift additional costs to other buyers, especially individual or small-group purchasers. In the new system, consumers would make the choices about where to receive care and how much they are willing to pay for it. Health systems, hospitals, physicians and other health professionals would compete at a new level (essentially disease-by-disease) to add value. The task force proposes having a system in which patients make choices directly, rather than the current system in which purchasers and plans generally make decisions on their behalf. The current system creates powerful incentives for all parties to shift costs to someone else; this further distorts the economics of the system. Large purchasers need to be persuaded that a focus on real value will generate more savings than cost shifting to others.

- *End discriminatory government pricing policy.* Government should buy health care services on the same basis as the private market. It does not cost providers less to provide care for Medicare beneficiaries than it does to provide the same care for non-Medicare beneficiaries. Government should not set arbitrary prices that may be less than actual cost in some situations and vastly higher than cost in others, nor should government use payment policy that promotes increasing the volume of service rather than delivering value. The results of current government policy shift cost onto other payers, creating additional pressure in the system. For example, as prices rise for non-Medicare patients, companies provide fewer insurance options at greater costs and more people become uninsured or underinsured. By emphasizing value in its payment systems, government would be better able to manage the rising costs of care that are volume- and supply-driven. Geographic inequities in payment rates should also be ended by the same mechanisms. If government does not make a shift to value purchasing, additional pressure on government budgets will mean a reduction in eligibility criteria. The result will be

a further increase in uninsured and vulnerable populations. The task force believes this recommended reform model is worth pursuing even if only the private sector market takes it up and government payers do not. However, private purchasers should understand the degree to which current public program payment approaches are distorting the market and should join in advocacy efforts to get the federal government to adopt the same value purchasing approach.

New Market Dynamics – A Few Key Differences

The following table highlights some of the differences between the current and the task force’s desired future system. A more detailed chart can be found in Appendix C.

CURRENT	FUTURE
Predefined benefit coverage levels, variable from plan to plan	Communitywide agreement on a set of essential services that are updated through a standard process and uniformly applied by all health plans; Consumers can buy supplemental coverage
Patients feel entitled to whatever plan covers; choose physicians or other providers based on referrals or word-of-mouth	Patients have more information, are more knowledgeable, and make decisions based on cost and quality and other value-based variables; have variable cost responsibility
Plans compete to enroll members in limited provider networks	Plans compete by helping consumers maximize the value of their dollars; patients can choose any provider, but face cost differentials
Plans and purchasers reduce costs for themselves, in part, by shifting the costs elsewhere	Providers reduce costs for payers and patients by improving care processes; plans and purchasers reduce costs by helping consumers stay healthy and maximize value for dollars invested

4 Systems that Fully Support the Delivery of High-Quality Care

Analyses of claims costs at both the national and state levels and by various health plans all confirm that health care spending is highly concentrated in a small percentage of patients. The task force found the visual display of costs and savings opportunities (see Figure 1) to be very helpful in understanding the opportunities for cost control in the system. The graphic portrays both the type of care and the potential for cost savings at various points along the spectrum.

In general, the task force concluded that cost-control efforts should be concentrated where the costs actually are (far right-hand side of graph), which is quite different from today’s focus, which tends to place unproductive controls on the lower-cost parts of the system. Most current cost-control methods add to the frustration of both patients and physicians and, ironically, may contribute to the system’s failure to prevent the progression of patients into the higher-cost areas of care.

The task force concluded that the greatest opportunity for significant and immediate savings is in better management of chronic diseases, especially those that result in hospitalization. The savings opportunities in the outpatient setting are more limited. Indeed, by increasing the delivery of effective care, we should expect to increase spending for office-based care. Significant per-case savings are possible by helping physicians to provide the best in science-based care for complex and chronic conditions, and by changing payment systems to reward team-based care in any setting. A more robust health information infrastructure will be needed to support these improvements. The public health strategies recommended earlier will also help to moderate the numbers of people presenting to the system with problems caused or exacerbated by preventable risk factors, ranging from infectious disease to chronic conditions to accidents and injuries. The recommendations to improve quality are detailed below.

Recommendations:

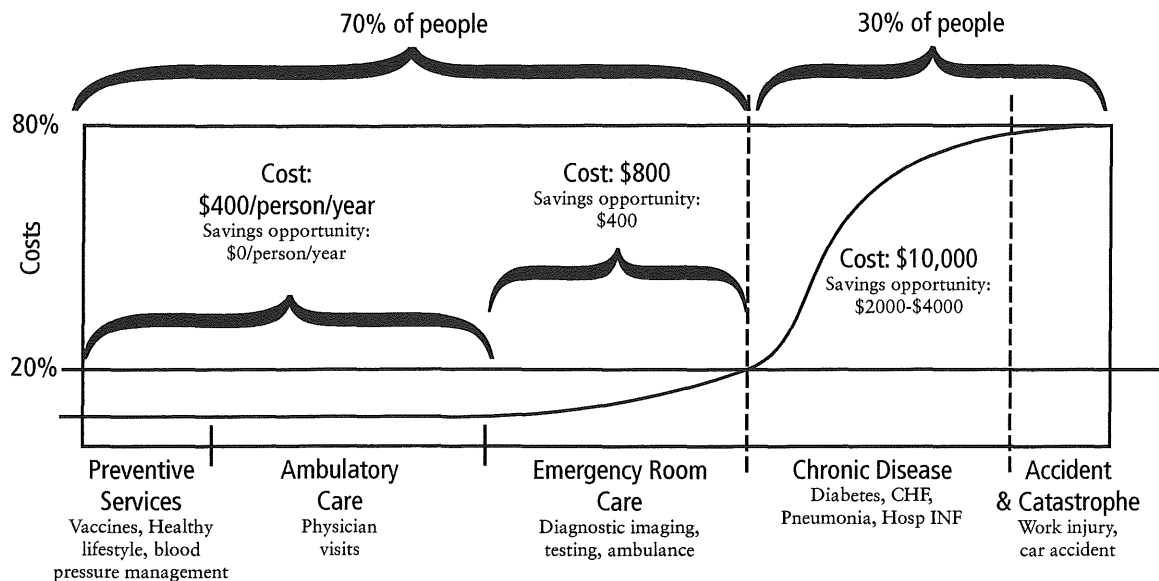
Further increase the amount of effective care that is provided:

- *Support physician-developed guidelines.*
The appropriate use of evidence-based, clinical guidelines is an important tool for clinical and shared decision-making. Although numerous sources of guidelines exist, guidelines must be developed in an open, multi-specialty process. Closed, proprietary models for guideline development are unsupportable. The task force urges the MMA to support efforts to develop and implement guidelines by working with the

Figure 1

Health Care Costs

Average Annual per Household Health Care Costs (MN): \$11,000



Graphic Concept: Doug Wood, M.D., task force member; various references for data on chart—available upon request

Institute for Clinical Systems Improvement and others. All guidelines should also be readily available for patient use. Patients need to understand how they should approach common health care problems and how to better understand what to expect from physicians and other health care providers.

- *Support expansion of an improved information infrastructure.*

Support statewide implementation of electronic health records that provide, at a minimum, for the exchange of summary report information that can be used for treatment decisions. The task force urges the MMA to support creation of state incentives to help establish and expand the state's electronic health care infrastructure. A public-private partnership should be created to assure that the roles of each sector in creating, expanding, and linking information and systems are complementary.

- *Support a "medical home" for every adult and child in Minnesota anchored in a continuous relationship with a personal physician.*

To promote continuous healing relationships and to better coordinate care through continuity of person, place, and information, every Minnesotan should have a medical "home." Physician practices that are organized for easy

patient access will facilitate greater patient use of the medical home as opposed to emergency or urgent care centers. In collaboration with others, the task force recommends that the MMA work to educate patients and payers about the importance of this concept. Significant evidence exists that having a personal physician improves quality, improves health outcomes, and controls costs. Employers, government, and plans should be encouraged to adopt payment plans and enrollment policies that increase the likelihood that patients can identify and sustain a relationship with a personal physician. Payment methods must be built to support the functions provided by a medical home, such as patient education and case management. Those services would be covered as part of the essential set of services.

- *Place the emphasis for cost control where the greatest opportunity exists – chronic care.*

More than 70 percent of health care costs are incurred by about 30 percent of patients. In fact, only 5 percent of patients generate more than 50 percent of all costs. Today's system largely tries to save money by extracting deep discounts for most primary care. The task force believes that system is inefficient and counterproductive. It keeps physicians and other health professionals from investing the time and resources in preven-

tion, health education, and care management, all of which can avert more expensive treatments in the future. The new system should focus cost-control efforts on chronically ill patients or those with complex diseases who generate the vast majority of the expenses.

Provide useful quality information:

- *Support transparency in quality measurement and reporting of system capability.*

In order to give all Minnesotans the kind of information they need to play a much more active role in their own health care decisions, public reporting of changes and improvements in various dimensions of the health system's performance is needed. As we seek to improve the available information over time, however, it is critical that patients, payers, purchasers, and health care providers understand the meaning of various measures and the limitations of measurement tools.

Within the health care system, there are three levels at which performance could be assessed: 1) at the population level; 2) at the facility level – clinic, hospital, nursing home, system; and, 3) at the individual clinician level.

Performance measurement tends to evoke strong reaction from many physicians and for good reason. The implications of measurement and public reporting can be significant both in terms of business/economic impact and professional reputation. In addition, it is no easy task to explain easily the value and limitations of performance measurement at each of the three levels (i.e., population, facility, and individual). The selection of appropriate measures is critical. Appropriate performance measures must be statistically valid, and they should measure things over which the object of the measurement has some control. Given both the large number of patients needed to meet statistical standards and the environmental influences on health status (i.e., factors often outside of the physician's control), outcome measures should only be used to assess progress in whole populations of people.ⁱⁱ

Process measures are appropriate for evaluating a clinic, hospital, or health system's performance (assuming adequate patient population size). For example, process measures could measure whether a clinic has systems in place to assure that immunizations, screening tests, or (for diabetics) hemoglobin A1Cs are offered and tracked.

Given the need for statistical validity and the limitations of current measurement techniques, performance or quality measures cannot be used at the individual physician or other clinician level. Rather, the performance or competency of physicians and other clinicians must be evaluated through other means (discussed below).

The task force suggests that the MMA take a leadership role in working with stakeholders to identify and disseminate appropriate outcome and process measures that can be used for system improvement and to aid in improved decision making by all stakeholders. In general, the task force suggests the following:

- Consumers should help to articulate what their information needs are. There should be public reporting of appropriate measures that consumers would find useful to help them make better decisions;
- Measures useful to provider systems for purposes of quality improvement should be fully disclosed and reported back to them;
- Organized medicine and individual medical groups should be consulted in the development of measures for accountability and improvement;
- The role of government should be to partner with the private sector in the use of measurement for purchasing and to support measurement at a communitywide level through incentives and regulation; and,
- Criteria to be used for selection of measures should include whether good evidence exists, and whether an opportunity for savings or other societal benefit exists if performance improves on a measure.

ii. Methodological challenges are real; consider this telling example from David Eddy: "The low frequency of certain outcomes has big implications for the sample size needed to measure a meaningful difference in outcomes across plans. If breast cancer mortality were to be used as a measure of breast cancer screening, a population of about two million women would be needed to find that size difference in mortality. The median-size health maintenance organization (HMO) has fewer than 10,000 women over age fifty, which makes this measure impossible to use for comparing the quality of breast cancer care." (Eddy D. Performance Measurement: Problems and Solutions. Health Affairs; 1998: July/August, 7-25.)

- *Support simplified quality measurement and reporting transactions.*

It is important to eliminate duplicative reporting and measurement efforts. Data should be collected only once in the process of clinical care, measurement, and reporting. A single, common data set for quality measurement should be adopted. The MMA should work to facilitate the transition from manual to electronic chart abstracting.

Develop payment systems to support quality practice:

- *Support payment processes that financially reward the implementation of guidelines, registries, and other efforts to improve quality of care.*

Significant national and local attention is being paid to the notion of “pay-for-performance.” The intent of this concept is to financially reward those health care providers that are delivering care (for some subset of selected diseases or conditions) above some level identified, generally, by health plans or purchasers. The task force notes that despite the rush to adopt such techniques, there is little or no evidence to indicate that it will achieve the desired improvements in quality that all seek to achieve.

The task force believes that its model for the future will eventually make the concept of pay-for-performance moot because patients will decide for themselves about the value offered in terms of performance and cost. However, in the short-term, employers and third-party payers appear to see the need to make value-based decisions on behalf of consumers and are moving to adopt some pay-for-performance models. Until the desired health care system that is articulated in this paper is achieved, the task force recommends that the MMA advocate for pay-for-performance models that reward near-term provider actions that would build their capacity and systems for efficient, effective care – the installation of electronic medical records, computerized pharmacy-order entry systems, clinical decision-support systems, disease and case management, team-based care, etc. The task force also believes that it is reasonable for the MMA, in the interim, to support models that appropri-

ately reward process improvements (e.g., documentation of appropriate recommendations made to patients). Given the limitations outlined earlier, the task force does not believe that the MMA should support pay-for-performance models that link payment with patient outcomes.

Ensure the safety and quality of health care:

- *Leverage existing quality improvement work.*
As the Minnesota Citizen’s Forum on Health Care Costs report documented, there is a tremendous amount of quality improvement activity already underway in Minnesota. Enough money is being spent already to fund an aggressive quality improvement agenda for the state. Much more could be accomplished if the activities were more efficiently organized and connected. Elimination of duplicate efforts would reduce wasteful spending on administrative functions and allow these precious resources to be better spent for direct patient care or funding of more critical needs. The task force believes that the MMA could serve an important function in integrating the various activities and in identifying those efforts that would benefit from MMA involvement.

- *To protect the safety of patients, the competency of health care professionals and institutions must be ensured.*
As discussed above, at the present time statistical quality measures cannot be fairly applied at the individual physician level. Instead, physician competency is assessed by methods such as state licensure and board certification. Board certification, in particular, is undergoing significant transformation. More emphasis is being placed on ongoing demonstration of performance rather than knowledge alone. The task force believes that the MMA could serve as a resource on the individual physician’s role and responsibility in ensuring physician competency and should consider supporting uniform disclosure of physician training and competency, as well as the disclosure of facility capability. As the new market system evolves, the role of various stakeholders in assuring competency will need to be reevaluated.

