Scott Leitz

Issues Related to Health Care Delivery Capacity in Minnesota

Minnesota Senate
Health and Family Security Committee
November 2, 2005

Scott Leitz, Director
Office of Health Policy
MN Department of Health

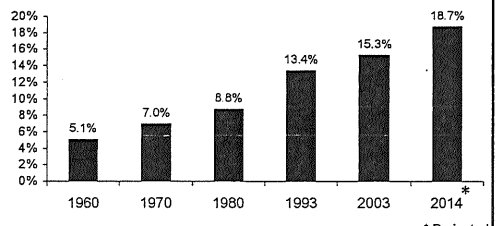
Julie Sonier, Director
Health Economics Program
MN Department of Health

Overview of Presentation

- Context and History of Health Care Capacity issues in Minnesota
  - Certificate of need
  - MinnesotaCare reforms
  - Public Interest Review
- Baseline Data on Capacity Investment and Use of Services
- Issues Related to Predicting Future Health Care System Capacity Needs

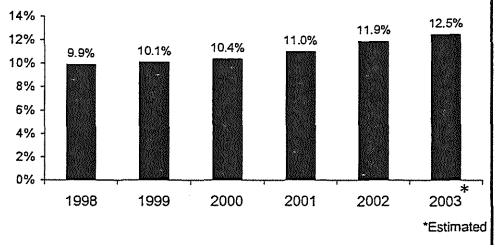
Context and a Brief History of Minnesota's Efforts to Monitor and Manage Health Care Delivery Capacity

Health Care Spending as a Portion of the U.S. Economy



Source: CMS, Office of the Actuary.

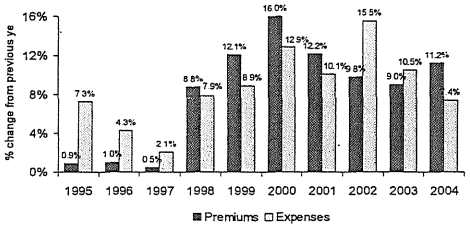
Health Care Spending as a Portion of Minnesota's Economy



Source: CMS, Office of the Actuary.

Private Health Insurance Premium and Spending Trends, 1995 to 2004

Per Minnesota Resident With Private Health Insurance



Source: MDH Health Economics Program. Fully-insured market only.

Selected Minnesota Efforts in the Regulation and Monitoring of Health Care Delivery Capacity

- Hospital Certificate of Need laws and subsequent hospital construction moratorium
- MinnesotaCare reforms and initiatives
- Hospital Public Interest Review

Hospital Certificate of Need (CON)

- Implemented in Minnesota in January, 1971
- Part of National Health Planning Act
  - Required establishment of CON laws in all states
- CON was system of review and approval of capital expenditures, construction projects, and other activities of health facilities
- Purpose:
  - Control growth and changes in the health care system in order to prevent inappropriate expansion of the system and to target limited resources to areas of greatest need

Certificate of Need in Minnesota

- 1982 legislature called for sunset of CON law by June 30, 1984
- 1984 legislature sunset CON law
  - Replaced with hospital moratorium
- Moratorium originally intended to expire in 1987 but is now permanent
- Prevents establishment of a new hospital or any other activity that increases a hospital's bed capacity, relocates beds from one location to another, or otherwise results in an increase or redistribution of beds
  - Has certain legislatively-mandated exceptions

How Does Minnesota Compare on CON?

- 37 states currently have CON laws
  - Scope of services and types of delivery settings regulated vary across states
  - Cost threshold that triggers review also varies
- Of states without CON laws (including MN), several have other types of capacity regulation
  - Moratorium on LTC facilities is common
  - Hospital moratorium in MN appears to be unique

CON Regulation by Setting and Type of Service

- Setting:
  - Inpatient hospital — 27 states
  - Surgical centers — 26 states
- Type of service (regardless of setting):
  - CT/MRI/PET scanners — 22 states
  - Long term care — 36 states
  - Cardiac services — 26 states
  - Obstetric/neonatal — 23 states
  - Mental health services — 28 states
- In some states, regulation is not just for adding new services – also applies to discontinuing specific types of services

1992 MinnesotaCare Act Preamble

- "The Legislature finds that the staggering growth in health care costs is having a devastating effect on the health and cost of living of Minnesota residents. The legislature further finds that the number of uninsured and underinsured residents is growing each year and that the cost of health coverage for our insured residents is increasing annually at a rate that far exceeds the state's overall rate of inflation."
  - Minn. Stat. 62J.015

1992 MinnesotaCare Act Preamble

* "The legislature further finds it must enact immediate and intensive cost containment measures to limit the growth of health care expenditures, reform insurance practices, and finance a plan that offer access to affordable health care for our permanent residents by capturing dollars now lost to inefficiencies in Minnesota's health care system."
  - Minn. Stat. 62J.015

MinnesotaCare Reforms

* A series of reforms passed between 1992 and 1994
* Aimed at reducing cost, increasing access and increasing quality
* Two specific reforms addressed capacity:
  - Capital expenditure reporting by providers
  - Antitrust exceptions for providers and health plans

Capital Expenditure Reporting
Minn. Stat. 62J.17

* Providers making a capital investment in excess of $1 million ($500K prior to 6/1/03) must report expenditure to MDH
* MDH conducts retrospective review of "appropriateness" of expenditure
  - Failure of retrospective review→ prospective review, with future expenditures of provider subject to prior approval by MDH
  - Does not prevent the filed expenditure from moving forward, but rather affects *future* expenditures made by the provider

Antitrust Exceptions

* Allowed MDH to sanction agreements between providers or purchasers that might otherwise be construed as violations of state or federal antitrust laws, if Commissioner determines agreement will reduce cost, improve quality or enhance access
  - Part of goal: to reduce duplication of services by allowing for cooperative and joint purchases
  - Substitution of regulation for competition
* Repealed in 1997
  - 1 exception granted for merger of the HealthOne and LifeSpan hospital systems, creating HealthSpan
  - Subsequently became part of Allina health system

Hospital Public Interest Review

- 2004 Legislature established a "public interest review process" for reviewing proposals seeking exceptions to the state's hospital bed moratorium
- Under the process, hospitals planning to seek an exception to the moratorium first submit plan to MDH for review
- MDH reviews plan and issues a finding to the Legislature as to whether plan is in the public interest, based on a series of factors
- Authority to grant or not grant exception still rests with Legislature

Hospital Public Interest Review

- First Proposals for review were for a new hospital in Maple Grove, MN
- Proposals received to Build a Hospital in Maple Grove: Received November 2004
  - North Memorial
  - Fairview
  - Allina/Park Nicollet/Children's ("Maple Grove Tri-Care Partnership")
- In accordance with the statute, MDH reviewed each plan separately and issued a separate finding for each plan

Hospital Public Interest Review

- MDH found it was in the public interest to build a hospital in Maple Grove, but not 3 hospitals
  - Population growth and aging will place increasing strains on the hospitals currently serving the existing communities
- We also recommended that the legislature should consider requiring the addition of **inpatient behavioral health services** as a condition of granting an exception to the hospital moratorium in the Maple Grove area

In Summary:

- Minnesota currently operates under a moratorium on hospital construction
- Requests for exceptions to the moratorium are guided by a hospital public interest review process administered by MDH
  - Legislature remains the ultimate decision-maker on whether to grant an exception
- Capacity investment is monitored through the capital expenditure reporting requirement under M.S. 62J.17
  - Both hospital and non-hospital

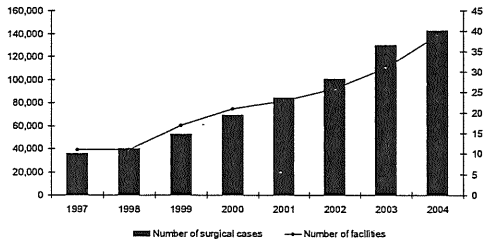
Julie Sonier

Baseline Data on Capacity Investment and Use of Services

Summary of Capital Expenditure Trends in Minnesota

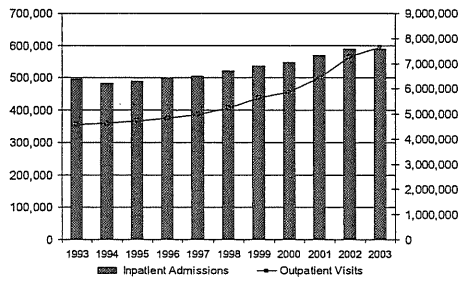
- Since the enactment of Minnesota's capital expenditure reporting law in 1992:
  - Over $4.0 billion in spending has been reported
  - Over 900 reviews have been completed
- Hospitals accounted for about 2/3 of reported capital spending
- Over ¾ of spending took place in urban areas
- Spending for imaging facilities has grown particularly rapidly over the past few years
  - Rapid change in technology
  - Growing number of uses for equipment
  - Growth in outpatient imaging centers

Freestanding Outpatient Surgical Centers



Source: Minnesota Department of Health. Data before 2000 are unaudited.

Minnesota Hospital Visits and Admissions, 1993 - 2003



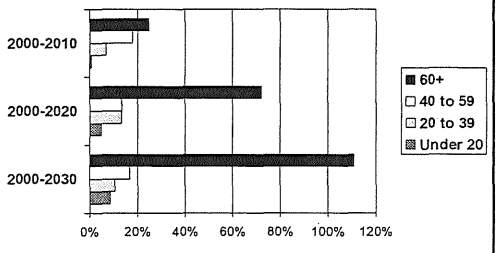
Source: MDH, Health Care Cost Information System

Predicting Future Capacity Needs

Factors Affecting Future Need for Capacity

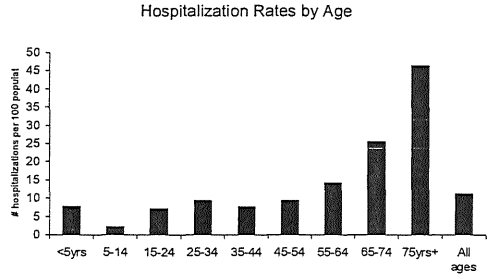
- Population growth
  - MN population expected to grow by 1 million people (20%) between 2000 and 2020
- Changing demographics (aging)
- Changes in use rates of health care services (caused by factors other than aging population)

Projected Minnesota Population Growth, by Age Group



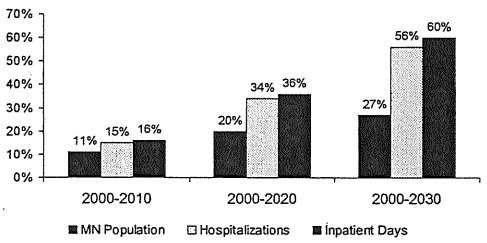
Source: Minnesota State Demographic Center

How Does Use of Health Care Services Vary by Age? Hospital Example



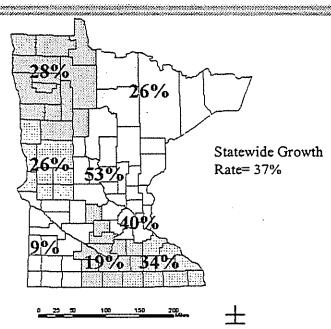
Sources: National Center for Health Statistics (2000 National Hospital Discharge Survey); U S Bureau of the Census

Projected Growth in Minnesota Hospital Utilization

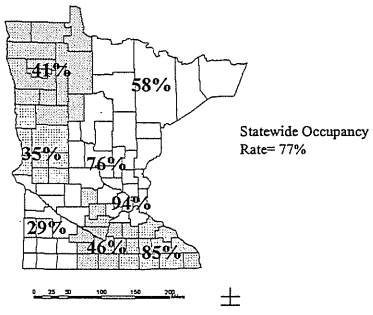


Source: Minnesota Department of Health, Health Economics Program

Projected Growth in Inpatient Days by Region, 2000 to 2020



Projected Occupancy Rates as % of 2003 Available Beds, by Region, 2020



Analysis of Need for Inpatient Services in Maple Grove

- MDH analysis conducted during public interest review of Maple Grove hospital proposals found:
  - Among 11 hospitals serving a majority of current Maple Grove area residents, occupancy rate was about 72% in 2003
  - For these same hospitals, occupancy rates are projected to rise to about 86% by 2015 if no new beds are added to the system

Summary

- 2 key components to Minnesota's approach to regulating health care delivery system capacity:
  - Moratorium on new licensed hospital beds unless authorized by the legislature
  - Retrospective review of capital expenditure projects in excess of $1 million
- Since the enactment of the retrospective review law in 1992, reported capital expenditures total about $4 billion

Summary, continued

- Questions about whether and how to regulate investment in medical facilities are likely to pose a continuing challenge for Minnesota
- Technological advance will continue
  - Most economists agree that technological advance is responsible for over half of increases in health care spending
  - Technological advance also generally results in improved health
- Population growth and aging will also likely contribute to rising demand

MEDIA RELEASE

Contact: Bob DeBoer 651-293-0575, extension 13 *November 2, 2005*

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Citizens League Begins Study on Medical Facilities

The Citizens League has appointed the members of the Medical Facilities Study Committee, which held its first meeting on Thursday, October 27. The committee will produce recommendations on a process for Minnesota to site major medical facilities in the future and will frame issues for possible future study.

The Medical Facilities Study Committee is charged with determining the following:

- How effectively are we able to determine health care service and facility needs throughout Minnesota?
- How do financial incentives affect investment in facilities and what is the impact on clinics and hospitals?
- What should the process be that links health care demand with facility need in an attempt to provide the most cost-effective health care system for Minnesota?

Co-chairs for the committee are Duane Benson, former head of the Minnesota Business Partnership and state senator from Lanesboro, and Peter Gove, a retired St. Jude Medical executive.

"Close to 40 lobbyists were engaged in efforts to persuade legislators to choose who will build a hospital in Maple Grove during the 2005 Legislature," said Benson. "This points to a problem with the process."

"Because there has been a legislative moratorium on new hospital beds since the 1980s, the Legislature is forced to focus on specific hospital proposals when they have to decide whether there should be an exception to the moratorium," said Gove. "The Citizens League wants to take a more comprehensive view and look more closely at the long-term role of medical facilities throughout Minnesota in terms of affordability, access and quality health outcomes."

"There was extraordinary interest in this study committee and I am impressed by the talented people who are willing to put forth an effort to find common ground in a difficult area of public policy," said Citizens League Board Chair Keith Halleland.

In addition to the co-chairs, there are 24 members of the Citizens League Medical Facilities Study Committee. For more information, visit www.citizensleague.net.

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555 N. Wabasha St., Suite 240
St. Paul, MN 55102
Phone: (651) 293-0575
Fax: (651) 293-0576
Email: info@citizensleague.net
Web: www.citizensleague.net

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Charge to the Medical Facilities Study Committee

Minnesotans care about good health, but are also concerned about rising health care costs. There is no process that provides basic criteria to help Minnesotans determine when a new or expanded medical facility is necessary to provide access to acceptable levels of health care and to keep the cost of health care as affordable as possible. In the case of our highest cost facilities – hospitals – the state does have the responsibility to conduct a public interest review, but there is no authority that extends directly from that review, nor is there consideration of hospital expansion in relation to the availability of other medical facilities that provide medical services on an outpatient basis. The result is an ad-hoc process that relies on legislative approval and does not account for the overall needs and relative costs of our health care system.

The Study Committee on Medical Facility Expansion is charged to determine the following:

- How effectively are we able to determine health care service and facility needs throughout Minnesota?
- How do financial incentives affect investment in facilities and what is the impact on clinics and hospitals?
- What should the process be that links health care demand with facility need in an attempt to provide the most cost-effective health care system for Minnesota?

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CITIZENS LEAGUE MEDICAL FACILITIES STUDY COMMITTEE		
Committee Co-chairs		
Duane	Benson	Executive Director, Minnesota Early Learning Foundation. Executive Director of the Minnesota Business Partnership from 1994 to 2003. State Senator from Lanesboro from 1980 to 1994. Selected as Senate Minority Leader three times.
Peter	Gove	Recently retired as an executive and officer of St. Jude Medical, the second largest medical technology company headquartered in Minnesota. His work at SJM focused on the public policy environment facing the medical technology industry including regulatory, reimbursement and market access challenges and opportunities. He worked for St. Jude Medical and Control Data Corp for 25 years. Prior to his business career, Peter spent a decade in state and federal government, including Executive Director of the MN Pollution Control Agency and Legislative Director for U.S. Senator Wendell R. Anderson. He served one term on the Citizens League Board of Directors and is a long-time member of the League.
Committee Participants		
Allan	Baumgarten	Self-employed analyst/consultant on health market trends and issues. Author/publisher of annual reports on markets in Minnesota and 8 other states.
Deb	Boardman	Secretary/Treasurer of the Minnesota Hospital Association, CEO of Riverview Health Association, Crookston.
Carrie	Coleman	Previously was Deputy Director, Texas Association of Health Plans; Medicaid specialist in Texas Senate; Senior Legislative Asst. to U.S. Rep. Ron Coleman; served on the White House Task Force on Health Reform; has expertise in health financing for the poor and working poor.
Gary	Cunningham	Director of Primary Care Department, Hennepin County NorthPoint Health & Wellness Center. Citizens League Board of Directors. Co-chair of the Citizens League Mental Health Action Group
Kathleen	Doran-Norton	President of the League of Women Voters in Northfield and Cannon Falls. Previously employed as a research analyst at the center for Government Research in Rochester, NY - included review of new psycho-geriatric unit. Masters degree in rehabilitation counseling. Internships at Rusk Rehabilitation (brain and spinal cord injury treatment), and Osawatomie State Hospital (mental hospital).
Candace	Dow	Currently working in affordable housing development. Previously has worked or consulted with health service purchasers, providers, regulators, and educators primarily in employee health benefits, market research, organizational strategic planning, and new product development. Clients and employers included Honeywell, Medtronic, Mpls. Public Schools, MN Dept. of Health, UMN Hospitals and Clinics.
Linda	Ewen	Member of the Citizens League Policy Advisory Committee, Anoka County employee involved with administration of the Medicaid program.
Tony	Jaspers	M.D., Multi-specialty group member of Mankato Clinic, Minnesota Medical Association.
Eric	Joranson	Law student at Hamline University; Editor-in-Chief of Hamline's law journal - the Journal of Public Law and Policy. Member of MSBA Health Law Section and enrolled in a Medical Malpractice Course. Previously a law clerk at Health Law Firm of Geraghty, O'Laughlin & Kenney with duties including extensive legal research and writing in medical malpractice law and general health law issues.
Sister Mary	Ashton	Minnesota health commissioner in the 1980s.

Lawrence	Massa	Current Chair of the Minnesota Hospital Association, Chief Executive Officer of Rice Memorial Hospital, in Willmar, Minnesota, since 1994.
Michael	Morrow	Senior Vice President of Business Development and Network Management for Blue Cross and Blue Shield of Minnesota; CEO, Blue Plus
Ed	Oliver	Currently a health insurance agent; was a Minnesota State Senator from 1993-2003 and served on the Health and Human Services Committee.
Christine	Rice	Currently a community volunteer working on health care issues. Member of the Epilepsy Foundation Board. Former deputy commissioner of the Minnesota Department of Health.
Doug	Robinson	Small business owner; formerly a senior executive with the Fairview Health System, Healthcare Management Consultant, United Health Group Division Executive.
Rochelle Schultz	Spinarski	Conducts rural health research, community health needs assessments, and assists rural health agencies with program strategic planning and development projects throughout the country. Serves national agencies in research and policy making capacity, Works across continuum of care as well as on helath workforce issues, though half of work is focused towards Critical Access Hospitals in small and rural areas.
Carolyn	Smallwood	Currently Executive Director for Way To Grow. Previously was Vice President for Sales and Marketing for Twin Cities Rise! She previously served as Executive Director of Minnesota Minority Supplier Development Council. Prior to entering the nonprofit field, Carolyn held a variety of senior executive positions with ADC, The Broadband Company, and US Bancorp.
Harry	Sutton	Recently retired from his position as a Senior Advisor for Reden & Anders, Ltd., having over 50 years of experience as an actuary and consultant. Was president of the Planning Agency for Hospitals of Metropolitan Minneapolis in the 1950s, which later merged with a similar agency in St. Paul. Has worked locally, as well as on a state and federal level, with HMOs and was active with MN Coalition on Health and the State Medical Society.
Tom	Swain	Former executive vice president of the St. Paul Companies, retired in 1986. President of the State Fund Mutual Insurance Company in 1992. University of Minnesota's acting vice president for Institutional Relations (1996-98). Chair of the Minnesota Health Care Commission, from its inception in 1992 through 1995. Swain also has served as director of the Courage Center and director of Select Care and as president of the Citizens League and of the University of Minnesota Alumni Association. Chief Advisor to Gov. Elmer L. Andersen.
Joseph	Tashjian	M.D., President, St. Paul Radiology, Staff Radiologist and Clinical Assistant Professor at the University of Minnesota Hospital's Department of Radiology. Executive Committee Member of the Minnesota Radiologic Society. Minnesota Medical Association.
Blair	Tremere	Currently at Met Council in general land use planning, locally and regionally. Previously was Committee Adminstrator at the MN House Tax Committee for Rep. Ron Abrams; former mayor of Golden Valley.
John	Tschida	Vice President of Public Affairs & Research at Courage Center. Previously held editor position at the non-partisan MN House Information Office.
Jonathan	Weiss	Quality Outcomes Manager at a treatment foster care organization. Previously worked as an analyst at the Office of Government Accountability (GAO) in Washington D.C.
Ron	White	Senior Vice President of HealthStaff Alternatives, LLC, and Board member of Children's Hospitals and Clinics. Previously employed at MMI Companies and Fortis in healthcare risk management; at UnitedHealth Care as Regional Vice President in its Small Business Group (SBG) division, and then in its Corporate Marketing & Business Development group.

MN JOURNAL

A Public Policy Monthly from the Citizens League

Citizens League
Common ground. Common good.