Financing the Future System

The task force believes that the recommended model for reform would eventually produce a more efficient system at all levels. However, up-front investments will be needed for covering the uninsured; building the information infrastructure; directly financing medical education and research; and, creating new capacity for consumer education and support. The task force suggests some ideas both for the redistribution of current expenditures and for raising new revenues. Some of these ideas are existing MMA policy (e.g., raising the tobacco tax); others deserve further study and debate. The task force suggests that as this reform proposal or key elements of it begin to gain traction, full cost and savings estimates be done by qualified researchers. In the meantime, financing ideas such as the following, which are offered for discussion purposes and not as specific financing recommendations, could be part of the community discussions the task force recommends:

- *In general the financing mechanisms must be broad-based, including reliance on progressive taxation systems.*
- *The costs of financing the needed subsidies for low-income Minnesotans could be partially recovered by capping the tax deductibility of health benefits at the essential benefit set level.*
- *Much more transparency in the system is needed to track where savings are being generated and captured.*
- *Cost savings from quality and efficiency improvements could at least partially be redirected into expanded access, system infrastructure needs, and prevention efforts with much longer-term payoff.*

- *A new focus for the competition among health insurers could redirect some administrative spending into investments to improve care processes and system infrastructure.*
- *Government could redirect some of its current investments in capital improvement to prioritize building the information infrastructure.*
- *Although the issue was discussed only briefly, most task force members expressed more support for market influences determining the distribution of supply than regulatory forces.*
- *Mechanisms to directly and adequately fund the costs of medical and other health professional education, and medical research, must be developed. The cross-subsidies and market disadvantages are now borne disproportionately by certain health systems that we rely on to provide these essential public goods. The more competitive market model advocated by the task force will exacerbate these problems unless a new financing method is developed.*
- *Taxes on products with correlations to health risks could be raised (e.g., tobacco, alcohol, snack foods, fast food). Such taxes not only generate revenue, but they also create price disincentives for use or overuse and help consumers to appreciate the connection between their own behavioral choices and the cost of health care.*

Issues Outstanding & Needing Development

Although the task force addressed numerous issues in the course of its deliberations, it did not have time to fully explore all of the important issues that affect the current health care system. Some of these issues are long-standing concerns, and others are questions prompted by the new model itself.

- *The mechanics of the new payment model(s) for physicians, facilities, and other providers. Much more specific work is needed to translate the task force's general ideas on what to do differently into how to do it. This will be of major concern to other stakeholders.*

- *Implications of the model on under-served communities, including low-income and vulnerable populations. How will access be ensured for these groups? Even in a competitive system, physician prices will always be "too high" for some simply because the demand is high, supply is limited, and the need is immediate. The task force talked generally about requirements that could be placed on plans and/or providers to ensure that care would be available to these populations, but this issue needs to be shaped with other stakeholders from the outset.*

- *Identify and address the unique issues facing rural communities. The implications of the proposed changes in insurance and care delivery markets must be evaluated. For example in rural (and also inner-urban) areas, where retention of providers and delivery systems is an issue, payers should provide stable support. The MMA should work with payers to prevent the creation of artificial competition that would drive providers from markets due to new payment systems.*
- *Long term care financing merits attention. In general, the systems of acute and long term care cannot remain as artificially separated as they are today if the goal is to create a system that better meets the needs of an aging population facing greater burdens of chronic disease.*
- *An improved and better-coordinated health care transportation infrastructure, including recent efforts to develop a trauma system for Minnesota, is needed to improve care delivery and remove barriers to access to care. The MMA could explore ongoing issues of concern, including payment policies that require transportation to the nearest medical facility.*
- *Identify separate and distinct funding streams for health professional education, research, and patient care. The MMA's prior work in this area should be updated and specific recommendations developed. The urgency of this problem is growing.*
- *Consider specific cost drivers such as pharmaceuticals. The task force discussed pricing and other national policy issues; but at the state level attention should be focused on ways to support appropriate prescribing and patient education.*
- *The appropriate standards of care at the end of life need to be discussed by the broad community, especially as technology marches on.*

Recommendations for Moving Reform Forward

Communicating Vision and Building Consensus for a New Model

Pursuing fundamental change will take years and will not be accomplished by the MMA in isolation. The best chance of success is to share and communicate the vision articulated in this report and invite others into the conversation. Rather than advance all of the concrete proposals immediately, the MMA should work to make sure the concepts it wants to get across are clear. It should then embark on a campaign to build enthusiasm for the possibilities, position the MMA as a leader and a resource to the community, and recruit partners. Some of the specific tasks to be undertaken include the following:

- *Convene discussions on the mutual responsibilities/principles framework*
- *Convene discussions on how the proposed new model would change the role of key constituencies (physicians, care systems, professional organizations, health care consumer/advocate groups,*

employers, health plans, government, patients).

- *Further explore the basic/essential benefit set concept in partnership with others. Study emerging literature on the topic, talk to other states, etc. Explore how such a model could be built and kept updated by a physician-led collaboration.*
- *Build coalitions to press for the needed fundamental changes.*
- *Seek waivers of federal laws that impede reform (ERISA, etc) and seek changes in federal government tax and payment policy that distorts the market (includes Medicare geographic equity).*

Immediate MMA Action

A number of recommendations contained in this report can be undertaken immediately by the MMA. Among the recommendations upon which the MMA can focus and work to provide leadership are the following:

- *Increase emphasis on prevention and health maintenance by strengthening public health policies and systems.*
- *Educate consumers and assist them in playing a more central role in decision making and participating in care management.*
- *Assist physicians and other providers in delivering evidence-based care.*
- *Support the establishment of a medical home for every Minnesotan through changes in administrative and payment policies.*
- *Build the information infrastructure to allow collection, reporting, and dissemination of the information needed to measure and improve quality and equip patients to make cost and quality choices (this should connect clinical with claims data for all clinics, hospitals, doctors, and insurers).*
- *Develop payment systems to support quality practice*
- *Leverage existing quality improvement work*
- *Make behavioral health care a part of basic medical benefits. Change health care contracts, consolidate medical and behavioral health networks, put behavioral health claims in the medical health adjudication system, support behavioral health providers giving care in the general medical sector, etc.*
- *Support efforts to improve care delivery and payment for patients with chronic and complex conditions (e.g., team-based care models, payment for non-visit care).*
- *Reduce administrative complexity and cost.*

Conclusion

The members of the MMA Health Care Reform Task Force are pleased to submit this report and the recommendations for reform to the MMA Board of Trustees. The central premise of this report is that fundamental changes in the shape of the insurance market and the economics of care delivery are needed in order to change the incentives of all parties so they are encouraged to increase value in the system. Leadership by the MMA is needed to broaden the terms of the health reform debate so that critical issues, such as covering all Minnesotans for essential services, improving quality to help control long-term costs, and assuring maximum prevention of avoidable health risks in the broad population are addressed.

Summary Chart of Recommendations

A Strong Public Health System

1. Lead in making public health more prominent.
2. Coordinate action to address modifiable risk factors.

A Reformed Health Insurance Market

1. Ensure universal coverage for essential benefits
 - a. Require that all individuals have insurance coverage.
 - b. Identify an essential benefits package that is adequate to protect health.
 - c. Ensure affordability through subsidies and targeted tax incentives.
2. Build a fairer system of spreading risk and sharing cost
 - a. Require statewide community rating and guaranteed issuance for the essential benefits package.
 - b. Reinsure high-cost claims.
3. Help employers make coverage options available.

A Reformed Health Care Delivery Market

1. Engage patients through greater accountability for medical decision making.
2. Create a fundamentally different economic model for medical care services
 - a. End discriminatory government pricing policy.

Systems that Fully Support the Delivery of High-Quality Care

1. Further increase the amount of effective care that is provided
 - a. Support physician-developed guidelines.
 - b. Support expansion of an improved information infrastructure.
 - c. Support a “medical home” for every adult and child in Minnesota.
 - d. Place the emphasis for cost control where the greatest opportunity exists – chronic care
2. Provide useful quality information
 - a. Support transparency in quality measurement and reporting of system capability.
 - b. Support simplified quality measurement and reporting transactions.
3. Develop payment systems to support quality practice
 - a. Support payment processes that financially reward the implementation of guidelines, registries, and other efforts to improve quality of care.
4. Ensure the safety and quality of health care
 - a. Leverage existing quality improvement work.
 - b. Ensure the competency of health care professionals and institutions.

Appendix A

Health Care Reform Task Force Charter

January 24, 2004

MMA Board of Trustees

Summary:

There is consensus that many aspects of our health care system are broken and need reform. The Board of Trustees believes the MMA should take a leadership role in addressing these issues of health care reform. Although the MMA tackles many aspects of reform on an ongoing basis, changes in the external environment (increased focus on cost, delivery and quality/safety) and member input point to the need for an increased focus at this time. It is hoped these efforts will not only contribute to HC System Reform but also strengthen MMA influence, build coalitions and engage members and consumers.

Charge:

A Health Care Reform Task Force will be created to:

Develop & Recommend a set of “principles” to guide the MMA’s positions/actions on health care reform

Recommend “next steps” for MMA involvement in health care reform

The Task Force should define reform broadly and deliberations should include a discussion of health care financing, costs, delivery, access, demand/supply, insurance reform, quality, manpower, technology and disparities across local, state, public and private sectors.

Scope of Work

Phase I

Understand current MMA policies and previous reform work

Understand AMA policies and reform work

Understand external viewpoints/data/recommendations on reform

Create a “vision” of the desired future to help create a common understanding of the goals for reform

Develop principles to guide the MMA

Phase II

Recommend “next steps” including

What MMA health care reform principles should be prioritized for additional policy development and advocacy?

In what areas should we lead current and future reform efforts?

With whom should we collaborate?

What current MMA policies should be changed and/or adopted?

Should the MMA develop a full reform proposal?

How should MMA principles be communicated to physicians/patients? What education of physicians and/or patients should occur?

Task Force Membership:

12-14 MMA members

Task Force members (including the chair) will be selected by the chair of the MMA Board of Trustees in consultation with officers, trustees and MMA staff. It is anticipated Task Force members will need to spend a minimum of 4 hours per month in meeting time during 2004 with additional time in preparation.

Communication:

The Task Force will provide regular updates to the Board, prepare a report for the 2004 MMA House of Delegates and complete work prior to the end of 2004.

Authority:

The Task Force does not have the authority to set MMA policy or direct action. Task Force recommendations will be reviewed by the Board.

Appendix B

Task Force Recommendations Compared to Other Proposals

Health Care Reform Task Force	1992 MMA Principles for Health Care Reform	Report of the Minnesota Citizens Forum on Health Care Costs (2004)	Institute of Medicine (various reports)
Preference-sensitive and supply-sensitive utilization and variation addressed through new model		Reduce variation	
Support appropriate transparency in measurement and reporting		Report quality	Collect data and publish reports (including national quality report)
New economic model rewards quality and value improvement (detailed work on payment systems needed)		Reward quality	New committee working on "pay for performance"
Patient Choice and Responsibility			
New model is fundamentally more patient-based with no limits on selection of physician/clinics	Multi-payer system better supports patient choice	Put Minnesotans in the drivers seat	
Sophisticated approach to cost-sharing by condition and evidence of effective intervention, as well as provider price	Appropriate cost sharing	Consumers need an economic stake in decisions	
Health behavior incentives allowed as adjustment to community rate; medical home supports education and decision-making	Increase incentives for healthy behavior	Incentives to promote healthy choices	
Relevant cost and quality information available to patients		Full disclosure of costs and quality	
Public Health			
Strengthen communitywide approaches to reduce risk factors	Significantly increase education on health risks and prevention	Strengthen public health approaches	Focus on the "ecological model" of health: behaviors, social and economic conditions (Future of the Public's Health in the 21st Century)
Reaffirm support for public health policy positions and point out the connection between health care cost and access debates	Reduce tobacco use		Need for a strong infrastructure for emergency preparedness

Appendix C

Current and Potential Future Stakeholder Roles in Creating Value

	Current	Future (Potential)
Patient/Consumer	<ul style="list-style-type: none"> • Chooses plan based on coverage levels, provider access, premium price • Seeks service • Pays co-pay (if any) • Feels “entitled” to services as covered • Uninsured pay nothing or full price (no discounts) • Higher co-pays for behavioral health services 	<ul style="list-style-type: none"> • Chooses plan based on price, quality of administrative services, availability of information to support provider choice, shared treatment decision making, prevention and care management. • Seeks services from any provider unrestricted by plan • Coverage level (patient’s cost) depends on category of service (essential benefit set or supplemental) and provider’s price
Physician/Provider	<ul style="list-style-type: none"> • Provides service • Paid primarily at negotiated (imposed) rate. • Care provided to uninsured either charged at full rate or provided as uncompensated care (occasional individual arrangements negotiated with selected providers) 	<ul style="list-style-type: none"> • Advises patient on treatment options • Provides service • Price is the same for all patients • Percent of bill paid by patient versus plan may vary among plans • Strives to improve safety, effectiveness, efficiency of care • Improves outcomes and develops expertise on which to compete • Provides information about cost and quality
Employer	<ul style="list-style-type: none"> • Selects plan(s) and products • Determines contribution levels • Can restrict or opt out of behavioral health coverage in comparison to general medical 	<ul style="list-style-type: none"> • Selects plan(s) to administer essential benefits • Elects to provide additional coverage (or not) • Determines contribution levels • Provides incentives and programs for health risk reduction/wellness • Example: employer pays both enrollee and physician to complete a health risk appraisal, and rewards both for improvement over time in risk factors
Health Plan	<ul style="list-style-type: none"> • Designs multiple benefit packages • Sets coverage criteria • Determines provider network • Effectively sets provider’s price/(payment) • Primarily concerned with control of unit prices • Independent behavioral health pricing, access and service limits and co-pays 	<ul style="list-style-type: none"> • Administers standard benefit set • Uses standard clinical guidelines • Does not define provider network, but assists consumers in finding a medical home and in maximizing the value of their dollars • Negotiates payment rates to providers (but doesn’t limit provider prices) • Payment shifts toward episodes of care or care for ongoing conditions • Provides information and other support for providers to improve care • Charges a community-rated premium for essential benefits based on estimate of costs • May continue to design and offer supplemental products • Participates in a statewide reinsurance pool with all its products
Government	<ul style="list-style-type: none"> • Focus on setting artificially low prices per unit cost • Shifts costs to other payers • Layers of regulation • Adopts benefit mandates 	<ul style="list-style-type: none"> • Ensures a well-functioning market • Protects against anti-trust • Provides tax incentives for coverage • Pays plans and providers a reasonable rate • Subsidizes coverage for people with low incomes and ensures access • Supports the information infrastructure (with funding, incentives, regulatory power) • Streamlined reporting • No more mandates for ineffective care • Ensures a strong public health system • Uses policy tools to reduce health risks

Appendix D

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Physicians' Plan for a Healthy Minnesota

The Minnesota Medical Association's Plan for Health Care Reform

Why We Need Health Care Reform

The U.S. spends twice as much per person on health care than any other country.

- In Minnesota, the average annual health care cost for a family is about \$11,000 and this is expected to double by 2010. Wages are not growing fast enough to absorb this cost.
- There are 275,000 Minnesotans who don't have insurance.
- There are opportunities to improve quality—especially in the treatment of chronic care.

We need an overall plan to reform the health care system – a vision of what we want our health care system in Minnesota to be.

That's why a task force of Minnesota physicians have been working together for a year to develop a plan.

What the MMA Health Care Reform Plan Will Accomplish

Physicians' Plan for a Healthy Minnesota is a guide to providing all Minnesota citizens with affordable insurance for essential health care services and improving the quality of care -- while at the same time holding down the rapid rise in health care costs.

Key Features

The key features are health insurance for all Minnesotans, a strong emphasis on public health and disease prevention, high quality health care and affordability. It gives people more information and more control of their health care decisions and stresses the importance of having a medical home with a personal physician.

Health Insurance for All Minnesotans

- Everyone is required to have insurance for essential health care services
- Essential benefits are defined through a physician-led community process. This sets a floor for insurance coverage– the health care everyone must have.
- All health plans offer the same essential benefits and charge everyone the same premium regardless of age or health status.
- Health plans are required to offer the essential benefit set to all Minnesotans.
- Minnesotans may buy coverage for supplemental benefits. Individuals, not health plans or purchasers, decide how to spend their health care dollars.

Prevention of Illness

- Public health systems are strengthened.
- Minnesota enacts public health policies designed to prevent illness such as a higher tobacco tax and clean-air laws to prevent cancer and heart disease, promotes immunization, and creates programs to prevent obesity.

- Patients receive information and counseling about weight loss, smoking cessation and other prevention measures.
- Individuals are given incentives for healthy behavior.

High Quality

- Incentives and policies encourage the use of evidence-based guidelines, disease management of chronic conditions, electronic medical information systems, preventive care and early diagnosis, coverage for behavioral health services, and a medical home with a personal physician for every Minnesotan.
- Minnesotans have more information about quality and cost as well as incentives to make wise choices.

Affordability

- Emphasis shifts from controlling costs in the generally healthy population to preventing serious illness and wisely managing care for the chronically ill whose care is most expensive.
- The state and federal governments no longer set prices; they buy health care services in the same way as private purchasers.
- Administrative expenses are reduced through simplification.
- Patients choose their physicians and health plans on the basis of the value that they perceive. Competition brings prices in line with value.

The MMA's plan sets out a long-range vision for a healthy future for Minnesota and a roadmap for achieving it. Although many details are still to be worked out through dialogue with other groups, the MMA timeline calls for progress to begin now.

Immediate first steps

During the 2005 session, the MMA will seek legislation that moves toward the goals of disease prevention and universal coverage:

- 1) A \$1 increase in the tobacco tax;
- 2) Use of funds from the tobacco tax increase to preserve Minnesota's health care programs and move toward the goal of affordable health insurance for all Minnesotans;
- 3) A statewide ban on smoking in bars and restaurants.

The MMA will move forward immediately in helping physicians deliver evidence-based care, supporting a medical home for every Minnesotan, building an information infrastructure, supporting physician's efforts to deliver chronic and complex care and reducing administrative complexity.

Collaboration

The MMA will also convene discussions with all stakeholders – physicians, health plans, legislators, consumers, the governor's administration, community groups. We want to build support for the MMA's long-range plan, fill in the details, and continue progress toward its long-range goals.

Current General Assistance Medical Care Program

Who is eligible? Low-income adults, ages 21-64, who have no dependent children under age 18 and who do not qualify for federal health care programs.

What are the income limits? These income limits are effective through 6-30-05.

The income limits for comprehensive coverage are up to and including 75 % FPG.	
Family size	Six Month Gross Income Limit
1	\$3,492
2	\$4,686

The income limits for GAMC hospitalization only (GHO) coverage are above 75% FPG up to and including 175% FPG.	
Family size	Six Month Gross Income Limit
1	Above \$3,492 to \$ 8,148
2	Above \$4,686 to \$10,932

What are the asset limits? The asset limit is \$1,000 for comprehensive coverage. The asset limit for hospitalization only coverage is \$10,000 for one person and \$20,000 for a household of two or more.

What services are paid? There are two levels of covered services.

The comprehensive benefit provides coverage for:

- Alcohol and drug treatment
- Chiropractic
- Dental care
- Doctor/Clinic visits
- Emergency room care and ambulance service
- Eyeglasses
- Family planning services
- Hearing aids
- Immunizations
- Inpatient hospital
- Lab and X-ray
- Medical equipment
- Mental health
- Outpatient surgery
- Prescription drugs
- Rehabilitative therapy

Comprehensive coverage through GAMC may begin no earlier than the date the county human service agency receives a signed and dated application or other written request for coverage.

Karen Gibson

Hospitalization Only provides coverage for:

- Inpatient hospitalization services -- \$1,000 co-pay applies to each admission
- Physicians' services received during hospitalization

No other services are covered for those who qualify for hospitalization only coverage.

Hospitalization Only coverage may begin on the day of hospital admission or the day the application is submitted to the county human service agency, whichever is later. Coverage ends on the day of hospital discharge.

What are the limits and cost sharing? There is a \$1,000 co-payment for hospitalization only coverage. There is no cost for comprehensive coverage for those who meet the income limits, but there are limits and co-payments for some services including:

- \$500 annual dental limit except for emergency dental services, dentures and extractions before dentures
- 50% co-pay on restorative dental services such as fillings and dentures
- \$25 co-pay on eyeglasses
- \$25 co-pay on non-emergency visits to an emergency room
- \$3 co-pay for brand name drugs and \$1 co-pay for generic drugs up to a maximum of \$20 per month. (No co-pay on some mental health drugs.)
- \$3 co-pay per visit for clinic and physicians' services for non-preventive care, chiropractic care, podiatry, audiologist and eye exams.

**Demographic Description of GAMC Enrollees
November 2004**

Gender	Count Unique Enrollees	Percent of People in Enrollment Group
Female	13,930	38.6%
Male	22,185	61.4%
Total	36,115	

Ethnicity/Race

Asian	1,005	2.8%
Black	8,799	24.4%
Hispanic	1,079	3.0%
Native American	2,461	6.8%
Unknown/Other	1,016	2.8%
White	21,755	60.2%
Total	36,115	

Age

0 - 2	-	0.0%
3 - 12	-	0.0%
13 - 17	-	0.0%
18 - 34	13,457	37.3%
35 - 50	15,144	41.9%
51 - 64	7,498	20.8%
65+	16	0.0%
Total	36,115	

Marital Status

Divorced	7,103	19.7%
Legally Separated	135	0.4%
Married	2,396	6.6%
Married, Living Apart (sep.)	4,151	11.5%
Never Married	21,464	59.4%
Unknown	94	0.3%
Widowed	772	2.1%
Total	36,115	

County of Residence

Greater MN	17,082	47.3%
Ramsey	3,970	11.0%
Hennepin	12,890	35.7%
Anoka, Carver, Dakota, Scott & Washington Counties	2,062	5.7%
Out of State	111	0.3%
Total	36,115	

Vicki Kueneth

Diagnosis Prevalence: GAMC Adult Enrollees

January 26, 2005

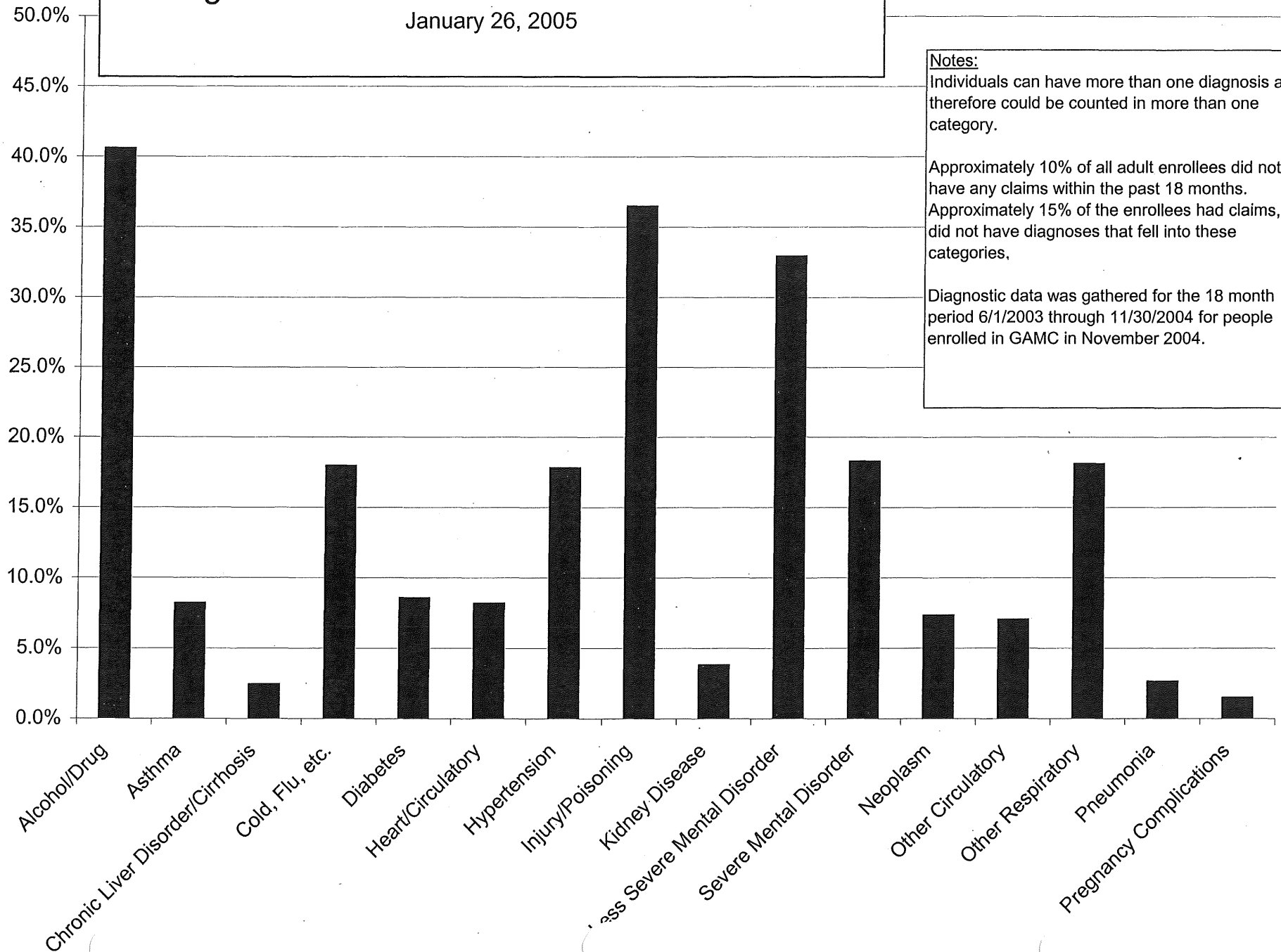
Notes:

Individuals can have more than one diagnosis and therefore could be counted in more than one category.

Approximately 10% of all adult enrollees did not have any claims within the past 18 months. Approximately 15% of the enrollees had claims, but did not have diagnoses that fell into these categories.

Diagnostic data was gathered for the 18 month period 6/1/2003 through 11/30/2004 for people enrolled in GAMC in November 2004.

4



**GAMC Enrollment, Per Member Per Month, Total Cost
November 2004 Forecast**

	Monthly Average Enrollees	Monthly Average Payment	Total Annual Payments (in 000s)
Forecast			
FY 2005	37,122	\$547.50	\$243,893
FY 2006	41,591	\$588.86	\$293,893
FY 2007	52,897	\$597.54	\$379,295

With the implementation of the department's web-based eligibility system, HealthMatch, the forecast is assuming a shift from MinnesotaCare to GAMC beginning in January 2006.

HealthMatch Shift

	MinnesotaCare	GAMC
Enrollment		
FY 2006	(2,920)	2,920
FY 2007	(12,443)	12,443
State Costs (in 000s)		
FY 2006	(\$9,666)	\$11,069
FY 2007	(\$60,493)	\$68,908

Note – A 12% higher cost is assumed in GAMC because of the different benefit set

George Hoffman

Length of Time on GAMC

Geo. Hoffman

On GAMC in June 2003

Number of persons 38,400

Months of eligibility from July '98 to June '03

Average GAMC months 16.6

Median GAMC months 11.0

Average months of GAMC,
MA, or MinnesotaCare 21.6

Median months of GAMC,
MA, or MinnesotaCare 16.0

On GAMC in June 2004

Number of persons 35,996

Months of eligibility from July '99 to June '04

Average GAMC months 17.7

Median GAMC months 12.0

Average months of GAMC,
MA, or MinnesotaCare 23.8

Median months of GAMC,
MA, or MinnesotaCare 19.0

Ever on GAMC July '99 to June '04

Number of persons 146,449

Months of eligibility from July '99 to June '04

Average GAMC months 11.7

Median GAMC months 7.0

Average months of GAMC,
MA, or MinnesotaCare 20.2

Median months of GAMC,
MA, or MinnesotaCare 14.0

Length of Time on GAMC

Eligibility for other programs:

61,328 (42%) also had eligibility for MA and/or MinnesotaCare during the 60 months.
The average number of months of eligibility in the other programs was 20.5.

More specifically:

45,694 (31%) had MA eligibility during the 60 months.
The average number of MA eligibility months was 19.8

23,328 (16%) had MinnesotaCare coverage during the 60 months.
The average number of months of MinnesotaCare eligibility was 15.9

Months of GAMC	Number of Persons	Percent
60	1,516	1.0%
49-59	1,987	1.4%
37-48	4,189	2.9%
25-36	9,714	6.6%
19-24	9,762	6.7%
13-18	17,849	12.2%
7-12	36,119	24.7%
1-6	65,313	44.6%
Total	146,449	100.0%

Months of GAMC, MA, or MinnesotaCare	Number of Persons	Percent
60	5,609	3.8%
49-59	9,670	6.6%
37-48	12,882	8.8%
25-36	18,962	12.9%
19-24	13,379	9.1%
13-18	18,763	12.8%
7-12	28,358	19.4%
1-6	38,826	26.5%
Total	146,449	100.0%



Testimony of Randy Ulseth
Chief Executive Officer, Kanabec Hospital, Mora
On behalf of the Minnesota Hospital Association

January 27, 2005

Madame Chair and Members:

My name is Randy Ulseth and I am the Chief Executive Officer of the Kanabec Hospital in Mora, Minnesota. Kanabec Hospital is a 49-bed hospital owned by Kanabec County. On behalf of the Minnesota Hospital Association and our 138 members, thank you for the opportunity to share some information with you about the General Assistance Medical Care program.

The General Assistance Medical Care program is the smallest of Minnesota's public health care programs, with about 36,000 individuals receiving care through GAMC, compared to about 469,000 Minnesotans receiving health care services through the Medical Assistance program and about 139,000 Minnesotans receiving services through the MinnesotaCare program.

That being said, GAMC is still very important to the hospital community. It is a program for the poorest of the poor, individuals earning less than \$7,000 a year and with less than \$1,000 in assets. Many of Minnesotans served have persistent mental health issues or chronic health conditions that, for the most part, will prohibit them from really ever moving out of extreme poverty.

I would like to share some information regarding hospital payments in the GAMC program.

- Rates for GAMC are based on costs incurred in 1998 and no inflation adjustment has ever been made.
- There have been several significant cuts in the rates hospitals are paid:
 - In 2002 GAMC hospital rates were reduced by point-five (0.5) percent.
 - In March of 2003 GAMC hospital rates were reduced an additional five percent.
 - In July of 2003 GAMC hospital rates were reduced *another* five percent.

As a result, GAMC hospital rates are now 10.5 percent below the 1998 cost of delivering care. And that ignores the growth in costs that hospitals have faced in the last seven years.

(over)

The governor's budget has now proposed an additional 5 percent cut in hospital payments in the GAMC program. Of course this just exacerbates the problem of government payments failing to keep up with costs.

All that being said, GAMC is still an important program — for those on it and for the hospitals that serve them. Having GAMC coverage for primary care services undoubtedly helps these very poor Minnesotans receive some preventive care. And when they need emergency room services, GAMC provides some payment.