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Minnesota's Anniversary Project

by Tom Horner

A Minnesota Poll taken during the 2004 presidential election found that 58 percent of those surveyed agreed that "so many people have taken extreme positions these days that it's hard to talk with anyone about politics unless you know they are likely to agree with you."

If nearly six out of 10 Minnesotans aren't talking [illegible]s with one another, it shouldn't be a surprise [illegible]we are represented by a deeply divided Legislature —and that this year we endured the second longest special legislative session and the first government shutdown in Minnesota's history.

Celebrate Minnesota's 150th anniversary with a bold new plan for the future: a vision for Minnesota defined by Minnesotans

What's the most significant challenge facing the next generation of Minnesotans? We asked five community leaders from around the state to share their answers. Turn to page 5 to find out what they had to say.

[illegible]ut is Minnesota as deeply divided as election results and political pundits would make us out to be? Or are we a state in which special interests and the extreme fringe of both major parties drive wedges, even as most of the state prefers building bridges?

The challenge of finding consensus is becoming increasingly urgent. Minnesota faces difficult choices in just about every area of our civic, economic and cultural lives. These choices go to the very heart of the kind of state Minnesotans want.

Unfortunately, in today's political environment, there is little incentive for politicians or for those representing special interests to build consensus. Redistricting creates non-competitive safe districts in which like-minded people elect and reward policy makers who share their views ... and only their views. At the same time, there is an erosion of forums devoted to objective news and common ground. Between February 2004 and February 2005, audiences for the 9 p.m. and 10 p.m. television news broadcasts declined 13 percent in a key segment (viewers between ages 25 and 54), to cite just one example.

Many viewers haven't abandoned politics or policy. But instead of getting their information from mass media, they go to the social forums on the Internet where blogs, wikis and the like join people who share political outlooks. Instead of understanding different views, more and more of us seek reinforcement of our own political ideologies, in part because we don't think we can get an objective viewpoint.

The Citizens League is embarking on a multi-year initiative to change this environment by facilitating a vision for Minnesota that is defined by Minnesotans. The goal is to engage the state's citizens in creating a sesquicentennial anniversary agenda: plans for action on a handful of critical issues that could be announced by May 2006, with the first steps accomplished by May 11, 2008, the 150th anniversary of Minnesota's statehood.

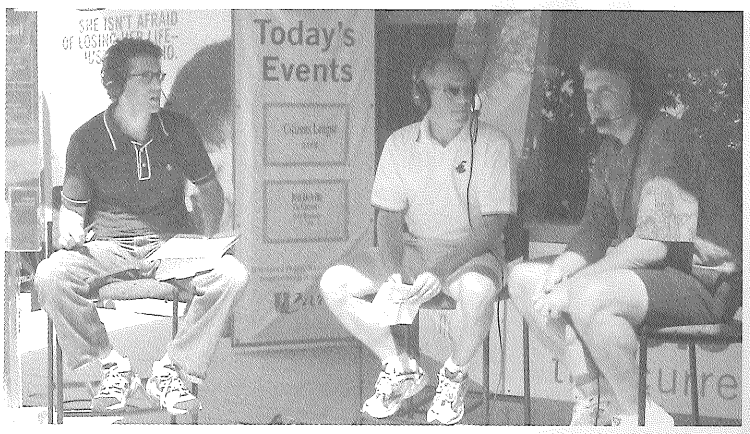
The plan calls for creating both short-term and long-term objectives. Re-engaging Minnesotans in the public process requires immediate successes. People need validation and they need to know that their voices and involvement make a difference. But we must also face the reality that many of the state's most difficult challenges have been years in the making and will require years for solutions to take effect. Therefore, the agenda must also include plans that look out a decade or more.

continued on page 4

INSIDE

CONNECTIONS

Building a League of Citizens



Citizens League President Sean Kershaw, Senator Geoff Michel (R-Edina) and Representative Joe Atkins (DFL-Inver Grove Heights) talk about the future of Minnesota politics at the Citizens League show at the Minnesota Public Radio booth at the Minnesota State Fair.

Upcoming projects

The Citizens League Study Committee on Medical Facilities will begin meeting in mid-October. Look for updates from the committee at www.citizensleague.net.

This fall, the Citizens League will also kick off a new research study on education and immigration. This is not a traditional study committee. Rather than trying to find policy solutions to an as-yet-undefined problem, we are going to instead focus on framing the key questions surrounding the education of immigrant students and finding the answers to those questions. Citizens League staff will be supported by a working group of citizens and experts in education and immigration. Look for updates on this project at www.citizensleague.net.

Policy and a Pint:

Co-presented by the Citizens League, 89.3 The Current and The Onion: Emergency Preparedness with United Way Twin Cities CEO Lauren Segal. Monday, October 24, 6 p.m. The Varsity Theater, Minneapolis. For more information: www.citizensleague.net

Leadership and the Fiscal Future of the United States.

Monday, October 17, 9 a.m.
Humphrey Institute, University of Minnesota West Bank Campus.
For more information: www.hhh.umn.edu/centers/policy-forum

How to get involved this month

Join the Facts Unfiltered Working Group! We're looking for a few good citizens willing to dig deep into policy research. The new Facts Unfiltered Working Group has two main tasks: to produce a monthly column—filled with unfiltered, unadulterated, unbiased facts about a policy issue—for the *Minnesota Journal* (turn to page 9 for the first installment); and to help Citizens League study committees gather the information they need to start making policy recommendations. For more information, or to join the working group, call or e-mail Victoria Ford: vford@citizensleague.net or 651-293-0575, ext. 17.

www.localevent.net

Community Connections Calendar: The one-stop shop for public affairs programming in the Twin Cities.

Correction

In the print version of the August-September issue of the Minnesota Journal, a handful of communities in Table 1 had rankings for 2005 Effective Tax Rate that are slightly incorrect (usually by one place or so). View the correct rankings online at www.citizensleague.net.

List of new members, don and recruiters

Individuals and Families
Stephanie Andrews and James Schowalter
Anita Segador Beaton
Michael Bischoff
Jon and Laura Bloomberg
Carrie Coleman
James and Celeste Gibson
Norman Glewwe
Jim Goff
Jim Hart
Jim Hunter and Michele Lewis
Carla Johnson
Steve Lepinski
Sarah Lutman
Edward Rapp
Gary and Susan Rappaport
Ann Seha
Richard and Stephanie Soskin
Scott Thiss
Claire Thoen-Levin
Kathleen Y.A. Whitley
Jeff Widseth
John Zimmerman

Firms and Organizations
Academic Health Center Communications
Cold Spring Granite
Designs for Learning
Education Minnesota
Idealogics
Insurance Federation of Minnesota
The James Ford Bell Foundation
Joint Religious Legislative Coalition
Larson, Allen, Weishair & Co. LLP
Northside Residents Redevelopment Council, Inc.

Sponsorships
Comcast
HealthPartners

Matching gifts
Fannie Mae Foundation
Xcel Energy Foundation

Recruiters
Emmett Coleman
Bob DeBoer
Stan Donnelly
Kent Eklund
Dave Hutcheson
Sean Kershaw
Kathryn Kmit
Aaron and Nena Street

VIEWPOINT

Voices In My Head

Renewing a hall for rational discussion

Rebuilding and redesigning the Minnesota Journal

by Sean Kershaw

Who knew that Steve Martin could have so much to say about public policy writing?

I'm not ashamed to admit that one of my favorite movie quotes is Martin's exasperated appeal to John Candy in *"Planes, Trains and Automobiles,"* when he says, "you know... you know when you're telling these little stories? Here's a good idea: have a point! It makes it so much more interesting for the listener."

Welcome to the redesigned *Minnesota Journal,* one of our new efforts to bring renewed purpose and clarity—a point!—to the work of the Citizens League.

Who knew the Citizens League's founders could have predicted one of our current needs?

The very first Citizens League *News-Bulletin* in 1952 stated: "Americans brag with justification about our democratic system. But the democratic system isn't worth talking about unless alert citizens make themselves effective in the affairs of the community. [illegible]lert citizen is a fellow with decent instincts *plus facts.*" [illegible]cts, presented without demagoguery and within a democratic set of values and "instincts," are potentially an antidote to the poisonous politics around us today, and the foundation of better policy solutions tomorrow. As former Citizens League Executive Director Ted Kolderie has said, we need "a way to see problems well ahead of us when they are not necessarily problems."

Who better to describe the purpose of this Journal than its founder?

Describing his reasons for starting the *Minnesota Journal* in 1983, editor Stephen Alnes said he hoped it would be a "conscious mix of newsletter and newspaper, of fact and opinion, of journalism and academe. The intent is to provide a hall for rational discussion of state and local public policy issues in Minnesota."

Steve was ahead of his time. Minnesota needs this common ground now more than ever.

A renewed purpose

Earlier this year more than 200 of you responded to a survey about the *Minnesota Journal* and told us that you wanted more objective analysis of current issues, more information on innovative policy [illegible]atives elsewhere, and more of the perspectives and opinions [illegible]sually go unheard in policy conversations.

[illegible]e heard you.

Our goal with the *Minnesota Journal* is to strengthen the relevance of the Citizens League by illuminating critical public policy choices, incubating new voices in public policy, and innovating public policy solutions.

Illuminating choices

Public policy "issues" are really just strategy options and choices framed around a public problem. The better you understand these choices, the better you understand the issue.

Our cover stories and features will offer clear and concise explanations of the pressing public policy choices that will shape Minnesota's future economic success and quality of life. We need a better debate to get better solutions.

We'll also make sure you have the facts in this debate. In each issue, our *Facts Unfiltered* section will highlight the critical facts on an important public policy issue.

Incubating new voices

Minnesota must consciously cultivate its next generation of civic leaders—new voices who can offer new solutions that really work, and new leadership that can really get the work done.

Our new *Perspectives* column will bring new and emerging leaders, as well as insight from throughout Minnesota, to the policy discussion.

Innovating policy solutions

We're at a turning point when traditional public policy solutions seldom work. Public policy needs to be about more than turning off/on the supply of public resources into existing policy solutions and public programs. We need new ideas, new ways of framing issues, and new opportunities that engage citizens in every institution.

Our refocused *Take Note* section will spotlight innovative ideas and policy solutions from within Minnesota and from around the world.

Building connections

And finally, nothing gets accomplished without a strong base of support—a "league of citizens." We know that our members and readers are busier than ever. Our new *Connections* section will help you stay involved in the Citizens League and connected to each other.

But more importantly, we know that citizenship isn't a spectator sport. We hope you will help us build this new *Minnesota Journal* by submitting essays, joining the new Facts Unfiltered work team, recruiting new authors, commenting on what you read here on our new and more interactive web site, and using the *Journal* to recruit in new members.

Our point: to change the civic and policy landscape in Minnesota!

Sean Kershaw is President of the Citizens League. He can be reached at skershaw@citizensleague.net or 651-293-0575x14.

Minnesota's Anniversary Project

continued from page 1

Minnesota's 150th Anniversary Project—or MAP 150—will have several components:

- People from a broad philosophical spectrum are taking the first cut at issues and solutions for the public to consider. Participants at this level of the project are people from public policy and nonprofit sectors, advocacy groups, education, business and other sectors. Their role is to narrow the scope of issues and solutions for the public to consider.
- The ideas emerging from these first panels will be put before the public for affirmation or rejection. Through forums and research, Minnesotans from all walks of life will be able to refine and narrow the proposed list of issues and solutions to include in MAP 150.
- Opinion gains power through discussion and agreement. Our hope (if funding permits) is to engage Minnesotans in innovative new ways, including an electronic town hall meeting, a real-time discussion of what is important to us as a state and the actions we should take. This discussion—and the ones that follow it throughout the MAP 150 initiative—will be informed by the facts that are critical to understanding and evaluating each issue. This effort builds on the Citizens League's successful Facts Unfiltered project last year. As the late Sen. Daniel Patrick Moynihan said, "Everyone is entitled to their own opinion, but not their own facts."

The hope is to identify the issues and solutions where there is consensus and urgency—where Minnesotans agree on the substance and the need for quick, yet thoughtful action. The agenda that emerges may well be a mixed bag of issues and solutions, not all of which call for government action. Minnesota's past suggests that when citizens start talking, government is only part of the answer. Recommendations could include steps that families, businesses, schools, the faith community or other institutions could take to make Minnesota a better state.

Shaping the agenda will begin by asking people to see choices within existing private and public resources. This isn't to pick sides in the "no new taxes" debate, but to encourage people to grapple with setting priorities.

Creating the agenda is only the first step in MAP 150. If the goal is to achieve the first steps of the agenda by May 11, 2008, then the issues and solutions proposed as part of MAP 150 need to become part of Minnesota's political discussion during next year's election campaigns and beyo[redacted]

In the long run, the greatest meas[redacted] of MAP 150's success may not be whether any individual agenda item is implemented, but whether the Minnesota Poll taken during our state's sesquicentennial shows that as a state we once again are willing and able to talk politics and public policy.

Much of MAP 150 will depend on funding. This is perhaps the most ambitious initiative the Citizens League has ever undertaken. If successful, we hope to engage other organizations in creating the agenda, announce it by May 2006 and pursue solutions that can be implemented by May 2008, Minnesota's sesquicentennial.

Information on this initiative and on opportunities to participate will be available on the Citizens League web site at www.citizensleague.net. ●

Tom Horner is Vice Chair of the Citizens League [redacted] of Directors and is President of Himle Horner I[redacted] a Minnesota public relations and public affairs [redacted]

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION Required by 39 U.S.C. 3685

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Extent and Nature of Circulation	Average No. Copies Each Issue During Preceding 12 Months	Single Issue Nearest to Filing Date
A. Total number of copies (net press run)	1800	1800
B. Paid and/or requested circulation		
1. Paid/requested outside-county mail subscriptions stated on form 3541	732	742
2. Paid in-county subscriptions	868	837
3. Sales through dealers and carriers, street vendors and counter sales	0	0
4. Other classes mailed through USPS	0	0
C. Total paid an/or requested circulation	1600	1579
D. Free distribution by mail		
1. Outside—county as stated on form 3541	60	60
2. In-county as stated on form 3541	40	40
3. Other classes mailed through the USPS	0	0
E. Free distribution outside the mail	0	0
F. Total free distribution	100	100
G. Total distribution	1700	1679
H. Copies not distributed	100	121
I. Total	1800	1800
Percent paid and/or requested circulation	94.12	94.04

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties). Signed, Sean Kershaw, publisher. September 23, 2005

We asked five Minnesota leaders with varying experiences and perspectives to answer one of the core questions of the Minnesota Anniversary Project: What is the most significant challenge facing the next generation of Minnesotans? Their responses—surprising, insightful, and essential—follow on the next few pages.

The interplay of crime, drugs and race

by Mitchell B. Pearlstein, Ph.D.

Given our aging population and the propensity of medical costs to defy laws of gravity, it would be easy to cite questions of health as the biggest challenge festering for a next generation of Minnesotans. It probably would be on-target, too, if for no other reason than health care is probably our biggest policy problem [illegible]ly. Yet while an adequate solution is not yet on the table, I [illegible] little doubt our cost troubles will be brought under some control, one way or another. My free market preference is to rely mostly on consumer choice and competition. But whatever steps are finally taken, rest assured they will be taken, somehow. They may not be healthy or wise steps, but the simple fact is the United States is unlikely ever to be wealthy enough to allow health costs to consume much more than the approximately 15 percent of GNP they currently do. Reality has a retaining wall out there somewhere, made of brick, and we'll hit it eventually.

There's another problem, though, for which I have a hard time even imagining sufficient improvement anytime soon: The malignant interplay of crime, drugs, educational failure, and the near death of marriage as an institution in some communities, all made even tougher by historically suffused issues of [illegible]. Just three quick sets of statistics to spotlight the sadness and [illegible]ies:

According to the African American Men Project, 44 percent of all African American men between the ages of 18 and 30 in Hennepin County were arrested in 1999. There's little reason to believe things have changed much since 1999.

As of the year 2000, only 23 percent of young black men in Minneapolis were graduating high school in four years.

And according to a recent study by the Minneapolis-based Council on Crime and Justice, approximately 10 million children in the United States have had a parent in prison sometime in their lives. Think of the dreadful damage this does to boys and girls.

For bad measure, disparities between blacks and whites in Minnesota in a range of areas, including educational performance and prison rates, are consistently among the most severe in the nation.

Disparities between blacks and whites in Minnesota in a range of areas, including educational performance and prison rates, are consistently among the most severe in the nation.

None of this should cloud the fact that a strong majority of African Americans in the United States, along with other minorities, are doing well in middle-class ways. Neither do I mean to imply by these horrible numbers that present-day racism is their main cause. Other factors—starting with the explosive dispersal of fathers in almost all communities over the last two generations—are profoundly more important.

Health care problems may be extraordinarily difficult to fix, but at least they're fundamentally problems of policy, meaning that presidents, governors, and legislators have a fighting chance of passing and implementing apt and useful laws. Problems resulting from young people routinely dropping out of school, joining gangs, committing crimes, and bringing babies into this world out of wedlock are far less amenable to the reach of public officials, as they are mostly cultural and spiritual at root. Or more to the point, unless things change deeply in hearts and souls, I'm afraid little will improve. (For people skeptical or uncomfortable with this kind of religiously flavored talk, they can conceive of what's called for as a "social" movement, akin to those which have succeeded over the last half-century on behalf of civil rights, women's rights, the environment, and the marginalization of smoking.)

Mitchell B. Pearlstein, Ph.D. is the Founder and President Emeritus of the Center of the American Experiment.

Remake our education system

by David Dayhoff

Remaking our education system—particularly K-12—is the most important policy challenge facing the next generation of Minnesotans. Of course education is important everywhere, but I think even more so here. Many elements of the "good life" in Minnesota depend directly or indirectly upon the success of our education system. At the same time, many Minnesotans are proud of our schools and want—or even feel we have a responsibility—to be a national or even international education leader. It is an especially appropriate aspiration because education is an area over which states (as opposed to municipal, national or international bodies) have the most influence, and I believe most Minnesotans are committed enough to come together to do something about it.

I also believe, however, that we dare not think of ourselves as leaders today, regardless of the condition of our education system relative to anywhere else. To the contrary, we should feel a crushing sense of urgency to overhaul our underperforming system immediately. Every day, the importance of education to our society grows, while our system's performance becomes more inadequate. Appallingly, significant segments of our student population not only fail to get an education that equips them well for the future, they fail to acquire even basic skills. Those who do go beyond the basics still get an education that falls short of what I believe ought to be an ideal in this age of technological splendor and exploding human knowledge.

We should feel a crushing sense of urgency to overhaul our underperforming [educational] system immediately. Every day, the importance of education to our society grows, while our system's performance becomes more inadequate.

Another reason education reform is the top policy challenge is that it must involve not just changing the schools, but also their relationships with families. Obviously, many of the causes of poor educational results lie outside the structure of the school system itself; a serious modernization project will by necessity consider those factors, too, and in so doing, the education reform effort will have broad policy impact.

It is so pressing that we revolutionize the system today because it will take years to see our innovations bear fruit. The next generation of Minnesotans is taking shape now, and its productivity, creativity and character will influence all of the other policy challenges we face.

The alarming tone in my words belies my optimism. I believe we can pull it off. Organizations like the Citizens League can help overcome the trench digging that is inevitable as we modernize the system. ●

David Dayhoff is a manager at Cargill, Inc. He resides in Minneapolis with his wife Aimée and infant son Wyatt.

Restore Minnesotans' civic pride and sense of citizenship

by Brian Rusche

When I moved to Minnesota in 1977, I observed a deep well of civic pride amongst Minnesotans. People understood that Minnesota was special and had a unique role in the Upper Midwest, and in the nation. Much was made of Minnesota leading other states in making smart policy choices. This sense of Minnesota exceptionalism must be resurrected: we should endeavor to build a healthy and prosperous state that again leads the nation by example.

To do so, we need to focus on our identity as citizens. Minnesotans are largely people of faith; we are third in the country in terms of the number of people with congregational affiliations. At least nominally, this suggests that Minnesotans connect with the idea of community. In most faith communities there is rich teaching and tradition to secure the well-being of our neighbors. We have an opportunity to take this sense of faithfulness and reattach it to a civic purpose and a common agenda.

To build a strong civic society, all institutions must reward citizenship, teach civic standards, and support civic work.

How do we get there? First, Minnesotans need to begin thinking of themselves not just as consumers of government services, but as citizens. The key difference between the identity of a consumer and a citizen is that citizens take on the responsibility of governance. One of our biggest initial challenges will be to examine and reconsider how institutions reward and encourage citizenship. The institutions in which we live our lives—our congregations, workplaces, neighborhood associations, and civic groups—have a tremendous impact on our perspectives. All institutions should "teach" citizenship, give us opportunities to govern our lives, and reinforce a sense of responsibility to community. Somehow we've come to expect that people just intuit what obligations and practices go along

Leadership that stands with courage

by Stephanie Autumn

"It is moral courage that determines the standard of leadership in the practical arenas of politics, business, academics and the community" – *Mohandas Karamchand Gandhi*

As Minnesota and its citizens move towards celebrating the 150th anniversary of the state, it is of the utmost importance that we take the time to pursue philosophical and political thought for the huge political challenges that are on our horizon.

American Indians are governed by a variety of complex laws throughout their lifetime, i.e.; treaty laws, county laws, state laws, federal laws, international laws, and most importantly *natural and spiritual laws.* The natural and spiritual laws that exist within our own sovereign nations, communities, and family circles are the center post of our daily existence. Our natural and spiritual laws dictate a responsibility to our community, its people and our families first, and the needs of a single individual second.

American Indian traditional, spiritual, and elected leaders are expected to uphold a higher standard of leadership that promotes respect, justice, and social-economic venues that nurture and protect the health and well-being of people and the environment. This higher standard of leadership, in application, dictates a lifetime commitment to being "clear and present" to the needs of the people—and to always stand with courage to protect the people in the face of any harm.