To close, I have a document prepared by the Minnesota Hospital Association that I would like to share with you today regarding the GAMC program. This provides some information regarding admissions by county and total GAMC payments. As you can see, the GAMC program is important to providers and communities around the state.

County / Hospitals	GAMC Hospital Admissions (fee for service only)	Total GAMC Payments All Providers, 2004
Aitkin	1	\$1,102,188
Riverwood HealthCare Center		
Anoka	455	\$12,614,977
Mercy Hospital		
Unity Hospital		
Becker	35	\$2,172,236
St. Mary's Regional Health Center		
Beltrami	156	\$2,682,148
North Country Health Services		
Benton		\$1,571,536
Big Stone	6	\$161,229
Graceville Health Center		
Ortonville Area Health Services		
Blue Earth		\$2,070,457
Immanuel St. Joseph's - Mayo Health System	129	
Brown	17	\$615,563
New Ulm Medical Center		
Sleepy Eye Municipal Hospital		
Springfield Medical Center - Mayo Health System		
Carlton	49	\$1,785,452
Cloquet Community Memorial Hospital & C&NC		
Mercy Hospital & Health Care Center		
Carver	33	\$1,338,254
Ridgeview Medical Center		
Cass		\$1,948,744
Chippewa	3	\$302,006
Chippewa County-Montevideo Hospital		
Chisago	22	\$1,588,456
Fairview Lakes Regional Medical Center		
Clay		\$2,342,383
Clearwater	3	\$348,614
Clearwater Health Services		
Cook	2	\$116,960
Cook County North Shore Hospital		
Cottonwood	5	\$576,562
Westbrook Health Center		
Windom Area Hospital		
Crow Wing	107	\$2,144,828
St. Joseph's Medical Center		
Cuyuna Regional Medical Center		

Randy White

County / Hospitals	GAMC Hospital Admissions (fee for service only)	Total GAMC Payments All Providers, 2004
Dakota	99	\$7,343,089
Fairview Ridges Hospital		
Regina Medical Center		
Northfield Hospital & Long Term Care Center		
Dodge		\$322,252
Douglas	45	\$966,638
Douglas County Hospital		
Faribault	8	\$412,975
United Hospital District		
Fillmore		\$729,280
Freeborn	20	\$1,022,420
Albert Lea Medical Center - Mayo Health System		
Goodhue	12	\$1,061,723
Cannon Falls Community Hospital		
Fairview Red Wing Medical Center		
Zumbrota Health Care		
Grant	3	\$205,283
ELEAH Medical Center		
Hennepin	3,412	\$89,270,763
Fairview Southdale Hospital		
Valley Hospital at Hidden Lakes		
Abbott Northwestern Hospital		
Children's Hospitals and Clinics, Minneapolis		
Fairview-University Medical Center		
Hennepin County Medical Center		
Phillips Eye Institute		
Shriners Hospitals for Children		
Veterans Affairs Medical Center		
North Memorial Medical Center		
Methodist Hospital Park Nicollet Health Services		
Houston		\$430,522
Hubbard	29	\$669,902
St. Joseph's Area Health Services, Inc.		
Isanti	101	\$1,106,287
Cambridge Medical Center		
Itasca	16	\$2,361,113
Bigfork Valley Hospital		
Deer River HealthCare Center		
Grand Itasca Clinic and Hospital & C&NC		
Jackson	1	\$258,186
Jackson Medical Center		

County / Hospitals	GAMC Hospital Admissions (fee for service only)	Total GAMC Payments All Providers, 2004
Kanabec	17	\$707,276
Kanabec Hospital		
Kandiyohi	44	\$1,507,523
Rice Memorial Hospital		
Kittson	-	\$121,399
Kittson Memorial Healthcare Center		
Koochiching	6	\$1,016,505
Falls Memorial Hospital		
Lac Qui Parle	-	\$255,424
Johnson Memorial Health Services		
Madison Hospital		
Lake	4	\$473,103
Lake View Memorial Hospital & Home		
Lake Of The Woods	2	\$87,441
LakeWood Health Center		
Le Sueur	-	\$680,115
Minnesota Valley Health Center		
Lincoln	-	\$126,385
Hendricks Community Hospital Association		
Divine Providence Health Center		
Tyler Healthcare Center, Inc.		
Lyon	6	\$682,851
Weiner Memorial Medical Center		
Tracy Area Medical Services		
Mahnomen	4	\$337,641
Mahnomen Health Center		
Marshall	-	\$308,458
North Valley Health Center		
Martin		\$946,492
Fairmont Medical Center - Mayo Health System	13	
Mcleod	42	\$825,721
Glencoe Regional Health Services		
Hutchinson Area Health Care		
Meeker	7	\$576,082
Meeker County Memorial Hospital		
Mille Lacs	7	\$1,376,938
Mille Lacs Health System		
Morrison	8	\$1,072,035
St. Gabriel's Hospital		

County / Hospitals	GAMC Hospital Admissions (fee for service only)	Total GAMC Payments All Providers, 2004
Mower	60	\$1,423,376
Austin Medical Center - Mayo Health System		
Murray	-	\$211,249
Murray County Memorial Hospital		
Nicollet	3	\$826,543
St. Peter Community Hospital and Health Care		
Nobles	22	\$653,262
Worthington Regional Hospital		
Norman	1	\$163,037
Bridges Medical Services		
Olmsted	393	\$7,141,723
Mayo Psychiatry and Psychology Treatment		
Olmsted Medical Center		
Rochester Methodist Hospital		
Saint Marys Hospital		
Otter Tail	43	\$1,635,205
Lake Region Healthcare Corporation		
Perham Memorial Hospital and Home		
Pennington	29	\$598,091
Northwest Medical Center		
Pine	10	\$1,621,227
Lakeside Medical Center, Inc. - Hospital		
Pine Medical Center		
Pipestone	4	\$278,605
Pipestone County Medical Center		
Polk	17	\$1,268,746
Riverview Healthcare Association		
First Care Medical Services		
Pope	6	\$397,306
Glacial Ridge Health System		
Minnewaska Regional Health System		
Ramsey	1,358	\$26,668,307
St. John's Hospital		
Bethesda Rehabilitation Hospital		
Children's Hospitals and Clinics, St. Paul		
Gillette Children's Specialty Healthcare		
Regions Hospital		
St. Joseph's Hospital		
United Hospital		
Red Lake		\$261,399

County / Hospitals	GAMC Hospital Admissions (fee for service only)	Total GAMC Payments All Providers, 2004
Redwood	2	\$463,777
Redwood Area Hospital		
Renville	4	\$431,150
Renville County Hospital		
Rice	18	\$1,497,129
District One Hospital		
Rock	1	\$131,790
Luverne Community Hospital		
Roseau	1	\$292,541
Roseau Area Hospital & Homes, Inc.		
St. Louis	512	\$14,074,421
White Community Hospital & C&NC		
Cook Hospital & C&NC		
Miller-Dwan Medical Center		
St. Luke's Hospital		
St. Mary's Medical Center		
Ely-Bloomenson Hospital & Nursing Home		
Fairview University Medical Center - Mesabi		
Virginia Regional Medical Center		
Scott	62	\$1,789,873
Queen of Peace Hospital		
St. Francis Regional Medical Center		
Sherburne	22	\$1,376,894
Fairview Northland Regional Hospital		
Sibley	1	\$350,083
Sibley Medical Center		
Stearns	269	\$4,118,028
Albany Area Hospital and Medical Center		
Melrose Area Hospital - CentraCare		
Paynesville Area Health Care System		
St. Michael's Hospital & Nursing Home		
St. Cloud Hospital		
Veterans Affairs Medical Center		
Steele	25	\$935,444
Owatonna Hospital		
Stevens	7	\$139,239
Stevens Community Medical Center		
Swift	8	\$402,809
Appleton Municipal Hospital and Nursing Home		
Swift County-Benson Hospital		

County / Hospitals	GAMC Hospital Admissions (fee for service only)	Total GAMC Payments All Providers, 2004
Todd	2	\$1,127,710
Long Prairie Memorial Hospital & Home		
Traverse	-	\$112,224
Wheaton Community Hospital		
Wabasha	4	\$439,065
Lake City Medical Center - Mayo Health System		
Saint Elizabeth's Medical Center		
Wadena	21	\$886,803
Lakewood Health System		
Tri-County Hospital		
Waseca	1	\$668,538
Waseca Medical Center - Mayo Health System		
Washington	27	\$2,803,746
Lakeview Hospital		
Woodwinds Health Campus		
Watonwan	1	\$269,601
Madelia Community Hospital		
St. James Health Services		
Wilkin	2	\$212,113
St. Francis Medical Center		
Winona	33	\$1,532,035
Community Memorial Hospital		
Wright	26	\$2,542,478
Buffalo Hospital		
Monticello-Big Lake Hospital		
Yellow Medicine	9	\$300,659
Sioux Valley Canby Campus		
Granite Falls Municipal Hospital & Manor		
STATEWIDE TOTALS	7,933	\$232,790,642

* Hospital payments from the GAMC program represent an estimated \$98 million.

Inpatient and outpatient hospital ffs payments for the GAMC program totaled \$50.6 million in 2004.

Managed care program payments in FY2004 totaled \$157.9 million, of which the hospital portion is estimated to be 30% or \$47.4 million.

Health and Family Security Committee
Chair, Sen. Becky Lourey
Noon – 2:30 PM, January 27, 2005
Room 15, Capitol

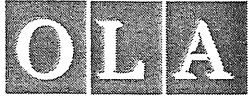
Members,

In your packets are six reports:

Four summaries of audits of health boards by the Legislative Auditor,

An as yet unpublished report from MDH on the Minnesota Public Health Information Network,

And two PowerPoint presentations from the Health Economics Division at MDH that Senator Berglin and Senator LeClair referenced during the HSA discussion.



Notice of Report Release
Minnesota Board of Chiropractic Examiners

Financial Audit Division Report 05-05

Released February 3, 2005

Conclusions:

- The Minnesota Board of Chiropractic Examiners needs to provide an independent review of receipt and disbursement transactions and further restrict access to its business systems.
- For the biennium ended June 30, 2003, the board did not comply with the statutory requirement that it collect sufficient fees to cover its costs. The under-recovery of costs resulted from extraordinary legal expenses incurred in the litigation of complaints. However, the board's receipts covered its costs in fiscal year 2004 and the board's financial projections indicate that it will recover its costs for the biennium ended June 30, 2005.

The report contained one finding relating to internal control. There were no prior audit findings.

Audit Scope:

Audit Period: July 1, 2000,
through June 30, 2003

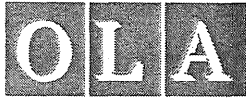
Programs Audited:

- Licensing and Fee Receipts
- Payroll Expenditures
- Administrative Expenditures

Agency Background:

The board regulates the licensing of chiropractors, corporations engaged in chiropractic medicine, and acupuncturists. In fiscal year 2003, the board collected approximately \$609,000 and incurred direct and indirect costs of about \$808,000. During that time, the board issued about 2,200 licenses and processed about 1,000 registrations.

For a copy of this report call
(651) 296-1235, or visit our website
at "www.auditor.leg.state.mn.us".



Notice of Report Release
Minnesota Board of Dietetics and Nutrition Practice

Financial Audit Division Report 05-07

Released February 3, 2005

Conclusions:

- The Minnesota Board of Dietetics and Nutrition Practice needs to develop mitigating internal controls to ensure the propriety of its receipts and disbursements, and needs to further restrict access to its business systems.
- The board complied with legal provisions for the items tested.

The report contained one finding relating to internal control. The office resolved all findings included in our prior audit report.

Audit Scope:

Audit Period: July 1, 2000,
through June 30, 2003

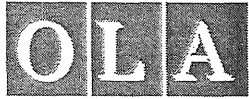
Programs Audited:

- Licensing and Fee Receipts
- Payroll Expenditures
- Administrative Expenditures

Agency Background:

The board regulates the licensing of dietitians and nutritionists practicing in the state of Minnesota. In fiscal year 2003, the board collected approximately \$103,000 and incurred \$81,000 in both direct and indirect costs. During that time, the board renewed approximately 1,000 licenses.

For a copy of this report call
(651) 296-1235, or visit our website
at "www.auditor.leg.state.mn.us".



Notice of Report Release
Minnesota Board of Dentistry

Financial Audit Division Report 05-06

Released February 3, 2005

Conclusions:

- The Minnesota Board of Dentistry needs to provide an independent review of receipt and disbursement transactions and further restrict access to its business systems.
- The board complied with legal provisions for the items tested. The board did not collect sufficient fees to recover its costs for the biennium ended June 30, 2003; however, the under recovery was about five percent of biennial revenues which we concluded was reasonable.

The report contained one finding relating to internal control. The board resolved the one finding included in our prior audit report.

Audit Scope:

Audit Period: July 1, 2000,
through June 30, 2003

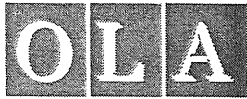
Programs Audited:

- Licensing and Fee Receipts
- Payroll Expenditures
- Administrative Expenditures

Agency Background:

The Board of Dentistry regulates the licensing of dentists, dental assistants, and dental hygienists engaged in the practice of dental medicine in the state of Minnesota. In fiscal year 2003, the board collected approximately \$1.1 million and incurred \$1.2 million in both direct and indirect costs. During that time, the board issued about 14,000 licenses.

**For a copy of this report call
(651) 296-1235, or visit our website
at "www.auditor.leg.state.mn.us".**



Notice of Report Release
Minnesota Board of Marriage and Family Therapy

Financial Audit Division Report 05-08

Released February 3, 2005

Conclusions:

- The Minnesota Board of Marriage and Family Therapy needs to strengthen its independent review of receipt and disbursement transactions and further restrict access to its business systems. However, we did not identify any erroneous or improper financial activities during our audit.
- The board complied with legal provisions for the items tested.

The report contained one finding relating to internal control. The office resolved the one finding included in our prior audit report.

Audit Scope:

Audit Period: July 1, 2000,
through June 30, 2003

Programs Audited:

- Licensing and Fee Receipts
- Payroll Expenditures
- Administrative Expenditures

Agency Background:

The Board of Marriage and Family Therapy regulates the licensing of professional marriage and family therapists engaged in practice in the state of Minnesota. In fiscal year 2003, the board collected approximately \$156,000 and incurred \$141,000 in both direct and indirect costs. During that time, the board issued about 950 license renewals, including 150 associate renewals.

For a copy of this report call
(651) 296-1235, or visit our website
at "www.auditor.leg.state.mn.us".

Minnesota Public Health Information Network (MN-PHIN)

Roadmap and Recommendations for Strategic Action

Report to the Minnesota Legislature 2005

Minnesota Department of Health

January 2005



Commissioner's Office
85 East Seventh Place, Suite 400
P.O. Box 64882
St. Paul, MN 55164-0882
(651) 215-1300
www.health.state.mn.us



Protecting, maintaining and improving the health of all Minnesotans

January 2005

Dear Colleagues:

Attached is the *Minnesota Public Health Information Network (MN-PHIN): Roadmap and Recommendations for Strategic Action* report delivered in accordance with the Laws of Minnesota 2004, chapter 279, article 11, section 8. This report fulfills the directive by the 2004 Minnesota Legislature to the Minnesota Department of Health to prepare a plan for the development and implementation of a statewide public health data management system in cooperation and consultation with representatives of local public health departments.

The vision for the Minnesota Public Health Information Network is to provide the timely and accurate information that enables public health professionals, policymakers, and community partners to efficiently and effectively respond to community health threats, protect the public from serious but preventable diseases or injury, and carry out their responsibilities to make Minnesota communities healthier places to live. It also enables consumers to access the public health and prevention information they need to make wise health decisions.

The Minnesota Public Health Information Network is a component of the larger Minnesota e-Health Initiative, a statewide public-private collaboration whose aim is to accelerate the use of health information technology in Minnesota

In addition, this report complements the Minnesota Governor's *Drive to Excellence* plan, which describes providing fast, reliable services to the citizens of Minnesota as its number one priority.

We hope that this report will help guide the Minnesota Department of Health and its local partners in developing a blueprint to establish a comprehensive Minnesota Public Health Information Network. For specific questions about this report, please direct your questions to Martin LaVenture at (612) 676-5017.

Sincerely,

A handwritten signature in black ink that reads "Dianne M. Mandernach". The signature is written in a cursive, flowing style.

Dianne M. Mandernach
Commissioner
P.O. Box 64882
St. Paul, MN 55164-0882

General Information: (651) 215-5800 ■ TDD/TYY: (651) 215-8980 ■ Minnesota Relay Service: (800) 627-3529 ■ www.health.state.mn.us

For directions to any of the MDH locations, call (651) 215-5800 ■ An equal opportunity employer

Minnesota Public Health Information Network (MN-PHIN): Roadmap and Recommendations for Strategic Action

January 2005

For more information, contact:

Public Health Informatics
Executive Office
Minnesota Department of Health
Post Office Box 64882
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Phone: (612) 676-5017
Fax: (612) 676-5666
TTY: (800) 627-3529

As requested by Minnesota Statute 3.197: This report cost approximately \$15,541 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille or cassette tape.

Printed on recycled paper.

**“Public Health is what we, as a society, do collectively to assure
the conditions in which people can be healthy.”**

Institute of Medicine (IOM), 1988

**“One of our greatest opportunities for success lies in the alignment of
the state’s technology strategies with the Administration’s business
objectives. Aggressive use of information technology will help allow us
to achieve our business objectives and offer better services for**

Minnesota citizens.”

**Governor Tim Pawlenty
*Minnesota Drive to Excellence, 2004***

Executive Summary

The vision for a Minnesota Public Health Information Network (MN-PHIN) is to provide the timely and accurate statewide information network that enables public health professionals, policymakers, and community partners to:

- respond efficiently and effectively to community health threats
- protect the public from serious but preventable diseases or injury
- carry out their responsibilities to make Minnesota communities healthier places to live

In addition, MN-PHIN will enable consumers to access the public health and prevention information they need to make informed health decisions.

Current local and state public health information systems have many challenges: they allow gaps in services to clients; they require maintenance of duplicate records, which is costly; and they do not meet national standards for interconnectivity.

Minnesota city and county health departments use excessive resources to process hundreds of thousands of transactions using out-of-date or limited capacity software applications or other technology.

Minnesota lags behind multiple states that have invested significant resources in updating their local and state public health systems.

Some funding opportunities are emerging nationally as this problem is recognized. Implementing the early phases of MN-PHIN will prepare Minnesota to better compete for some of those resources.

In order to protect, maintain, and improve the health of all Minnesotans, a seamless system for the communication of information and access to knowledge is essential. Clear and compelling evidence shows the value of effective implementation of information technology in and across public health organizations.¹ In an increasingly automated world, rapid detection of problems, rapid communication, and rapid response to any event with public health consequences is now an essential activity.

The MN-PHIN is a component of the larger Minnesota e-Health Initiative, a statewide public-private collaboration whose aim is to accelerate the use of health information technology in Minnesota to improve health and safety. Its goal is to make the information needed for good health decisions available whenever and wherever health decisions are made. This report includes three strategies and seven recommendations for strategic action to improve the public health, safety, and

¹ Government Accounting Office, 2003, National Institute of Medicine (IOM) Reports, 2000, 2002, 2004.

quality of services provided through local public health departments and the Minnesota Department of Health (MDH). The plan includes preliminary cost estimates for the planning and development of a statewide system.

Specific strategies are:

1. Integrate information systems to support public health practice and prevention.
2. Interconnect local, state, federal, and key partners.
3. Make personalized prevention and public health information and knowledge available to consumers.

Recommendations for strategic action are:

- a. Establish a joint state-local governance structure.
- b. Identify policy reform needed to implement and integrate information systems, stimulate capital investment, and ensure sustainability.
- c. Adopt national data and technical standards.
- d. Establish uniform policies and practices to ensure protection of confidentiality and security of health information.
- e. Improve and integrate software applications that support the local public health essential activities and statewide public health programs.
- f. Provide training for public health leaders and staff in the core competencies of public health informatics.
- g. Implement MN-PHIN as an integral part of the Minnesota e-Health Initiative.

The preliminary two-year cost estimates for Phase 1, with a state and local component, is \$1.38 million.

This Minnesota Public Health Information Network (MN-PHIN): Roadmap and Recommendations for Strategic Action report has been prepared in accordance with the Laws of Minnesota 2004, chapter 279, article 11, section 8. This report fulfills the directive by the 2004 Minnesota Legislature to MDH to prepare a plan for the development and implementation of a statewide public health data management system in cooperation and consultation with representatives of local public health departments.

The State Community Health Services Advisory Committee (SCHSAC) oversaw the production of this report throughout 2004. In particular, work was carried out by the SCHSAC Strategic Plan Subcommittee, which consisted of representatives from local public health departments, the MDH, and others with knowledge of health information technology. The Chair of the Strategic Plan Subcommittee was Karen Zeleznak, Director of the Bloomington Division of Public Health.

Further work will be performed in the spring of 2005 to carry out the strategic actions outlined within this report.

Introduction

In Minnesota, a partnership of state and local public health departments have the unique responsibility of protecting and improving the health of the community. This is quite different from the medical approach, which treats people one at a time. But to do their jobs effectively and efficiently, public health professionals, state, and local health officials, policymakers, and other public health partners need timely, accurate, and reliable information about the people they serve.

This report highlights the health information challenges facing public health today, the opportunities the current environment presents for addressing these challenges, a vision for a Minnesota Public Health Information Network, and a Roadmap and Recommendations for Strategic Action. It includes cost estimates for the next nine years and a call to action.

The report recommendations are consistent with the Minnesota “Drive to Excellence” initiative

aimed at providing modern, comprehensive and user-friendly access to state services; ensuring a more secure operating environment to safeguard information and citizen privacy; and decreasing the administrative cost of government while increasing the quality and efficiency of public services.

The report was created by staff representing local public health departments, the Minnesota Department of Health (MDH), the Public Health Informatics Institute (a nonprofit organization), and other public health information technology experts, based on information collected through meetings, interviews, and surveys.

Health Information Challenges for Public Health

Public health today faces challenges that, in turn, present opportunities for transformation.

- Recent events have underscored the urgent need for public health, healthcare, and the public to have access to and be able to share comprehensive, timely, accurate information. Terrorist acts against our country, anthrax incidents, and SARS and West Nile outbreaks have turned the spotlight on the huge deficit in information system capacity and the limited ability to communicate across systems that currently exists in most public health departments.

- Public health officials’ need for rapid access to critical information – lab results, disease reports, birth certificates, disease (surveillance) data, preparedness data and knowledge sources – has never been greater. Officials rely on speedy technology to gather information, send it where it is needed, and store it securely. Rapid response using data is essential to controlling epidemics and dispelling worries.

- Technology continues to advance at great speed, and the opportunity for positive impact on the effectiveness, efficiency, and quality of health within our communities is

tremendous. Yet keeping up with technology has become a necessary challenge and a responsibility for state and local health departments. Each purchase decision requires research and review, installation, training, and oversight. However, the challenge of upgrading current software applications to contemporary integrated and interconnected systems has been overwhelming for many and cost prohibitive for most local health departments.

Local and state public health professionals in Minnesota have a long history of using health information and health information technology as tools to address every day and emerging public health challenges. (See Appendix A, *Stories from Across Minnesota*.) Over the past several years, however, this committee and others have documented the limitations and gaps of Minnesota’s public health information systems in addressing the state’s public health concerns and challenges.

Information for Health

Population health improvement requires the collection of timely, accurate, and detailed information that enables assessment of community health, risk factors, research, and the reporting of critical findings back to public and private officials and the public in ways that are useful to decision-making.

State of Public Health Information Technology in Minnesota

The Minnesota public health system relies on effective coordination and collaboration between state and local public health and partners. The need for rapid access to critical information – lab results, disease reports, surveillance data, birth certificates preparedness data and knowledge sources – has never been greater. The need for the speed provided by electronic exchange is growing. As public health officials seek to control epidemics and dispel worries, they rely on technology to gather information, send it where it is needed, and store it securely – in a matter of hours, not days. In an increasingly automated world, rapid detection of problems, rapid communication, and rapid response to any event with public health consequences is now an essential activity.

The health information flow among partners in Minnesota, however, is complex. Fifty-two Community Health Boards (comprising 87 counties and four city public health departments) interact with program staff in seven divisions at MDH. MDH currently relies on a complex array of over 65 information systems to support information management at the state level. Each local public health (LPH) department utilizes 12-33 different, unconnected applications. Although a number of systems and applications are continuously being developed at both (see Appendix B, *Examples of New or Evolving Public Health Information Systems in Minnesota*), relatively few meet the interconnectivity and uniform functional requirements of today's public health professionals, public health officials, their partners, or the public.

Most notably, an estimated 2 percent of state and local applications and systems comply with national standards for linking systems electronically. This deficit has multiple consequences. Silo applications used by MDH and LPH departments

require duplicate entry and complex manual transfer of information, and individual custom programs to transfer the data electronically often are needed. This results in inaccurate and untimely data for public health decision-making, as well as poorly utilized staff. Additionally, it limits information sharing between MDH and LPH departments and with community partners, healthcare organizations, or other authorized partners. Similarly, lack of statewide standards for strong security, login processes, and encryption require multiple security processes that are expensive to operate and administer.

Appendix C, *Minnesota Public Health Information: Challenges, Solutions, and Gaps*, summarizes many of the challenges, solutions, and gaps in the state's health information technology. Some are technological in nature,

while others are organizational. A common theme is the limited capability for electronic access and exchange within the public health system.

Some challenges are organizational in nature. Less than 5 percent of LPH departments and 10 percent of MDH staff have had training on national informatics

practices. The organizational processes and metrics to assess the status of LPH and MDH health information technology do not exist. Activities are focused on single applications, rather than cross-department applications, resulting in duplicative expenditures on information technology.

Another major challenge is the lack of applications supporting community-focused public health and prevention profiles. Accessing existing statewide data often requires separate special requests from programs, and even MDH access is limited. Data from other community agencies is rarely included. Before such profiles can be developed, however, LPH departments must reach agreement upon requirements for a community profile.

Preliminary Results of Minnesota LPH Department Survey

- 900 data sets – (>1 million transactions/clients per year)
- ~ 500 applications (12 - 33 range)
- ~ 200 locally created applications
- ~ 90% use CHAMP, CareFacts, or PH-DOC
- ~ 8 "silo" State and Federal applications
- ~ 2% of applications comply with standards for connecting

N = 45 / 91 LPH cities / counties to date

Public Health Information Technology: How Minnesota Compares

Minnesota is not alone in facing these challenges. Numerous states are already investing in comprehensive, integrated statewide health information systems that better meet state and local public health needs for timely, accurate, and secure information, as well as the needs of healthcare and other community partners. These programs are also investing in the organizational changes needed to ensure success and financial sustainability.

In **Pennsylvania**, Pennsylvania's National Electronic Disease Surveillance System (PA-NEDSS), a statewide electronic disease reporting application, establishes a near real-time, secure communication link between laboratories, hospitals, medical practices, local public health departments, and the state department of health. PA-NEDSS seeks to improve the timeliness and accuracy of disease reporting and expand public health infrastructure to improve response to possible bioterrorism attacks. Over 2,000 individuals currently access PA-NEDSS.

Other states, such as Utah, Florida, California, North Dakota, and South Dakota have implemented similar systems. In contrast, **Minnesota's** disease surveillance systems are not currently interconnected. Local health departments are unable to access case management information, which leads to inefficiencies and can ultimately delay response time to preventable disease outbreaks.

In **Missouri**, community profile data in such areas as chronic disease, unintentional injuries, and cause of death are available online for public health officials, the healthcare community, and the public through the Missouri Information for Community Assessment (MICA) system. Each community data profile table provides data on 15-30 indicators for each county or city selected. Information provided includes the number of events, county/city rate, statistical significance, quintile ranking, and the state rate. The user can access resource pages that provide definitions of risk factors, condition

description, intervention strategies, state and community resources and programs, published reports, and related web sites. The community-specific information is used for improving policy and decision-making.

In contrast, **Minnesota** has developed the Minnesota Vital Statistics Interactive Queries (I.Q.), a web-based query system that will query births, deaths, and population. An expansion to support queries for data on other areas such as morbidity, healthcare utilization, chemical health indicators, environmental health, and maternal and child health is needed and readily available if funded. Modern geographical information systems (GIS) like those used by South Carolina, New York, and Virginia need to be accessible to Minnesota decision makers as well. The consequence of not funding these systems is that state and local public health and policy makers must rely on out-of-date information or expend scarce resources to make decisions based on community-specific information.

In **Rhode Island**, KIDSNET provides automated public health management and follow-up for children's preventive health services, links primary care health providers to the health department, and improves contacts with families and children. The system integrates information from nine state health department programs – immunizations, newborn developmental risk, newborn hearing, metabolic screening, childhood lead poisoning, vital records, early intervention, home visiting, and WIC. Information is used by healthcare providers, schools, HeadStart programs, home visiting agencies, public health officials, as well as public health program staff.

In contrast, **Minnesota** collects this same information about its child health programs using independent software programs, and little, if any, information is interconnected. Consequently, public health professionals and officials do not always have access to critical child development information when working with families in our communities or have access to timely community profiles when needed for policy decision making.

Health Information Opportunities

A National Movement

The limitations of Minnesota's state and local public health information systems are typical. They illustrate why there is growing momentum at the federal, state, and local levels to adopt crosscutting and unifying initiatives to improve health information system interconnections and technical and organizational infrastructure. Some initiatives are targeted to improving healthcare quality, and others to improving public health. Still others recognize that collaboration between the two sectors is fundamental to meeting the nation's health needs.

Sponsors of health information systems infrastructure projects include federal and state agencies. The National Health Information Infrastructure (NHII) initiative of the Department of Health and Human Services is the most encompassing of the federal initiatives. It proposes a network of interoperable systems covering clinical, personal, research, and public health information with the goal of improving the effectiveness, efficiency, safety, and overall quality of health and healthcare in the United States. An initial focus of the NHII is the development of collaborations known as Regional Health Information Organizations (RHIOs). A number of RHIOs comprising healthcare organizations and partners, including public health, are forming around the country.