Minnesota needs to chart a course of courage: to expect and demand a higher standard of leadership—leadership that is guided by values that reflect compassion, courage, and respect for people of all colors.

Have American Indian communities and nations struggled to find leaders of such caliber and integrity? The answer is a resounding "yes!" But American Indian communities in Minnesota and their tribal governments are challenging themselves to create political atmospheres, agendas, and leadership standards that will result in violence reduction, elimination of drug and alcohol abuse, increased economic opportunities, revitalization of culture and language, protection of the environment, and quality educational, health, and judicial agencies within their communities.

Can American Indian communities be successful without the support of Minnesota's political leaders and its citizens? The answer is "no!" Our future depends on all Minnesotans asking for a higher standard of leadership from its elected officials. Minnesota needs leaders who will adhere to ethics and values that will guide them to chart a course of public policy that benefits and protects all of Minnesota's ethnic and cultural populations. Minnesota needs political leaders to chart a course of public policy that reflects equal concern for the state's rural and reservation communities as it does its urban communities. Minnesota needs political leaders to chart a course that says that quality of life is of more value than the profit and loss statements of corporate business. Minnesota needs political leaders to chart a course that demands and increases fair and affordable housing and dispels the myth that more prisons means safer communities.

Most importantly, each and every one of us in the state of Minnesota needs to chart a course of courage: to expect and demand a higher standard of leadership—leadership that is guided by values that reflect compassion, courage, and respect for people of all colors. As we celebrate Minnesota's 150th anniversary let us work together to create new political agendas, strategies, and policies that will nurture and sustain our children, communities, and the land on which we live for the next seven generations.

Stephanie Autumn is a member of the Hopi Nation, mother, grandmother, American Indian activist and staff member for the Center for Reducing Rural Violence.

with citizenship. This is wrong. Each generation must pass on to the next what we've learned about citizenship and democracy. We should emulate the zeal of newly arrived Americans to learn and practice citizenship. But the key point is not to look at civic work as "government's job" or "schools should teach it." To build a strong civic society, all institutions must reward citizenship, teach civic standards, and support civic work. Minnesota, more than most places, has a predisposition to being a civic-minded place.

A word of warning. I think our democracy is in trouble. The level of cynicism among people—in Minnesota and around the country—is toxic. Citizens need to know that they really can, and must, govern. One of the biggest barriers to this is the influence of big money in our elections. Many people don't think they matter because they don't have the money to buy influence. We need to cast out the money changers and once again lead the reforms toward fair and clean elections. Several other states are way ahead of us in bringing sanity and real competitiveness to their elections. This is a linchpin issue dealing with the mechanics of democracy, but we need a larger change to see the civic role of every institution, too.

Brian Rusche is Executive Director of the Joint Religious Legislative Coalition, an interfaith public policy organization sponsored by the Minnesota Catholic Conference, the Minnesota Council of Churches, the Jewish Community Relations Council, and the Islamic Center of Minnesota.

Reduce pregnancy rates for teens of color

by Carol McGee Johnson

Growing up African American in Minnesota *in the '50s,* I believed Minnesota was different, special. I thought people of color in Minnesota were far better off than people of color in other states. Imagine my surprise to learn otherwise in *my fifties.*

One disparity brings this home to me in striking ways.

Minnesota teens of color experience some of the highest teen pregnancy rates in America, particularly among Hispanic, African American and American Indian teens, two to five times higher than white teens. Research also tells us that teen pregnancy is the single greatest lifelong predictor of poverty and a major barrier to economic independence for girls.

Minnesota needs to invest in helping to build protective factors for teens of color, such as greater access to higher education, greater positive self-concept, increased perception of the negative consequences of pregnancy, greater positive attitude toward school and more egalitarian family and gender roles.

It therefore does not require major analysis to determine who will continue to be the poorest individuals in the state of Minnesota in the future: teen mothers and women of color. Understandably then, reducing the rate of teen pregnancy among Minnesota's teens of color is probably one of the best courses Minnesotans can take to increase the economic potential of women of color and the economic health of the state.

What policies stand in the way of such a clear cut objective?

Repeal of the Minor's Consent Law that provides minors with confidential health services would be disastrous for Minnesota's teens of color. By restricting minors' access to confidential reproductive health services, including contraception, teens of color are at even greater risk for teen pregnancy and future economic failure.

Additionally, there is an equally strong need to support Comprehensive Sex Education for teens of color that provides accurate medical information, is developmentally appropriate for all teens, and culturally appropriate for teens of color who are at higher risk for teen pregnancy. Research has shown that abstinence-only-until-marriage education *does not work.*

Armed with good information, teens of color can make better choices and will be more likely to delay pregnancy. Just as wine growers say, "No wine before its time," communities of color might say, "No child before its time." The question is one of maturity and growth. All in good time. And, in the event a teen of color becomes pregnant, a full range of reproductive choices, up to and including abortion, should be legal and available to them.

Our state needs to invest in helping to reduce factors among populations of color that put teens at greater risk for teen pregnancy, such as poverty, and other racial disparities, such as high unemployment, low income, and high crime rates to name a few. Minnesota needs to invest in helping to build protective factors for teens of color, such as greater access to higher education, greater positive self-concept, increased perception of the negative consequences of pregnancy, greater positive attitude toward school and more egalitarian family and gender roles.

The girlsBEST (Girls Building Economic Success Together) Initiative of the Women's Foundation of Minnesota supports programs that build supportive environments for girls, environments in which the protective factors against teen pregnancy are increased and the risk factors are decreased, thus helping to insure girls' future economic well-being. girlsBEST serves girls in 11 programs across the state, 70 percent of whom are girls of color. These programs are culturally specific, girls have access to many mentors and role models, girls develop effective, community-based leadership skills, and become academically prepared for higher education. As a philanthropy, girlsBEST is an important investment that the Women's Foundation is making. We challenge the state to make similar investments in innovative programs that foster protective factors for girls.

To the extent state dollars do not flow to programs that help to reduce the likelihood of teen pregnancy for girls of color, Minnesota is not helping its teens of color to thrive. Instead, the state is helping to seal a future of poverty and economic distress for a vital segment of its population.

Is this what Minnesota wants to be known and recognized for–the highest rates of teen pregnancy in the nation for its teens of color? Just as hurricane Katrina exposed the poverty-stricken underbelly of New Orleans (and America, by extension), it would not take much to expose a portion of Minnesota's underbelly: girls of color at higher risk for economic failure than anywhere else in the country.

Think about it.

Carol McGee Johnson is Vice President of Community Philanthropy and Programs for the Women's Foundation of Minnesota.

FACTS UNFILTERED

In the course of the past three months, the Citizens League spring series "Show Us the Money! Public Finance Explained," has explored various topics in public finance. To recap: what is public finance? Where do we spend our public money? And why does it matter to citizens?

Q What is public finance, anyway?

A Wikipedia defines public finance as "the field of economics that deals with budgeting the revenues and expenditures of a public sector entity, usually government." In other words: public finance is the ways in which governments raise and spend money.

Q So how do governments raise and spend money?

A There are four main ways that state governments can raise money: taxes and fees, borrowing, transfers from other governments, and procuring property through eminent domain. The federal government can also print money (although this is usually a bad idea; for more information on why, check out "Why Not Just Print More Money?" on About.com).

According to the Minnesota Department of Finance, in 2004, Minnesota's state revenues totaled $22.3 billion: 64 percent from taxes (mostly sales and income taxes); 26 percent from federal government grants; and 10 percent from other sources.

Governments can, of course, spend money in a myriad of ways. In 2004, the state Revenue Department reported spending of $22.5 billion: 37 percent on health and human services, 34 percent on education, 10 percent on transportation and 19 percent on everything else (including property tax aids and credits, public safety, the environment, agriculture and economic development, debt service, and more).

Q Isn't Minnesota's state budget supposed to be balanced?

A Yes and no. There is no explicit requirement for a balanced budget in the state constitution. Rather, the constitution says that the state can issue debt (that is, finance projects by selling bonds) only for specified purposes, and borrowing money to pay for a budget deficit is not one of those purposes. The budget passed by the legislature, however, can be structurally unbalanced (note that in 2004, spending slightly exceeded revenue. The legislature maintains a $653 million budget reserve that it can dip into to manage these kinds of deficits.

Q What goes into that health and human services category?

A The health and human services bill is wide ranging. It covers four main areas: children and economic assistance, health care, continuing care, and state operated services. Those subgroups contain many programs, including the Minnesota Family Investment Plan, child care assistance grants, Medical Assistance (Medicaid), General Assistance Medical Care, the prescription drug program, long-term care, mental health care, aging and adult services, the Community and Family Health Program, veterans homes, the Council on Disability, and the Ombudsperson for Families.

Q What is Minnesota going to be spending its money on in the future?

A Medical care. As the number of Minnesota retirees increases, so will the demands on the state's medical system. Minnesota's retirement-age population (65+) will start to increase in 2008; the first wave of baby boomers will start to retire in 2011. By 2020, the state's retirement-age population will surpass the K-12 population for the first time in history. This demographic reality has significant implications for state revenues and spending.

State revenues likely will decrease. Workers approaching retirement want to both maintain their standard of living and increase their savings—so as our population grows older, there will probably be an increase in pressure to reduce taxes. Retirees already pay less in taxes than the general population (as a result of special tax benefits and reduced income and consumption), so as more Minnesotans retire, revenue for state and local government will likely go down.

At the same time, because baby boomers are expected to live longer than their parents, and because medical technology has advanced, the next generation of retirees will need higher levels of medical care for longer periods of time than previous generations. Minnesota already spends $3 billion each year on Medical Assistance, General Assistance Medical Care and Minnesota Care. These programs are growing fast: the current two-year state budget saw a 15 percent increase in the cost of these programs from the last budget. Unless there are significant changes in policy, Minnesota's health and human services budget will have to increase dramatically to cover these costs.

Minnesotans will have to make decisions about how to spend money in the future. As a state, it is time for us to begin to think about what our priorities are.

For more information on this topic, check out these websites:

The Citizens League's "Show Us the Money!" series: www.citizensleague.net
Minnesota House of Representatives House Research: www.house.leg.state.mn.us/hrd/hrd.htm
Minnesota State Budgets: www.budget.state.mn.us
Minnesota State Department of Finance: www.finance.state.mn.us
Minnesota State Department of Revenue: www.taxes.state.mn.us
Minnesota State Demographic Center: www.demography.state.mn.us

Each month, Citizens League members and staff will collaborate to select an timely policy topic, then ask the important—and sometimes uncomfortable—questions and dig up the answers. Just the facts, unadulterated and unspun.

Questions, comments, corrections? We need more Facts Unfiltered volunteers! If you are willing to roll up your sleeves and dig into the facts, if you have suggestions for a future Facts Unfiltered policy topic—or if you just think we got something wrong—call or e-mail Victoria Ford: vford@citizensleague.net or 651-293-0575 ext.17.

TAKE NOTE

Innovative Policy Initiatives from Around the World

Take Note is taking a new direction. In the past, we've used this space to comment on releases of new sources of data, policy initiatives and political curiosities. But in the 2005 Member Survey, you told us that you wanted to hear more about "innovative policy initiatives from around the world"—and that's what we're delivering. From now on, Take Note will highlight and analyze policy innovations. Enjoy, and let us know what you think.

Making hospitals safer and doctors more effective

THE BOTTOM LINE: Hospitals in Pittsburgh cut central line infection rates in half by instituting small adjustments to their processes, such as making sure that gloves were kept at the top of supply kits and regulating the size of drapes used to cover patient wounds.

"Today, going to an American hospital seems about as safe as parachuting off a bridge." So wrote Steven J. Spear, Senior Fellow at the Institute for Healthcare Improvement, in an Aug. 29 *New York Times* commentary. But a number of initiatives are in the works that should help make hospitals safer and doctors more effective.

In August, President Bush signed a bill authorizing the creation of "patient safety organizations," where health care providers will be able to report errors without fear of malpractice lawsuits. The patient safety organizations will analyze the information and make recommendations on how to avoid similar mistakes.

But research by the Institute for Healthcare Improvement suggests that hospitals can significantly improve safety by following the lead of some of the world's most successful industrial organizations like Toyota, Alcoa and Vanguard. Rather than working around problems, health care workers should slow down and consider what is causing the problem. The case of central lines—catheters inserted into a major vein to deliver medicine or fluids—illustrates the point: "A quarter-million patients nationwide who receive (central lines) each year suffer bloodstream infections as a result, and of those, 15 percent die. To eliminate these infections, [hospitals in the Pittsburgh Regional Healthcare Initiative] taught themselves to find problems and institute small process enhancements at a rate far faster than a national reporting program will most likely allow. Together, these small fixes added up to a significant improvement." And what were these small fixes? "One hospital realized that in its line-maintenance kits, gloves were stored at the bottom, causing nurses to fish through sterile material with bare hands. Other kits had drapes—sheets that isolate the area on which a nurse or doctor is working—that were either too small to be effective or so large that patients knocked them out of the way."

These small changes added up to major improvements in safety. The Pittsburgh hospitals cut central line infection rates in half and some hospitals nearly eliminated the problem. All this just from trying to act like Toyota.

Links:

Institute for Healthcare Improvement: www.ihi.org
"The Health Factory," by Steven J. Spear: www.nytimes.com
(requires Times Select subscription)

A new state slogan? Maine: the digitally literate state

THE BOTTOM LINE: Maine gives away a free laptop to every seventh- and eighth-grader—and the results are good. So good, in fact, that the state's former governor started a foundation to spread the program.

In Maine, every seventh- and eighth- grader—and all of their teachers—get a free iBook laptop at the beginning of the school year, almost 40,000 total. Former Maine Governor Angus King, who created the program, said at the time that he wanted to make Maine the most "digitally literate" state in the country.

The Maine Learning Technology Initiative, more commonly called "the laptop program," has been practically and politically successful, beyond even its supporters' initial hopes. Researchers at the University of Southern Maine Center for Education Policy, Applied Research & Evaluation, found that "the introduction of laptops may have the potential to encourage significant and rapid shifts in the role of teachers and students in classroom learning, as well as supporting broad improvements in teaching and learning." Among the findings:

- More than 70 percent of teachers said laptops helped them to more effectively meet their curriculum goals and individualize curricula to meet particular student needs.
- More than 75 percent of teachers said the laptops helped them better meet Maine's statewide learning standards.
- More than 4 out of 5 teachers surveyed reported that students are more engaged in learning and produce better quality work.
- More than 70 percent of students said laptops helped them to be better organized and get their work done more quickly and with better quality.

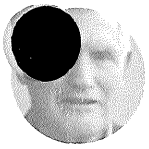
King, who left the governor's office in 2002, is still working to close the digital divide. This summer, he raised $850,000 to create the nonprofit Maine Learning Technology Foundation. This year, the foundation is paying for free internet access for students in the laptop program who qualify for free- or reduced-price lunches.

Links:

Maine Learning Technology Initiative: www.state.me.us/mlte/
University of Southern Maine Center for Education Policy, Applied Research and Evaluation: www.usm.maine.edu/cepare/
"Maine closing technology gap for students," www.stateline.org

PERSPECTIVES

Expanding Minnesota's Conversation



Minnesota should develop a four-year university in Rochester

by A.M. (Sandy) Keith

As Minnesota established public colleges and the University of Minnesota in the early days, no one could predict that Rochester would emerge as the state's third largest city with a diverse population approaching 100,000, and a metropolitan statistical area of 172,476. Rochester is home to Mayo Clinic, a world leader in health care. It is Minnesota's largest private employer with 47,000 workers, of which 28,100 work in Rochester. IBM Rochester, a world leader in technology, is now home to BlueGene, the world's fastest supercomputer. In a decade, Rochester has become a research and development hotbed, attracting more than 30 companies working at the cutting edge of technological, medical and biological advances. Rochester is poised to become a major player in bio-industry but cannot achieve this goal, which will be of great benefit to the entire state, without the support of a major research university.

Civic leadership

In 1985, Rochester undertook a broad planning process called FutureScan 2000. It was no surprise that higher education was named among the top five priorities to ensure future vigor and quality of life in Rochester. A key recommendation was to form a board of citizens to champion higher education. I agreed to chair this group, which we called the Greater Rochester Area University Center Board of Directors (GRAUC). Today, the GRAUC Board continues to serve as a catalyst for growing higher education in Rochester. Like the Twins League, GRAUC brings together business and civic leaders, area policymakers and citizens to identify needs, force recommendations and influence policy.

University Center Rochester

Through a series of agreements between the Minnesota State Colleges and Universities (MnSCU) and the University of Minnesota (U of M), a collaborative model known as University Center Rochester (UCR) was created to serve Rochester's higher education needs. Both systems are justifiably proud of the progress made in student enrollments, increases in programs, and the establishment of the U of M Rochester (UMR) in 1999.

> Perspectives is an opportunity to hear from Minnesotans about the issues that affect them and their communities and to bring new voices into Minnesota's policy conversations.

Despite investments in campus infrastructure and incremental steps to advance higher education, funding for expanding upper division, professional and graduate programs has not come close to meeting the region's economic and demographic changes. The current UCR model meets basic workforce needs, but doesn't have the capacity to serve the research-based, educational needs of Rochester's global industries, particularly healthcare and technology. Collaboration clearly is beneficial with regard to open access, technical education and associate degree programs through Rochester Community and Technical College. However, in an era of limited public resources for higher education, it is imperative that the most effective and efficient structures and/or funding mechanisms be considered to advance higher education.

Bioscience: a growth industry

In 2003, Gov. Pawlenty recognized bioscience as a key driver of Minnesota's economic growth. He encouraged the U of M and Mayo Clinic to form the Minnesota Partnership for Biotechnology and Medical Genomics with $1 million of state funding. Rochester's nearly 500 acres, designated for a Bioscience Tax-Free Zone, stimulated Mayo Medical Laboratories to move into a vacant building there and complete a $7 million renovation. In the last two years, it has increased its staff by more than 200 FTEs to meet the increased testing workload.

In 2005, the Legislature approved a $21.7 million medical genomics research addition atop Mayo's Stabile Building, and earmarked $15 million in state research funding for the Partnership. This will bring more research scientists and provide greater opportunity for new treatments and technology to fight diseases and improve health.

These investments are projected to yield an economic impact to the state of $320 million along with 4,300 direct and indirect jobs by 2010. They also contributed to IBM creating a Center of Advanced Studies in Life Sciences and Bioinformatics in Rochester to focus on applied research leading to new products, technology and services.

A window of opportunity

The GRAUC Board recognizes that future progress in the Greater Rochester Area is heavily dependent on an increased role for the U of M in economic development. Since UMR's formation in 1999, the University has made significant investments in Rochester by appointing a provost and hiring an academic development team, consolidating the extension service for southeast Minnesota, and initiating academic, research, and outreach programs.

continued on page 12

continued from page 11

Expanding partnerships in genomics and supercomputing by the U of M, Mayo Clinic and IBM, in alignment with the University's Academic Health Center and Institute of Technology, provide evidence of the critical role demanded of UMR in preparing the workforce of tomorrow. Minnesota must invest in a four-year university in Rochester to realize the full potential for strong economic growth and high-skill jobs.

GRAUC's University Growth Vision:

- Preserve the academic base and grow the "South Bank" of the UMR
- Signature baccalaureate, graduate and professional programs focused on health sciences, technology, business and agribusiness
- Innovation in technology-enhanced learning
- Strong public-private partnerships
- Leverage strategic investments

Rochester Higher Education Development Committee

In 2005, Gov. Pawlenty and the Legislature established the Rochester Higher Education Development Committee to research, recommend and develop a proposal for expanded higher education programs or institutions in the growing Rochester area. The Minnesota Office of Higher Education staffs the committee and provides oversight of the $3.2 million state appropriation. We look forward to the committee's report, due to the governor and Legislature next January, with recommendations on programs, facilities, governance and funding. The University Center Rochester model has served us well, but it limits the opportunity to build upon the research and development engine in biotech that has become the hallmark of our community. Minnesota must strategically align its higher education resources to keep our industries globally competitive so our state continues to create new medical and technology opportunities that benefit all Minnesota, our nation and the world. ●

A.M. (Sandy) Kieth, retired Chief Justice of the Minnesota Supreme Court, is a former state se[illegible] and former Lt. Governor of Minnesota. He is cur[illegible] serving as Executive Director of the Rochester Downtown Alliance.

UPCOMING EVENTS

Turn to page 2 for details

10/17
Leadership and the Fiscal Future of the United States

10/24
Policy and a Pint: Emergency Preparedness with United Way Twin Cities Executive Director Lauren Segal. Co-presented by the Citizens League, 89.3 The Current and The Onion.

The Minnesota Journal
Publisher – Sean Kershaw
Editor – J. Trout Lowen
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Contributing Editor – Ted Kolderie

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MN JOURNAL

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Ann Kinsella

An Overview of Federal and State Fraud & Abuse Provisions

November 2, 2005

Overview

- Federal Anti-kickback Law (primarily a criminal statute)
- State Anti-kickback Law (civil statute)
- Federal Stark Law (civil statute)

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Federal Anti-kickback Law

- Establishes criminal penalties for any person who knowingly and willfully offers, pays, solicits or receives any remuneration to induce or in return for:
- 1) referring an individual to a person for the furnishing (or arranging for the furnishing) of any item or service payable in whole or in part under a federal health care program, OR

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Federal Anti-kickback Law

- 2) purchasing, leasing, ordering, or arranging for, or recommending purchasing, leasing, or ordering any good, facility, service or item payable under a federal health care program.
- "Remuneration" is broadly defined to include the transfer of anything of value, in cash or in kind, directly or indirectly, overtly or covertly

See 42 U.S.C. Secs. 1320a-7b(b)(1), (2)

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Federal Anti-kickback Law

- Felony violation, punishable by a maximum fine of $25,000, five years in prison, or both
- Conviction can also result in exclusion from Medicare, Medicaid and other federal health care programs
- Violations can also be subject to civil monetary penalties of up to $50,000 and damages of up to three times the illegal kickback

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Federal Anti-kickback Law

- Law clearly prohibits payments for patient referrals
- Some courts have determined the law is violated where "one purpose of the payment in question was to induce referrals, regardless of other legitimate purposes." (*United States v. Gerber*, 760 F.2d 68 (3rd Cir. 1985)
- OIG has adopted the "one purpose" test in its advisory opinions

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Federal Anti-kickback Law

- The Office of the Inspector General (within the U.S. Department of Health and Human Services) has adopted "safe harbors" (exceptions) by regulation
- Safe harbor protection is only available if the arrangement meets all of the elements in the applicable safe harbor
- Many of the safe harbors are designed to protect arrangements whereby commercially reasonable items or services are exchanged for fair market value

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Federal Anti-kickback Law

- Safe harbors include those concerning:
  - space rentals
  - equipment rentals
  - personal service and management contracts
  - employment arrangements
  - price reductions offered to health plans
  - coinsurance and deductible waivers
  - provider recruitment in underserved areas
  - sales of practices by one practitioner to another

(*See generally* 42 C.F.R. Sec. 1001.952)

- Failure to satisfy a safe harbor does not necessarily mean Anti-Kickback Statute has been violated.