Funding Opportunities for Public Health Information Technology

Federal and state government agencies, as well as private foundations, are funding health information system initiatives that can help patients receive necessary and timely medical treatment, reduce medical errors, and enable public health officials to more quickly identify and respond to threats from naturally occurring diseases and potential bioterrorism attacks. As a result, states and private healthcare partners are scrambling to compete for the limited funding for health information technology (HIT) funding.

- While the majority of this funding is targeted to advancing HIT adoption among healthcare providers (individuals and organizations), public health will also benefit – if it is at the table as a partner in these initiatives. Making health information readily accessible to consumers is also a primary objective of these initiatives.
- The Robert Wood Johnson Foundation is supporting collaborations among states to develop public health information infrastructure. Minnesota is one of 26 states participating in a collaboration to develop infrastructure for public health laboratory information management systems (LIMS).
- The limited funding provided by CDC has remained largely categorical, that is, supporting specific program objectives and a national view of PHIN. It is up to individual states to redistribute that funding to address cross-agency integration needs for local and state health departments.

Minnesota e-Health Initiative and Minnesota Public Health Information Network

In Minnesota, the e-Health Initiative, a partnership of the Minnesota Department of Health, local public health departments, and healthcare organizations, is poised to ride this wave of support. The initiative has four strategic goals: inform clinical practice, interconnect clinicians, personalize care, and improve population health. The Minnesota Public Health Information Network (MN-PHIN) represents the fourth goal.



Figure 1. Four Dimensions of Minnesota's e-Health Initiative

Minnesota e-Health is a statewide public-private collaboration to accelerate the use of health information technology in Minnesota. Its goal is to make the information needed for good health decisions available whenever and wherever health decisions are made. It encompasses four dimensions representing users of health information: Public Health (state and local), Clinical (healthcare providers and health plans), Consumers (all of us), and Policy and Research (health education and research institutions). The maximum value is realized for "all of us" when we share information across all four dimensions.

Vision for Minnesota Public Health Information Network (MN-PHIN)

The Minnesota Public Health Information Network (MN-PHIN), a component of the Minnesota e-Health Initiative, provides the timely and accurate information that enables public health professionals, policymakers, and community partners to efficiently and effectively respond to community health threats, protect the public from serious but preventable diseases or injury, and carry out their responsibilities to make Minnesota communities healthier places to live. It also enables consumers to access the public health and prevention information they need to make wise health decisions.

MN-PHIN:

- Is a statewide network of interconnected, electronic health information systems.
- Is focused on the health of communities.
- Is collaboratively developed by the Minnesota Department of Health (MDH) and local public health departments.
- Provides the tools and strategies that enable MDH and local public health departments to use IT resources more effectively and cost efficiently.
- Is driven by community and state needs.
- Employs an incremental approach in achieving its vision.
- Leverages existing information systems.
- Facilitates strategic development of new information systems.
- Supports electronic exchange of data.
- Safeguards confidentiality and security of information.

Roadmap for Strategic Action: Minnesota Public Health Information Network (MN-PHIN)

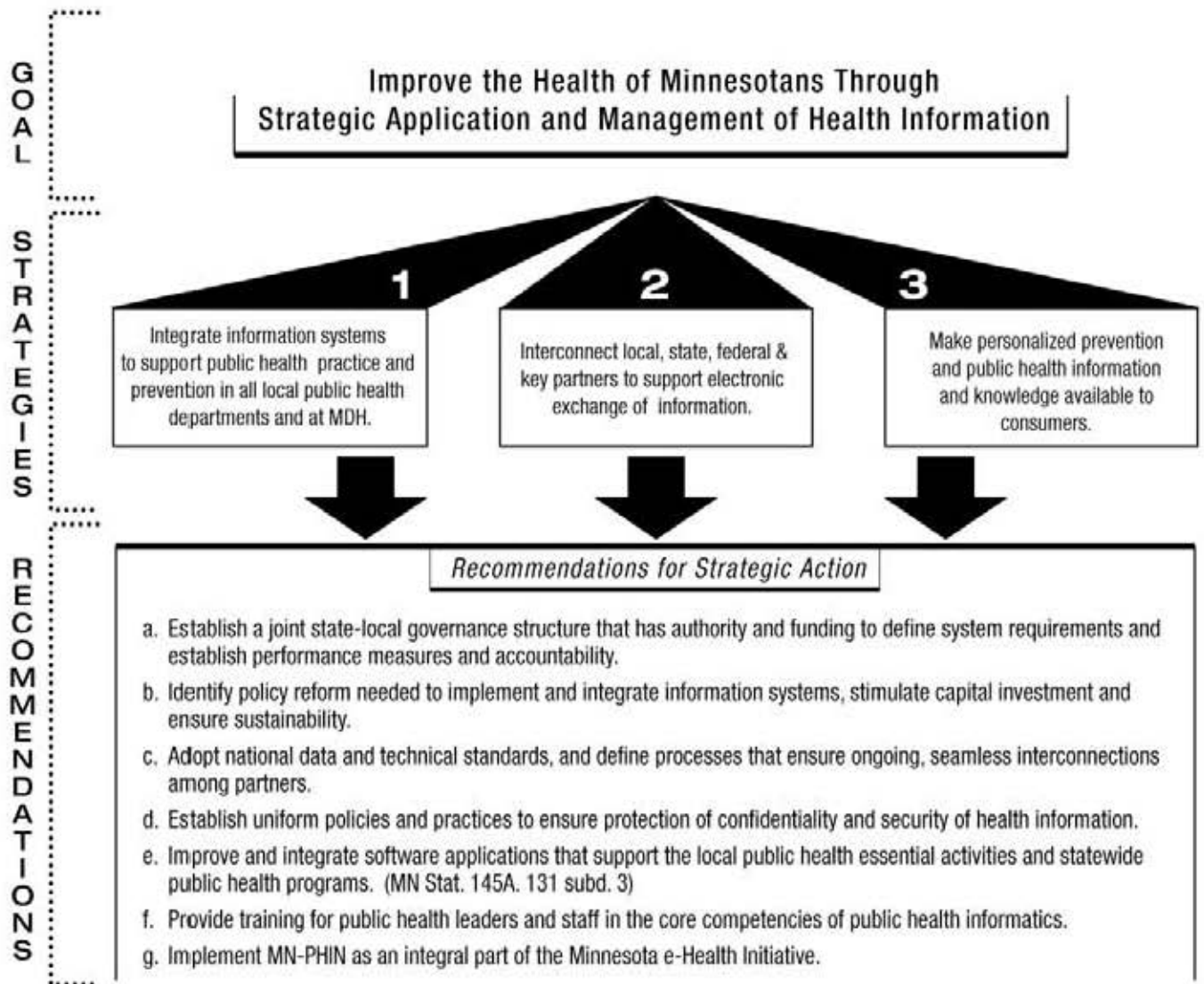


Figure 2

Roadmap for Strategic Action: Minnesota Public Health Information Network (MN-PHIN)

The *Roadmap for Strategic Action* outlines the goal, three strategies, and seven key recommendations for developing MN-PHIN, a comprehensive Minnesota public health information network. All were informed by input from staff of local public health departments and MDH, a survey of local public health information systems, and experts in public health information technology. By design, the *goal* is ambitious and the three *strategies* are broad. They are consistent with federal health information infrastructure initiatives and the Minnesota e-Health Initiative. The *recommendations* are first steps in carrying out these strategies.

Goal

The goal of Minnesota's *Roadmap for Strategic Action* is to improve the health of Minnesotans through strategic application and management of health information.

Strategies

1. Integrate information systems to support public health practice and prevention in all local public health departments and at MDH.

Public health professionals need access to information and knowledge to support public health and prevention decision-making. Implementing efficient, effective, integrated information systems in each LPH department and at MDH will improve the quality and efficiency of public health work. In particular, it will provide a mechanism to LPH departments and MDH for reporting service delivery results and health outcomes.

2. Interconnect local, state, federal, and key partners to support electronic exchange of information.

It is essential to ensure electronic exchange of vital information by interconnecting federal, state, and local public health departments and connecting with key partners. This will allow information to follow clients from one point to another, as necessary, for public health and prevention efforts. This requires implementing compatible applications and an infrastructure based on common vocabulary and data standards to help exchange critical health information when vital individual or public health or prevention decisions are needed.

3. Make personalized prevention and public health information and knowledge available to consumers.

Consumer-centric prevention information and knowledge is essential to good decision-making and informed consumer choices. This strategy encourages the use of personal health records and prevention information that support healthy behaviors.

Recommendations

Seven recommendations (a-g) were developed; all apply across the three strategies. They address governance, policy, standards, confidentiality and security, the development of integrated applications, training, and finally, MN-PHIN as an integral part of the Minnesota e-Health Initiative.

a. Establish a joint state-local governance structure that has authority and funding to define system requirements and establish performance measures and accountability.

An effective governance structure is crucial for guiding the development and operation of information systems. A joint MDH-LPH collaborative governance structure/steering committee should be established to set direction and priorities for MN-PHIN; to take into account stakeholder perspectives; to ensure performance; and to exercise stewardship over public resources. Good governance can also shape policies that facilitate information technology innovation and resourcefulness. Governance in this context includes the following activities: (1) defining functional outcomes for MN-PHIN, (2) creating accountability, (3) setting priorities, (4) making major policy decisions, and (5) overseeing allocation of resources.

b. Identify policy reform needed to implement and integrate information systems; stimulate capital investment and ensure sustainability.

Numerous barriers to implementation of integrated systems have been identified. They include technology, financial, organizational, privacy, and limited use of standards. Policy changes are needed to overcome these barriers. Policies should be adopted that encourage capital investment in information systems and establish a sustainable funding and organizational commitment.

c. Adopt national data and technical standards, and define processes that ensure ongoing, seamless interconnections among partners.

A joint MDH-LPH effort should be established to review, select, adopt, and implement national standards. This includes a process for monitoring national standards and providing feedback into the national standards development process.

d. Establish uniform policies and practices to ensure protection of confidentiality and security of health information.

A variety of practices currently exist at MDH and at LPH departments for the collection, access, and distribution of information. A process for harmonizing policy and processes that support

state and federal requirements across the public health system should be established and linked to compliance with Minnesota's data practices act and federal HIPAA requirements.

e. Improve and integrate software applications that support the local public health essential activities and statewide public health programs. (*MN Stat. 145A. 131 subd. 3*)

LPH departments use considerable resources to manage dozens of software applications that have only limited or no limited interconnectivity. The power and value of integrated information systems should be employed, beginning with a project to define the functional specifications for LPH department applications. A parallel project to identify opportunities for integration of MDH applications internally and with LPH department systems should also be initiated. The initial efforts should focus on information systems involving child health issues.

f. Provide training for public health leaders and staff in the core competencies of public health informatics.

Reports from the Institute of Medicine, the Public Health Informatics Institute, CDC and others highlight the informatics skills public health professionals need in this information age. As an emerging discipline, training in this area is just beginning and should be actively expanded. Education and training for informatics competencies should proceed in a systematic and structured fashion for MDH and LPH department staff.

g. Implement MN-PHIN as an integral part of the Minnesota e-Health Initiative.

It is essential that MN-PHIN be part of the broader Minnesota e-Health efforts in order to leverage resources and extend organizational partnerships with the healthcare system. Minnesota e-Health is a statewide public-private collaboration to accelerate the use of health information technology in Minnesota. Its goal is to make the information needed for good health decisions available whenever and wherever health decisions are made. It encompasses four dimensions representing users of health information: Public Health (state and local), Clinical (healthcare providers and health plans), Consumers (all of us), and Policy and Research (health education and research institutions). The maximum value is realized for all when we share information across all four dimensions.

Cost Estimates for MN-PHIN

Approach

The Minnesota Public Health Information Network comprises a complex set of multi-year projects in three phases over a span of nine years. Each successive phase builds on the foundation of the previous work.

Because these projects utilize common definitions and standards, significant progress can be made through incremental development and implementation. MN-PHIN is not an “all or none” single application. The approach will leverage existing applications, and ensure state and local public health activities will continue while new systems are developed.

Costs estimates are provided for the Phase I only (see Table 1, page 14). Estimates for successive phases will be developed in Year 2 of Phases 1 and 2, based on work accomplished in those phases.

Phase 1 (July 2005 – June 2007)

Phase 1 presents the recommendations in two groups for the purpose of estimating costs.

1. Recommendations *a, b, c, d, f* and *g* should be implemented as part of joint MDH – LPH projects. The cost estimate assumes 1.0 FTE project manager and 0.5 FTE project staff are needed to accomplish this work in the timeframe specified. Also included are contracts for specific technical and informatics support.

2. Recommendation *e* calls for integrated software applications. The cost estimates assume two parallel efforts, one for LPH departments (2a) and the second for MDH applications (2b). The cost estimates propose projects to create functional requirements and logical design documents in each instance.

2a. The LPH department functional requirements project will prepare detailed functional requirement and data and technical specifications needed to meet public health responsibilities, ensure interoperability among LPH department and with state and federal agencies, and better inform consumers. Significant savings will be achieved by using a statewide collaborative approach to development. Two FTEs and a contract for project management and technical and informatics assistance are proposed.

2b. The MDH application integration project will prepare detailed functional requirements and data and technical specifications to ensure MDH connectivity with LPH software applications. The initial project focus is on LPH interconnection to MDH programs with child health information, including WIC, Immunization, Lead Screening, Newborn Metabolic and Hearing Screening, as well as MN-NEDSS (disease surveillance systems), Environmental Health, Vital

Six Areas of Public Health Responsibility

- Assure an adequate local public health infrastructure
- Promote healthy behaviors and healthy communities
- Prevent the spread of infectious disease
- Protect against environmental health hazards
- Prepare for and respond to disasters, and assist communities in recovery
- Assure the quality and accessibility of health services

Records systems, the MDH Laboratory Information Management System, and the Department of Human Services systems. Two FTEs and a contract for project management and technical and informatics support are proposed.

Projects 1, 2a, and 2b will utilize subject matter experts, consultants, and staff to create, review, and publish requirements, definitions and logical design documents that provide a basis for evaluating existing information systems and serve as the framework for system development prioritization.

Phase 2 (July 2007 – June 2009)

Phase 2 will pilot implementation of enhancements to the systems determined to be priorities in Phase 1. Costs and resources needed for specific enhancements to MDH and LPH department systems will be prepared in Phase 1, Year 2. A business case and cost analysis will be conducted for expanding to all LPH departments and additional MDH systems.

Phase 3 (July 2009 – June 2014)

Phase 3 will expand implementation of MDH and LPH systems based on knowledge gained from the pilot efforts in Phase 2. Cost and resources needed for software application enhancements will be made in Phase 2, Year 2.

Conclusion

The strategic application and management of modern health information technology has the potential to improve the health of all Minnesotans. *The time is right for the Minnesota Public Health Information Network.*

- All levels of government – federal, state, and local – recognize that speedy electronic exchange of health information is critical to the mission of public health agencies to protect the public and respond to public health threats.
- Health information technology initiatives are underway across the nation. Healthcare providers (individuals and organizations) are increasingly forming partnerships with public health agencies to address comprehensively community and regional health information needs.
- Sophisticated software application technologies are now available to meet the needs of public health, but leadership, organizational commitment, and multi-agency collaboration are needed to move forward.
- Initial funding investments now will position state and LPH departments to take advantage of future multiple funding sources.

The vision for MN-PHIN will be realized incrementally over the next decade through a well-conceived strategic process developed collaboratively by MDH and LPH departments. However, it is important to begin to put the fundamental building blocks in place now. The will, funding, and technology to provide timely, accurate, reliable information that enables public health staff to do their jobs effectively and efficiently are aligned. By acting now, the Minnesota Public Health Information Network can leverage activities of national initiatives, the Minnesota e-Health Initiative, other state agencies' efforts, as well as funding opportunities. We must be prepared to take advantage of these opportunities and to work collaboratively with these partners.

Appendices

- Appendix A: Stories From Across Minnesota**
- Appendix B: Examples of New or Evolving Public Health Information Systems in Minnesota**
- Appendix C: Minnesota Public Health Information Technology: Challenges, Solutions, and Gaps**
- Appendix D: Minnesota Public Health Information Network (MN-PHIN) Membership List: Initiative Steering Committee and Strategic Plan Subcommittee**
- Appendix E: Acronyms and Glossary**
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Appendix A. Stories From Across Minnesota

Every day of every year, staff of local health agencies and the Minnesota Department of Health (MDH) work to help keep all citizens healthy and help assure the public is protected from serious disease or injury. Information technology provides the information they need to do their jobs.

ACROSS MINNESOTA – Information systems to measure progress toward health goals require investment and a strategic planning and development process. From 2000-2002, two MDH initiatives supported by tobacco settlement funding, the Minnesota Youth Tobacco Prevention Initiative (MYTPI) and the Youth Risk Behavior (YRB) program, planned and developed the E-Chronicle, a comprehensive, web-based reporting system. The information system enabled grantees, including local public health agencies and community-based organizations across the state, to efficiently and effectively input data and measure progress against their stated goals. Through a collaboration of MDH program staff, MDH IT staff, and consultants, the MDH E-Chronicle was developed to serve multiple MDH programs' monitoring needs by creating a flexible system that also could adapt to their needs. The Teen Pregnancy Prevention (MN ENABL) programs as well as other MDH programs continue to use the outcomes-driven system to monitor their programs' progress, generate summary reports at local, regional and statewide levels, compare efforts statewide, and provide the information that assist program staff in program quality improvements. Jennifer Ellsworth, acting program manager for the MDH Tobacco Free Communities program, oversaw the intensive planning, development, and implementation of E-Chronicle. She says, "Had we not taken the time, it would not have been as useful."

In contrast, MDH received substantial funding in 2000 and again in 2001 to support home visiting programs in the state's 87 counties and 11 tribal governments. Although the funding was substantial, even with significant decreases in funding, home visiting programs continue today. In the first year of the program an assessment of the various types of information systems that were in use throughout the local public health system was completed. In an effort to utilize existing data systems at the local level and as a result of limited funding for strategic planning and/or database development, it was decided to have local public health agencies collect required data elements in their own data systems and report the data to MDH in a stand alone database. Local public health and tribal governments received technical assistance via interactive videoconferences and individual site visits from home visiting staff. In addition, administrative guidelines that included standard definitions for the program were created. Unlike E-Chronicle, funding did not allow for dedicated resources for staff for ongoing training, technical assistance, or database management. Another challenge created was that, as the program matured, and as feedback from local public health and the tribes was collected, changes in the data collection system were necessary thereby complicating the ability to compare some of the data from year to year.

Jill Briggs, Maternal Child Health Section Manager, MDH, the first coordinator for TANF Home Visiting, noted, "I'm certain that if we had had more funding and more time for planning and development, we would have developed an information system that clearly illustrated the positive outcomes of home visiting. It has been said that 'What gets measured, gets done.' If funders want to measure what gets done, then they need to support the development of

information systems by designating funds not only for the program implementation, but also for information system planning, training, and technical assistance.”

DAKOTA COUNTY – Integrating data saves time and helps seniors. Local public health department nurses and social service staff screen approximately 500 individuals annually who are age 65 and older, under 65 and disabled, and are at risk for nursing home or hospital placement. Case management services are provided by the local public health department for eligible participants in need of home services such as respite care, personal care, and delivered meals. The data about the services they receive, however, reside in separate public health and social services databases, impeding sharing of information about the clients that both departments serve. Lila Taft, Health Planning Coordinator for Dakota County Public Health Department, says that’s about to change – for the better. In January 2005, public health and social service staff will begin to enter data into the same information system, enabling staff from both agencies to access important information about the individuals they serve. Information about needs resides in still another state database; county staff is beginning to retrieve that county data in order to better understand the needs of elderly across the county.

ACROSS MINNESOTA – Access across agencies improves service and is efficient. The state’s Women, Infants and Children (WIC) information system currently contains information on pregnant women, new mothers, and their children who are provided WIC services at clinics across Minnesota. Just a few years ago, a client who received WIC nutrition vouchers, counseling, or referral to health services in Minneapolis, for example, would have to be re-certified for the WIC program if she moved to another county or tribal jurisdiction. Not only would all the information about her need to be re-entered into the system, she also would have to wait until the paper work from her previous WIC clinic arrived at the new one before food vouchers could be issued. Today, all WIC clinic staff can locate her record in a matter of minutes, verify her eligibility, and issue vouchers or provide services that ensure continued good nutrition for her and her child.

ST. LOUIS COUNTY – Rapid access to data and information is essential for outbreak detection, control and prevention. In early June 2004, local clinical laboratories submitted samples of *E. coli* 0157:H7, a potentially deadly bacteria, to the MDH Public Health Laboratory. The samples were from two individuals who had become seriously ill; the cause was not yet known. Within four days, the MDH laboratorians had conducted DNA “fingerprinting” of the specimens and interviewed the victims. Epidemiologists were able to link the cases to the same food source: frozen steaks sold door-to-door.

The MDH laboratory, which serves as the Midwest regional laboratory for six states, then searched PulseNet, a national information network that links the regional labs. Through finding similar patterns on PulseNet, scientists can determine whether an outbreak is occurring, even if the affected persons are geographically far apart. The database had two matching cases reported from Michigan and Kansas. Within two weeks, four culture-confirmed and two probable cases of *E. coli* 0157:H7 were identified in Minnesota; three of the cases were hospitalized. Other outbreak-associated cases were confirmed in Kansas, Iowa, Michigan, and North Dakota. Just before the July 4 weekend, when thousands of families traditionally fire up their barbecues, a nationwide recall was issued for approximately 739,000 pounds of steaks that had been injected with meat tenderizer.

“The four cases served as an indicator of a larger problem,” says Dr. Kirk Smith, MDH epidemiologist. He notes that although it is difficult to say how much disease may have been prevented by the quick action of the public health scientists involved, “it was a textbook example” of how technology and information systems can help public health control outbreaks.

OTTER TAIL COUNTY – Technology is an essential tool for program assessment and targeting limiting resources. Each year, 400-500 babies are born in Otter Tail County. Fortunately, public health staff can identify the children who are likely to have developmental delays that can result in difficulties with communication, or fine or gross motor skills. Each birth certificate is reviewed for information about risk factors for developmental delays: low birth weight, premature birth, maternal smoking, drugs or alcohol use, and maternal age. Public health staff send questionnaires to high-risk families, asking about their child’s development. Children identified with delays are screened with the result that approximately 6 percent of all children born in Otter Tail County are referred to needed services, such as speech, physical, and occupational therapy, while they are still infants, instead of waiting for these problems to be identified in kindergarten.

The health department has been following children in this way for over 20 years, but with computerization of the information in the last three to four years, public health staff can now analyze data. Says Diane Thorson, Community Health Services Administrator for Otter Tail County, “We’re now looking at who has *not* returned the questionnaire,” which helps the public health staff identify children who may be at risk and falling through the cracks.

“It’s a valuable tool for assessing our early identification efforts,” says Ms. Thorson. “The percentage of children we identify and refer to services is comparable to the national average.”

DAKOTA COUNTY – Community specific information helps direct services to those in most need. When St. Paul experienced an outbreak of measles in 1999, neighboring Dakota County public health staff was ready to ensure the outbreak didn’t spread among their residents. Data about children who had contracted the disease indicated that the outbreak was principally among the Hispanic population, so the Dakota County Public Health Department used data showing the neighborhoods with the greatest number of Hispanic births to guide where they should locate immunization clinics. Although the outbreak subsided, health officials are ready to dust off the plan again.

SOUTHWEST MINNESOTA – Information technology unequivocally helps protect children and communities by keeping them healthy. In the late 1990s, the Southwest Regional immunization registry automatically generated and sent reminders to families to let them know their children were due for shots, sent recall notices to families when the shots were overdue to let them know their children were due for shots, and then sent recall notices when the shots were overdue. But when the registry moved to using the new web-based statewide Minnesota Immunization Information Connection (MIIC), reminders and recalls were deferred during the transition, and immunization rates quickly dropped. The rate for fourth dose of DTaP (diphtheria, tetanus and pertussis), for example, dropped from 74 percent in 1999 to 58 percent in 2001. Recalls have since resumed using MIIC; rates have risen to 65 percent and continue to climb. Although they have detected no increased incidence in the childhood diseases that immunizations protect against, physicians and public health officials know that children who are not getting reminders and shots are also missing their well child visits. Says Sandy Macziewski

of the Southwest registry, “We know the use of an information system to improve one area of preventive healthcare can have positive spillover effects to other areas of prevention and early detection.”

ACROSS MINNESOTA – Interoperability and statewide access improves service.

Throughout the past decade, local public health agencies, schools, and healthcare clinics have been working together to build regional immunization information systems (IIS), also called immunization registries. An IIS is a computerized, confidential information system that consolidates immunization histories from multiple sources in order to accurately determine what shots are still due. Each region had either developed or purchased their own IIS software application, with little compatibility among them and no ability to exchange and consolidate data among them. Health systems with clinics in different regions found they could not relate to a single IIS system. In 2000, the regions and MDH worked together to select a single, statewide, secure web-based IIS application that could meet everyone’s needs. This saved on redundant regional development costs, provided a single, web-based IIS application for clinics and schools to use, provided secure statewide access to immunization data, and ensured compatibility with national and state standards.

Appendix B. Examples of New or Evolving Public Health Information Systems in Minnesota

State systems used by the Minnesota Department of Health

- Statewide Electronic Birth Records (connects hospitals and counties)
- Statewide Electronic Death Records (connects mortuaries and medical examiners)
- Center for Health Statistics Data Access project (interactive queries project)
- State Health Alert Networks (rapid messaging using e-mail)
- Minnesota Electronic Disease and Laboratory reporting
- Minnesota Immunization Information Connection (MIIC) – statewide immunization registry
- Statewide Women Infants and Children (WIC) system
- Minnesota Statewide Laboratory Network, including the Statewide Laboratory Reporting Network (LRN)

Local systems and applications used specifically by local public health agencies

- Local Health Alert Networks (for timely and critical communications via e-mail)
- CHAMPS system (client management)
- PH-DOC software application
- CareFacts software application

Systems shared with other agencies

- Health Alert Network and Internet
- Immunization Registry (MIIC)
- Department of Human Services Systems (CATCH III, Medical Assistance eligibility)
- Infant Follow-along
- Women, Infant and Children (WIC) system

Appendix C. Minnesota Public Health Information Technology: Challenges, Solutions, and Gaps

Challenges	Solutions	Gap
<ul style="list-style-type: none"> ▪ Silo applications (MDH and counties) require duplicate entry, complex manual transfer of information. ▪ Local public health (LPH) departments use 12–33 different silo applications 	Upgrade applications; link applications using national standards	Estimated only 2% of applications support/use national standards for linking
Older, limited function applications and dozens of separate independent data sets results in inefficient use of state and local health department staff	Increase productivity with updated, integrated applications	<ul style="list-style-type: none"> ▪ MDH~160 data sets; LPH ~ 10-50 data sets/department ▪ Few state or local public health department applications funded for upgrade
Limited staff trained in informatics skills to support integration of health information technology into the organization	Implement training and education efforts focus on CDC informatics competencies	Estimated 5% of local staff and 10% of MDH staff has training on informatics competencies
Lack of system compliance with national vocabulary/technical standards	Upgrade systems to meet national standards	Estimated 2% of state and local systems compliant
Providers/partners required to adapt to multiple different, interfaces / authentication and log-on processes	<ul style="list-style-type: none"> ▪ Harmonize current access points and adopt and implement uniform access interface and log on ▪ Work with partners for design/training 	No process is in place to harmonize access points and processes for access
Electronic file exchange process varies across MDH, LPH departments, and partners. Still highly manual	<ul style="list-style-type: none"> ▪ Adopt and implement uniform exchange standards ▪ Work with partners to update systems 	<ul style="list-style-type: none"> ▪ 2 of 50 state systems use national standards ▪ 1 of 87 counties uses national standards
Lack of common consumer portal for secure access to information	Establish infrastructure and policies for access to information	No consumer portal exists for access
<ul style="list-style-type: none"> ▪ Lack of applications supporting community-focused public health and prevention profiles ▪ Accessing existing statewide data often requires separate special requests from programs ▪ Rarely includes cross-agency data 	Implement applications at LPH departments and MDH that integrate summary data into a community profile on demand for local decision-making; expand the current MDH system	<ul style="list-style-type: none"> ▪ MDH access is limited and does not include city information ▪ Lack of LPH specifications and requirements for information in a community profile
Limited use of automated mapping - geographic information systems (GIS)	Integrate GIS into applications	Automated GIS is integrated into less than 3% of the applications
High fiscal and organizational risk of failure with the deployment of complex LPH information systems	Spread the risk out and use best practices that support cross-LPH department collaborative approach to design, develop, implement	<ul style="list-style-type: none"> ▪ No state/local forum or process exists to support cross department activity ▪ Activities limited to single applications
Lack of systematic readiness assessment and health information technology status for LPH departments and MDH	Conduct a comprehensive readiness assessment for status of information systems	No process or standard metrics exist to assess readiness

Source: Workgroup communications and Survey of Local Public Health Data Set and Software Applications, 2004.

Appendix D. Minnesota Public Health Information Network (MN-PHIN)
Membership List: Initiative Steering Committee and Strategic Plan
Subcommittee

Initiative Executive Sponsors

Brenda Menier, Chair, Minnesota Local Public Health Association (LPHA)
Aggie Leitheiser, Assistant Commissioner, MDH
Heather Robins, Chair, Statewide Community Health System Advisory Committee (SCHSAC)
Mary Sheehan, Community and Family Health, MDH
Carol Woolverton, Assistant Commissioner, MDH

Initiative Steering Committee

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Pat Adams, Dakota County CHB
Liz Auch, Countryside CHB
Jill Briggs, Community and Family Health, MDH
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Appendix E. Acronyms and Glossary

Association of State and Territorial Health Officials (ASTHO)

Centers for Disease Control and Prevention (CDC)

Department of Health and Human Services (DHHS)

Geographic Information Systems (GIS)

Information systems that provide data displayed in by geographic formats such as many types of maps. Highly effective when rapid analysis of outbreaks and health threats and crisis exists, as well as in day-to-day program operations.