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State Anti-kickback law

- In 1992 the Minnesota Legislature adopted a state anti-kickback statute, Minn. Stat. Sec. 62J.23
- The State statute incorporates the federal anti-kickback law and regulations, except that the state law applies to all health care transactions, not just those involving government dollars

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State Anti-kickback law

- The Minnesota law applies "to all persons in the state, regardless of whether the person participates in any state health care program." Minn. Stat. Sec. 62J.23, subd. 2 (2004)
- The federal statute only concerns health care services that may be reimbursed by a federal health care program (including Medicare and Medicaid)
- Thus, the law applies to all payers, and not just federal or state government payers

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State Anti-kickback law

- There are exceptions in the Minnesota law
- For example, discounts, reductions in price, or limited-time free samples of a prescription drug, medical supply or medical equipment are allowed *if* certain conditions are met, including:
  - that the discount or reduction in price is provided in connection with a purchase,
  - the discount or reduction in price does not exceed the amount paid by the individual, and
  - the arrangement otherwise complies with state and federal law

See Minn. Stat. Sec. 62J.23, subd. 2 (b) (2004).

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State Anti-kickback law

- Generally, penalties specified in Section 62J.23 are that the Commissioner of Health may assess a fine for violations
- Section 62J.23 can also be enforced pursuant to Minn. Stat. Sec. 8.31.

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Proposals to Amend State Law

- There have been proposals to strengthen Minnesota's anti-kickback law
- In an August 2003 report titled *Controlling Improper Payments in Medical Systems Programs,* the Legislative Auditor noted that Minnesota, unlike many other states, has not adopted criminal anti-kickback laws

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Proposals to Amend State Law

- Corruption in Health Care Act, S.F 1627, was proposed in 2004
- Proposal made the interim restrictions in Section 62J.23 permanent, and made offering or soliciting kickbacks in connection with health care a criminal offense
- If found guilty, an individual or corporation could be fined up to $25,000 or imprisoned for up to five years

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Proposals to Amend State Law

- Like the current Section 62J.23, the proposal would have applied to all health care transactions (unlike the federal law which only applies to government dollars)
- Fine for violations of Section 62J.23 remained the same
- Legislation passed in the Senate as part of a budget bill but did not pass the House

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Federal Stark Law

- The "Stark" law is another federal fraud and abuse law designed to address financial incentives to refer patients
- The Anti-Kickback Statute and Stark law are separate regulatory schemes, which means that complying with one does not mean the other can be ignored. Compliance with both is necessary.

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Federal Stark Law

- Generally, the law prohibits "physicians" from "referring" Medicare and Medicaid patients to an "entity" for the furnishing of certain "designated health services," if the physician (or an immediate family member) has a "financial relationship" with the entity.
- Unless an exception applies-
  - A number of exceptions exist, many of which are similar to the Anti-kickback law's safe harbors
  - Each exception has a number of very specific criteria that must be met in order for it to apply

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Federal Stark Law

- Generally, the Stark law and its regulations are narrower and more technical than the anti-kickback statute
- Stark is a civil statute
- Violation of Stark's self referral prohibitions subject the offending individual or entity to a range of sanctions, including civil monetary penalty and exclusion from Medicare and Medicaid
- Federal Center for Medicare & Medicaid Services has authority to issue Stark law advisory opinions

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Federal Stark Law

- Originally the law applied only to clinical laboratory services, but now applies to 10 other categories of "designated health services," including:
  - inpatient and outpatient hospital services
  - radiology services
  - radiation therapy services and supplies
  - durable medical equipment and supplies
  - prosthetics, orthotics and prosthetic devices
  - home health services
  - outpatient prescription drugs

42 U.S.C. Sec. 1395nn(h)(6)

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Federal Stark Law

- Statute and regulations are definition driven, with detailed definitions for, among other things, "referral," "entity," and "financial relationship"
- Generally, a financial relationship can be an ownership interest (either direct or indirect) or a compensation interest (either direct or indirect)

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Differences between Stark-Anti-Kickback

Generally (there are more)-

- Stark applies only to prohibited referrals under Medicare and Medicaid; anti-kickback applies to all federally funded health care programs
- Stark regulates conduct within a physician's practice, whereas anti-kickback has not been interpreted by the courts to apply to a referral to oneself
- Stark applies only to arrangements between physicians and "entities;" any two parties may violate the anti-kickback statute
- Stark only prohibits referrals, anti-kickback law prohibits broader conduct
- Anti-kickback enforcement has been in high gear since the 1990s; Stark enforcement is only starting to take shape now

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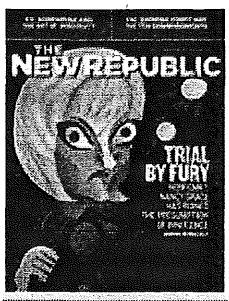
THE NEW REPUBLIC ONLINE



MEDICINE AND THE FREE MARKET.

The Health of Nations

by Arnold S. Relman

Post date 03.01.05 | Issue date 03.07.05

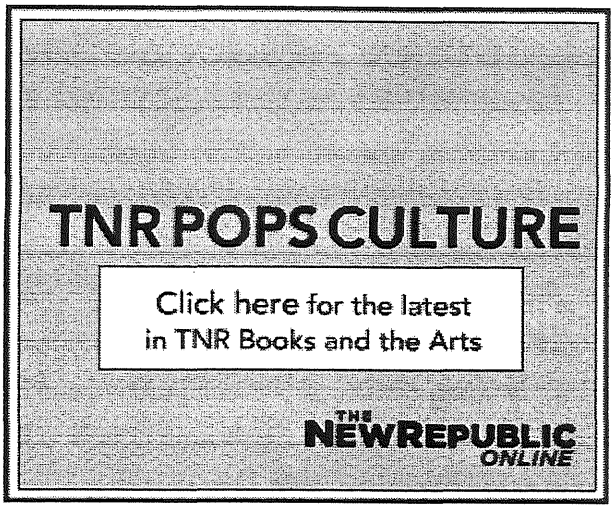
I.

In this past election season, our dysfunctional and extravagantly expensive health care system was pushed off the front pages by concerns about the candidates, the fight against terrorism, and the war in Iraq. And yet the health system's problems will not go away; sooner or later we will have to solve them or face disastrous consequences. Over the past four decades (starting just before the arrival of Medicare and Medicaid), both the system itself and ideas about how it should be reformed have changed a lot, but an equitable, efficient, and affordable arrangement still eludes us.

During the past four decades our health policies have failed to meet national needs because they have been heavily influenced by the delusion that medical care is essentially a business. This delusion stubbornly persists, and current proposals for a more "consumer-driven" health system are likely to make our predicament even worse. I wish to examine these proposals and to explain why I think they are fundamentally flawed. A different kind of approach could solve our problems, but it would mean a major reform of the entire system, not only the way it is financed and insured, but also how physicians are organized in practice and how they are paid. Since such a reform would threaten the financial interests of investors, insurers, and many vendors and providers of health services, the short-term political prospects for such reform are not very good. But I am convinced that a complete overhaul is inevitable, because in the long run nothing else is likely to work.

ADVERTISEMENT

Let us begin by looking back. Just over four decades ago, in 1963, medical care in the United States consisted mostly of personal transactions between physicians



and patients, which took place in patients' homes, doctors' offices, or not-for-profit hospitals and clinics. Only a few of these transactions involved expensive technology or highly specialized facilities, and primary-care physicians could spend the necessary time with their patients. Total expenditures for medical care were about 5 percent of the economy, and the government paid for less than a quarter of it. Health insurance purchased by individuals and insurance paid by employers for their employees accounted for a small part of the rest. Most of this insurance was of the "indemnity" type, that is, the insurance company paid the doctor and the hospital and charged the patient premiums that covered those bills, plus its modest overhead. Most patients were uninsured. They usually paid their bills directly out of pocket if they could, but there were far too many who simply could not afford the services that they needed. They had to rely on private charity or tax-supported institutions. Few observers thought the system was a "market" or an "industry," investors were not much interested in health care services, and hardly any economists or business leaders paid much attention to it.

In 1963, a seminal analysis of the medical care system as a market was published in the *American Economic Review* by the distinguished economist Kenneth J. Arrow. He argued that the medical care system was set apart from other markets by several special characteristics, including these: a demand for service that was irregular and unpredictable, and was often associated with what he called an "assault on personal integrity" (because it tended to arise from serious illness or injury); a supply of services that did not simply respond to the desires of buyers, but was mainly shaped by the professional judgment of physicians about the medical needs of patients (Arrow pointed out that doctors differ from vendors of most other services because they are expected to place a primary concern for the patient's welfare above considerations of profit); a limitation on the entry of providers into the market, resulting from the high costs, the restrictions, and the exacting standards of medical education and professional licensure; a relative insensitivity to prices; and a near absence of price competition.

But perhaps the most important of Arrow's insights was the recognition of what he called the "uncertainty" inherent in medical services. By this he meant the great asymmetry of information between provider and buyer concerning the need for, and the probable consequences of, a medical service or a course of medical action. Since patients usually know little about the technical aspects of medicine and are often sick

and frightened, they cannot independently choose their own medical services the way that consumers choose most services in the usual market. As a result, patients must trust physicians to choose what services they need, not just to provide the services. To protect the interests of patients in such circumstances, Arrow contended, society has had to rely on non-market mechanisms (such as professional educational requirements and state licensure) rather than on the discipline of the market and the choices of informed buyers.

Of course, another conclusion could have been drawn from Arrow's analysis (though he apparently did not draw it). It is that medical care is not really a "market" at all in the classical economic sense, and therefore that the basic theories of economics are not relevant to the discussion of the first principles of health care. But our society assumes that market economics applies to virtually all human activity involving the exchange of goods or services for money, and this dogma is rarely questioned. Most economists would acknowledge that medical care is an imperfect or idiosyncratic market, but still they believe that it is a market, and that it should therefore obey economic predictions.