Health Information Technology (HIT)

The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of healthcare information, data, and knowledge for communication and decision-making. Examples include using sophisticated software applications to help document and maintain client health records, electronic exchange of information, to provide prevention or clinical alerts and reminders, for provider order entry, nursing documentation, decision support systems, and disease surveillance and monitoring systems.

Interoperability

The ability of two or more information systems or components to exchange information and to use the information that has been exchanged.

Institute of Medicine (IOM)

Laboratory Reporting Network (LRN)

Minnesota Public Health Information Network (MN-PHIN)

National Health Information Infrastructure (NHII)

Public Health Informatics Institute (PHII)

Public Health Information Network (PHIN)

Consolidated Health Informatics (CHI) Initiative

One of the 24 Presidential eGovernment initiatives with the goal of adopting vocabulary and messaging standards to facilitate communication of clinical information across the federal health enterprise. CHI now falls under Federal Health Architecture (FHA).

Decision-Support System (DSS)

Computer tools or applications to assist physicians in clinical decisions by providing evidence-based knowledge in the context of patient-specific data. Examples include drug interaction alerts at the time medication is prescribed and reminders for specific guideline-based interventions during the care of patients with chronic disease. Information should be presented in a patient-

centric view of individual care and also in a population or aggregate view to support population management and quality improvement.

Electronic Health Record (EHR)

A real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision-making. The EHR can automate and streamline a clinician's workflow, ensuring that all clinical information is communicated. It can also prevent delays in response that result in gaps in care. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting.

Federal Health Architecture (FHA)

A collaborative body composed of several federal departments and agencies, including the Department of Health and Human Services (HHS), the Department of Homeland Security (DHS), the Department of Veterans Affairs (VA), the Environmental Protection Agency (EPA), the United States Department of Agriculture (USDA), the Department of Defense (DoD), and the Department of Energy (DOE). FHA provides a framework for linking health business processes to technology solutions and standards, and for demonstrating how these solutions achieve improved health performance outcomes.

Personal Health Record (PHR)

An electronic application through which individuals can maintain and manage their health information (and that of others for whom they are authorized) in a private, secure, and confidential environment.

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Upon request, this information will be made available in alternative format; for example, large print, Braille, or cassette tape.

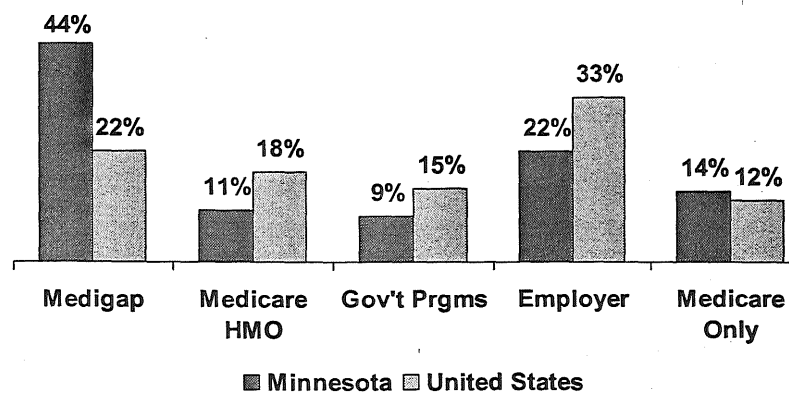
Health Insurance Options for Long-Term Care

Julie Sonier
Assistant Director, Health Economics Program
Minnesota Department of Health

September 10, 2004

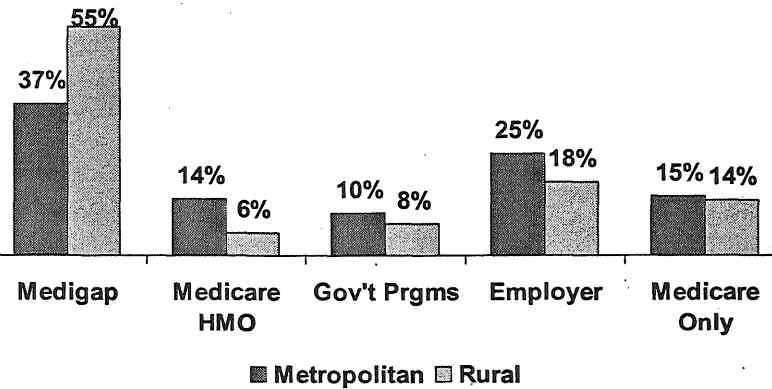


Sources of Supplemental Insurance Coverage for Medicare Beneficiaries, MN and US



Source: Minnesota Department of Health, Health Economics Program, 2001 Minnesota Health Access Survey; Centers for Medicare and Medicaid Services, 2000 Medicare Current Beneficiary Survey.

Sources of Supplemental Insurance Coverage for Minnesota Medicare Beneficiaries, Metropolitan Areas and Rural Areas



Source: Minnesota Department of Health, Health Economics Program, 2001 Minnesota Health Access Survey

Who Buys Long-Term Care Insurance and HSAs?

- * Currently, LTC insurance is mostly purchased by higher-income people for asset protection
- * Although HSAs are still in their infancy, it appears that they are also most attractive to higher-income (and healthier) people
- * So, as a potential future means of saving Medical Assistance dollars the impact of LTC insurance and HSAs is likely limited – unless the population that buys these products changes



Adding LTC coverage to Medicare supplement insurance

- ★ Would likely hurt the MedSupp market without increasing LTC coverage
 - January 2000 MDH report estimated premiums for LTC insurance purchased at age 65 were 4 times the premium for the most popular Medigap policy
- ★ Questions about cost-effectiveness of subsidizing premiums for low-income people
- ★ Potential interaction with HSA policy options: HSAs **cannot** be used to pay for Medigap premiums (but can be used to pay for LTC insurance premiums)



Additional issues related to HSAs as a vehicle for saving for LTC expenses

- ★ According to a July 2004 analysis by the Employee Benefits Research Institute, the amount of money a person can potentially accumulate in an HSA is generally far less than he/she will need for health care expenses in retirement
- ★ Some examples follow...



Source: Paul Fronstin and Dallas Salisbury, "Health Care Expenses in Retirement and the Use of Health Savings Accounts," Employee Benefit Research Institute Issue Brief No. 271, July 2004

How Much Money Can Be Accumulated in an HSA for Health Care Needs in Retirement?

Account balance assuming \$1,000 annual contribution and 5% rate of return

	50% of end-of-year account balance rolled over	90% of end-of-year account balance rolled over
10 years	\$2,000	\$8,000
20 years	\$2,000	\$13,000



Source: Paul Fronstin and Dallas Salisbury, "Health Care Expenses in Retirement and the Use of Health Savings Accounts," Employee Benefit Research Institute Issue Brief No. 271, July 2004

How Much Money Can Be Accumulated in an HSA for Health Care Needs in Retirement?

Account balance assuming \$2,600 annual contribution and 5% rate of return

	50% of end-of-year account balance rolled over	90% of end-of-year account balance rolled over
10 years	\$6,000	\$21,000
20 years	\$6,000	\$33,000



Source: Paul Fronstin and Dallas Salisbury, "Health Care Expenses in Retirement and the Use of Health Savings Accounts," Employee Benefit Research Institute Issue Brief No. 271, July 2004

How Much Is Realistic to Expect Can Be Rolled Over in an HSA from Year to Year?

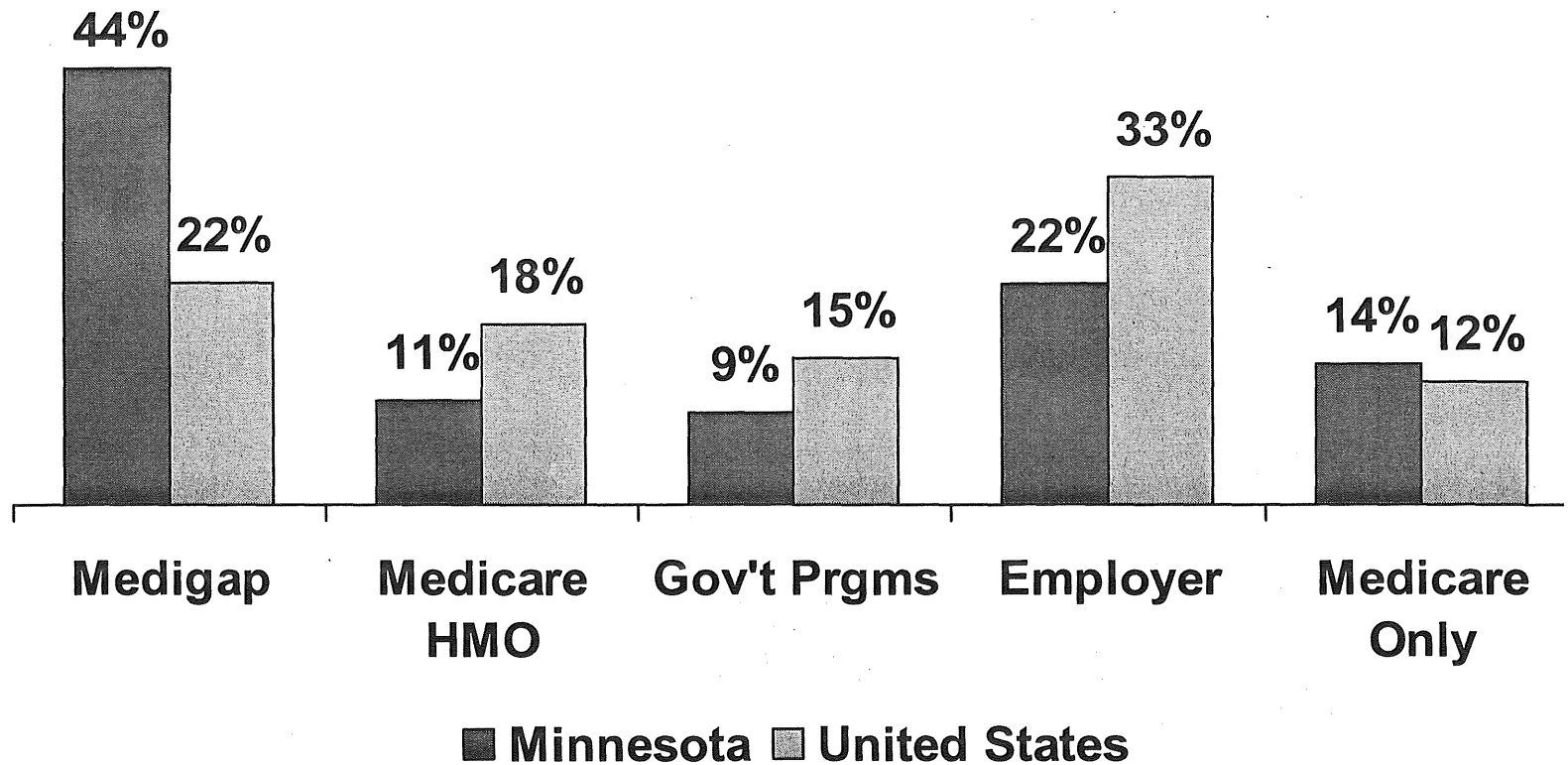
Percent of households with medical spending less than the minimum HSA deductible:

	Individual	Family
Deductible	\$1,000	\$2,000
% of households with expenses less than deductible	58.0%	32.6%



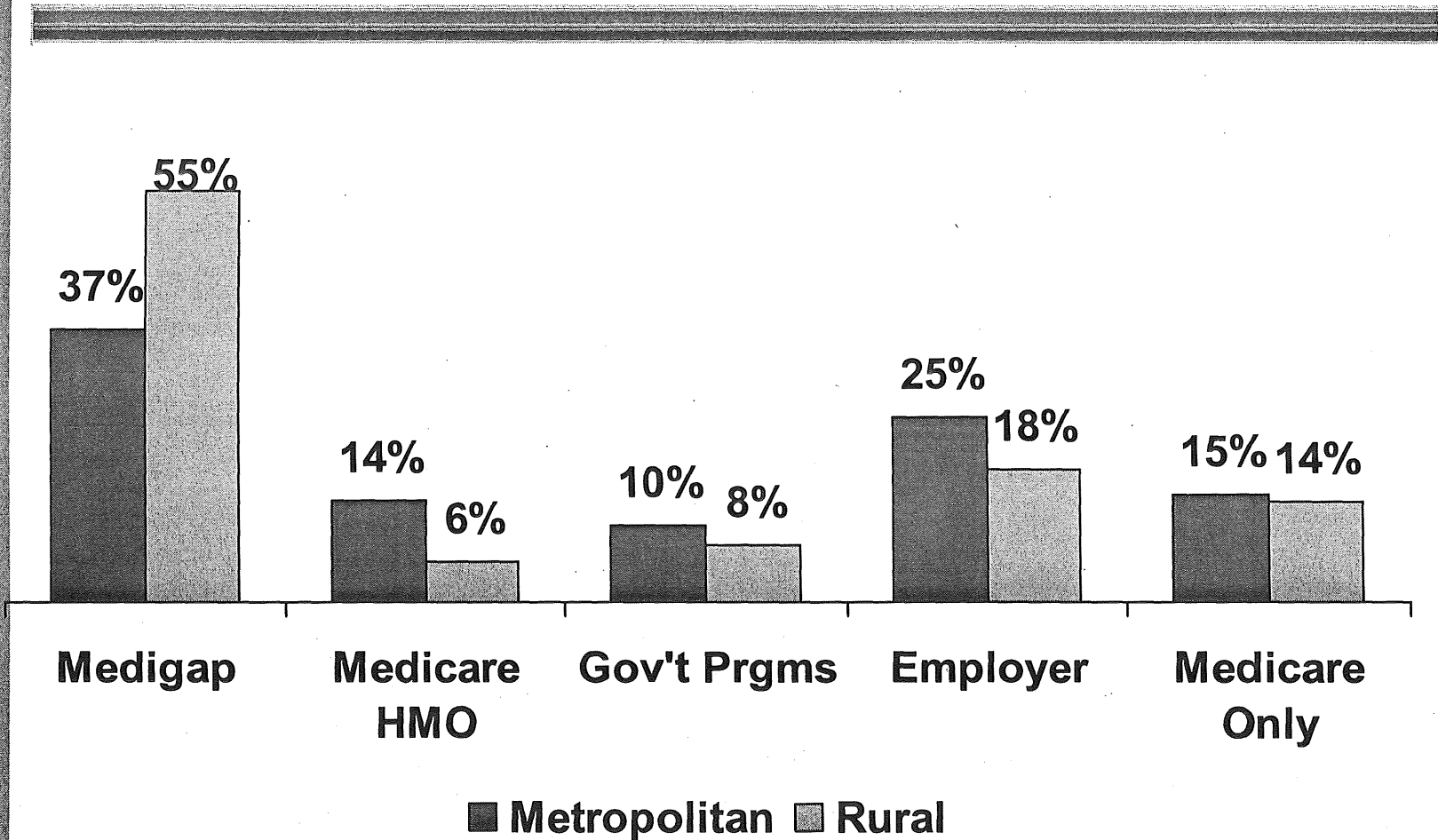
Source: Linda Blumberg and Leonard E. Burman, "Most Households' Medical Expenses Exceed HSA Deductibles," Urban Institute and Brookings Institution Tax Policy Center, August 16, 2004.

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