Arrow's paper attracted much attention from economists and social scientists, and it is generally acknowledged to have been a landmark in the early literature of health economics. It might have had more influence on health policy had not the whole system begun to change dramatically soon after his article was published. With the passage of Medicare and Medicaid legislation in 1965, large amounts of government money entered the health system through these insurance programs. Including the value of tax benefits, the government now pays for more than half of all health care costs. At the same time, funding through private insurance was also expanding greatly, due to the growth of employment-based health coverage that is tax-deductible by employers. The great majority of large- and medium-sized businesses began to offer their employees (and their families) medical insurance coverage as a tax-free fringe benefit. Today more than 160 million people are insured in this way, accounting for slightly less than half of all funding for health care.

In response to the business opportunities afforded by the abundant new supply of insurance money, medical entrepreneurialism blossomed on a grand scale. Private investor-owned health care firms proliferated, including investor-owned hospitals, nursing homes, and ambulatory facilities. Many practicing physicians joined in this medical gold rush, and even many "not-for-profit" hospitals and ambulatory-care facilities became income-maximizers in what increasingly looked like a competitive "health care industry." This economic expansion-- this monetization--of health care in the 1960s and 1970s was also stimulated by a large increase in the number of doctors, both American-trained and foreign-trained, most of them specialists. There also occurred a great expansion of medical research and development, leading to expensive new treatments, devices, and drugs--which could be reimbursed by

insurance on an item-by-item basis. New technology, new medical and surgical specialists, and piecework reimbursement by insurance were an explosive economic mixture that drove up health care expenditures and generated new opportunities for commercial gain.

Adding to the effects of these changes, the federal courts handed down a series of rulings that decided that the practice of the professions (including law and medicine) should not be exempted from the reach of antitrust law. Beginning in 1975 with a landmark ruling by the Supreme Court in *Goldfarb* v. *Virginia State Bar*, the courts applied antitrust law to professional practice. The effect of these rulings was to deter professional groups and associations from limiting competitive commercial activity by practitioners, which they had previously done through such time-honored measures as suggesting fair prices and banning advertising. The courts seemed to be saying that medical financial transactions were not different from ordinary commerce, and therefore attempts to limit market competition would violate antitrust laws. There was also the implication that competition in medical markets would serve consumer interests by moderating prices and improving quality, as it was supposed to do in other markets. These rulings cowed the American Medical Association and other professional societies, which thereafter carefully avoided any attempt to stem the commercialization of medical practice.

The result of all these economic and legal developments was to diminish the special aura of professionalism and social service that had traditionally surrounded the practice of medicine and kept it apart from commerce. Ignoring Arrow's wise argument that medical care was inherently different from most other markets and therefore required non-market mechanisms for its regulation, economists, health policy experts, and the courts began to think of it as simply a specialized form of business enterprise that was best left to market forces. And for this they could hardly be faulted. Health care had indeed begun to resemble a gigantic industry, and it was consuming a growing fraction of the national economy.

II.

In 1980, in *The New England Journal of Medicine*, I described this changing face of American health care as the "new medical-industrial complex." The term was derived, of course, from the language that President Eisenhower had used ("military-industrial complex") when warning the nation, as he was retiring, about the growing influence of arms manufacturers over American political and economic policies. Referring to Arrow's analysis, I suggested that market-driven health care would simply add to the explosion of medical expenditures and the growing problems of inequity and variable quality. I was also worried that this uncontrolled industrial transformation would undermine the professional values of physicians, which are surely an essential ingredient of any decent medical care system. Financial incentives were

replacing the service ethic of doctors and hospitals, as the providers of care began to compete for market share and larger income. Yet competition on the basis of the price and quality of services--an essential characteristic of most free markets--was little in evidence, demonstrating again the truth of Arrow's argument that the medical care market was different.

As expenditures on medical care continued to rise rapidly, the major payers (employers and government) began to resist. Employers revolted against the unpredictable and seemingly uncontrollable costs of the indemnity insurance that they were buying for their employees, and they demanded a different kind of coverage. In response, a new and largely investor-owned health insurance industry quickly appeared, which contracted with employers to provide "managed-care" insurance plans, or HMOs. The plans controlled their payments for medical services (they called them "medical losses") by requiring beneficiaries to select a primary-care physician from among a panel of doctors under contract with the plan. These doctors had to approve referrals to specialists and had to get approval from the plan before admitting patients to the hospital. Primary-care physicians were usually paid on a per capita basis and could refer only to selected specialists who had agreed to accept the discounted fees negotiated by the plan. The expenditures and the referral patterns of the primary-care physicians were monitored by the plan, which used financial rewards and penalties to ensure compliance with its policies. Although the HMOs claimed these policies were primarily intended to improve the care of patients and to eliminate the risks and expense of unnecessary procedures, they were perceived by most physicians and patients as restrictions on care that were essentially designed for the benefit of the insurers and employers. And that perception was probably correct.

The government tried to control its costs by contracting with private HMO plans for many of its Medicaid beneficiaries, by encouraging Medicare beneficiaries to join HMOs, and by reducing its payments for services covered by Medicare. Physicians' fees were sharply discounted and based on a "relative value" scale. In a major change in its method of hospital payment, Medicare paid fixed sums related to the diagnosis and the type of treatment, rather than reimbursing for the individual items of service provided and the days of hospital care. Cost-controlling efforts by private and public insurers also included so-called "case management" and "disease management." Under these new approaches, nurses were employed to facilitate early discharges of patients from hospitals and to help ambulatory patients with chronic diseases avoid hospitalization through more careful compliance with therapeutic and preventive regimens. Like other aspects of "managed care," these programs were claimed to improve the effectiveness of treatment, but they also cut expenditures on hospital care.

During the mid-1990s, private managed-care insurance plans briefly succeeded in controlling the rise in the premiums charged to

employers, while still making substantial profits for themselves. But there ensued a major backlash from employees, who resented the restrictions on their care and their access to specialists, and this soon forced employers to abandon HMO plans in favor of so-called "PPO" plans that were more expensive but allowed beneficiaries greater choice of physicians and easier access to specialized care. At the same time, the financial pressure from new and more expensive technology was constantly increasing. The inevitable result was a resumption of cost increases for private insurers and an escalation in the premiums paid by employers. Government insurance also was affected by the increased use of technology, and, despite all efforts at control of payments to providers, Medicare expenditures per capita continued to rise almost as rapidly as expenditures in the private sector. Much of the new expensive technology (including drugs) was being used in outpatient settings, so restraints on hospital spending did not solve Medicare's problems.

In an increasingly profit-driven and entrepreneurial medical market, piecework payment for specialized outpatient services stimulated an even greater fragmentation of medical care and a greater use of individually billable items of outpatient technological service. Less attention was given to the continuity and the integration of care, and to preventive medicine. Decreased payments to primary-care physicians and increased pressure on them to see more patients reduced the time that they spent with each patient. As a consequence of all these developments, the quality of primary care suffered, and the difference between the quality of average medical care and the best medical care widened, even as per capita expenditures rose and the number of uninsured and underinsured patients increased. This quality "gap" was the subject of a major report in 2001 from the Institute of Medicine of the National Academy of Sciences, which described the many deficiencies in the way patients were being treated and suggested how their medical care could be improved. Unfortunately, the experts preparing the report were not asked to consider how the system itself might be restructured to facilitate the needed improvements.

And so we now live with a seriously defective medical care system, based more heavily on market incentives than the health care regime of any other country in the world. The commercial tone is set by investor-owned insurance companies (the major share of the private insurance market), investor-owned hospitals (about 15 percent of all community hospitals), and investor-owned ambulatory-care facilities and nursing homes (the great majority of both these markets). The behavior of many of the so-called "not-for-profit" health care facilities is not much different from that of their investor-owned competitors, because they have to survive in the same unforgiving marketplace, which is indifferent to the social values that originally motivated most health care institutions. As for American physicians, their attitude toward their profession has also been changed by the new medical marketplace. To a degree greater than anywhere else in the world, our doctors think of themselves as competitive businesspeople. As such,

they own or invest in diagnostic and therapeutic facilities (including specialty hospitals), they form investor-owned medical groups, and they advertise their services to the public.

The total cost of the health care system is now a staggering $1.6 trillion. It consumes more than 15 percent of our economy, and the total is rising steadily at a rate of approximately 7 to 9 percent per year. Obviously, this rate of inflation is unsustainable. Neither the government nor private employers can keep up with rising health costs. Per capita, we spend one-third more on medical care than the next closest country (Switzerland), and almost twice as much as the majority of other technically advanced Western countries. Yet as a consequence of our failure to provide affordable and good-quality medical care to so many of our citizens, we are not getting anywhere near our money's worth. Economists and vendors of new drugs and technologies may allege that the life-enhancing and lifeextending benefits of many medical advances are good value for the money, but when the mediocre performance of our system as a whole (as judged by such measures as insurance coverage, life expectancy, and infant mortality) is compared with that of other advanced countries, which spend far less, it is an unpersuasive argument. Our best medical institutions and our most advanced technology lead the world in their sophistication, but we neglect the poor and the uninsured.

Our failure to address the glaring deficiencies and inequities in our health care system is nothing to be proud of. A growing number of people are losing their private health insurance. There are now more than 45 million Americans without coverage. Much of this is due to the loss of good jobs, but high costs are also a significant factor. The financial burdens of those who are insured increase steadily, as hard-pressed employers reduce covered benefits and increase the fraction of insurance costs being shifted to beneficiaries. Rising health costs are threatening the financial stability and competitiveness of many American businesses, and are discouraging the hiring of new full-time workers. The government is also shifting insurance costs to Medicare beneficiaries, as exemplified by the recent large increase in the premium charged for coverage of outpatient medical services and physicians' care ("Part B").

What really astonishes me is that so many conservative business and health policy experts continue to hold an unshakable faith in a market solution for our system's major problems. They believe that market forces have not been allowed to contain costs or to improve access and quality because of government regulation, and because of badly designed insurance that prevents consumers from playing an appropriate role. They think that the consumers of medical care in both public and private insurance systems have not had enough influence on the supply of services and have not been sufficiently involved in price negotiations with providers. These days the "free market" is held to be the solution to most social and economic problems, and it is commonly believed that in health care the most important missing ingredient of a free market is the traditional consumer who has the incentive and the ability to bargain for

the desired price and quality of services. So it shouldn't be surprising that the idea for improving our health care system that is currently most popular is socalled "consumer-driven health care," or CDHC.

Next: The term "consumer-driven health care" is used to mean a market for medical care in which patients, as the "consumers" of medical services, would have a lot more responsibility for choosing those services and would share more of the costs. ... Despite the optimism and the enthusiasm of their proponents, it is too early to say whether any of these plans will prove generally popular, or even come close to meeting expectations.

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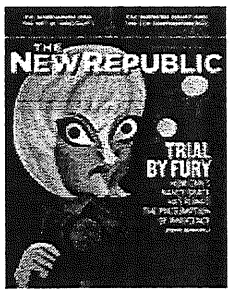

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