Sen. Solon

MULTIPLE-SHARE HEALTH COVERAGE PROGRAM
DEMONSTRATION PROJECT FOR NORTHEASTERN MINNESOTA

Proposal: Implement a five-year Multiple-Share Health Coverage Program demonstration project in Northeastern Minnesota that expands coverage to the low-income, uninsured, employed population.

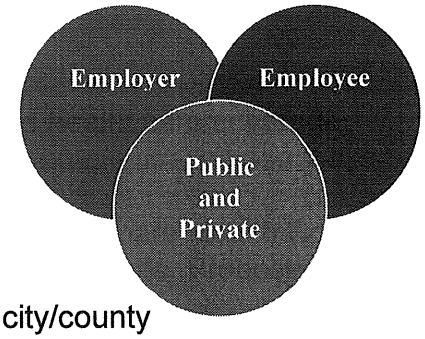
Legislative Request for a Demonstration Project:

1. Establish legislative rules for a community-based health care coverage program.

2. Provide funding ($3.5 million) for a five-year Multiple-Share Health Coverage Program demonstration project in Northeastern Minnesota. Proposed funding source is the Health Access Fund.

Multiple-Share Coverage Program Concept

Multiple-Share Health Coverage Programs build upon the current model of employer-based health insurance that operates in the US. These programs are intended for small businesses that do not provide health insurance benefits and whose employees earn below the community's median wage. Several multiple share programs are operational in other parts of the country (i.e. Muskegon, MI; Huntington, WV; Jacksonville, FL; both Oklahoma and North Dakota are discussing statewide plans). Other names for multiple share programs are three-share or premium subsidy assistance programs.



The key feature of the multiple-share concept is that the cost of coverage is shared among several sources. In addition to employer and employee contributions, community and public funding is available to make the health program affordable to both the business and the employee. In communities operating these types of programs, the community/public funding has been derived from city/county revenues, state assistance, and grant funding.

An affordable benefit package of health services is locally designed and only offered through participating area health care organizations. The coverage program is available to small businesses that do not offer health insurance benefits to their employees. Costs are typically in the $150- $200 per member/per month range. Model programs have employers and employees each paying a monthly fee between $35-$65, and a community fund paying the balance.

Underlying Principles of the Proposed NE MN Multiple – Share Demonstration Program:

- Targets low-wage, employed people.
- Program is priced to be affordable to both the employer and employee, thus encouraging participation.
- Leverages contributions from employers who are not currently providing health coverage to their employees. (MinnesotaCare is a shared cost between solely the individual and the state; employer funds would also supplement the cost in the proposed model.)
- Those eligible for public programs, particularly children, are encouraged to enroll in existing programs.
- The business is determined eligible based on median wage; there is no means test for employees.
- This program would cost less than that currently incurred to operate the MinnesotaCare program because of the employer contribution and limited coverage by a select group of participating health care providers.

Uninsured in Northeastern Minnesota

State and local population-based surveys indicate that an estimated 12,000 people are uninsured for the entire year in a four county area of northeastern Minnesota; Carlton, Cook, Lake and St. Louis. (2004)

Recent data from the Minnesota Department of Health indicates that 75% of the uninsured in the state are employed. Of those who are employed:

- 13.7% are self employed
- 91% have only one job
- 76% work 31+ hours a week
- 80% have permanent jobs
- 54% are in firms of less than 51 employees

There are an estimated 4,000 people in the area that meet the criteria of uninsured and employed by a small business, ≤ 50 employees. (Approximately 500 small businesses in the four county region)

In 2004, the Twin Ports Health Access Program received funding from the Healthy Community Access Program through the US Department of Health & Human Services. The Program's overall goal is to increase access to care for low-income, uninsured area residents using community-based solutions. The Program's collaborative partners include local health care providers, county public health and human services, non-profit agencies, and faith-based organizations.

Proposed Program Design

A. Target Market:
   - Small Businesses (≤ 50 employees).
   - Businesses located in northeastern Minnesota served by local, participating health care organizations.

B. Eligibility: Businesses are eligible if both criteria are met:
   - Median wage paid by the business is ≤ $12.50 per hour (275% of the federal poverty for a single person).
   - Have not offered health insurance benefits to their employees for at least 12 months.

C. Coverage Program Features
   - Basic benefit services will be provided at local health care organizations serving the Northeastern Minnesota geographic area that agree to participate.
   - Exact set of services will be determined by potential program users and health care organizations; potentially, they would include office visits, hospitalization, ancillary services, mental health, and pharmacy products.
   - Benefit cap will be established with input from health care providers and potential program participants.
   - Incentives will be used to encourage primary care and healthy behaviors in an attempt to avoid crisis care and use of emergency room services.

D. Provider Participation
   - Hospitals and clinics in Northeastern Minnesota will be encouraged to participate. Area health organizations have the incentive to sign-on in order to obtain some reimbursement for the uninsured who currently utilize local resources. Currently, the cost of covering the uninsured are often classified as charity care or bad debt from which health organizations receive very little or no payment.
   - Rates will be based on the Medicare fee schedule.

E. Program Management
   - Generations Health Care Initiatives, a Duluth-based, non-profit foundation focused on expanding health care access, will assume responsibility for establishing an operational structure to successfully administer the program.
   - Services such as eligibility screening and case management services would be an essential program component provided by Generations.

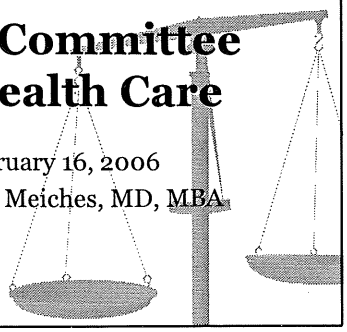
F. Program Financing
   - Anticipated cost of the total five-year demonstration project is $7 million.
   - The cost of the program would be shared among participating employers and employees, and a community fund.
   - Proposed initial partners in the community fund would include Generations Health Care Initiatives and the State of Minnesota ($3.5 million).
   - Budget is based on serving 150 participants during the initial start-up year, and reaching 1000 participants in year five.
   - Projected per member/per month cost averages $228.

G. Program Evaluation
   - Program evaluation criteria would be established to include items such as: reduction in the number of uninsured, funding leveraged from employers and employees, health status of program participants, reduced crisis/emergency care by the uninsured, and reduced overall costs.

Joint Committee on Health Care

February 16, 2006

Robert K. Meiches, MD, MBA



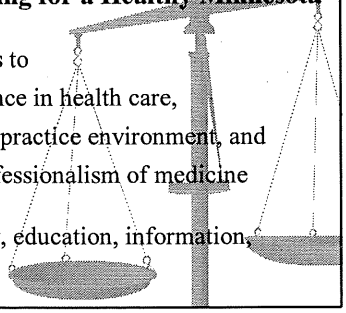
MMA Today

Physicians Working for a Healthy Minnesota

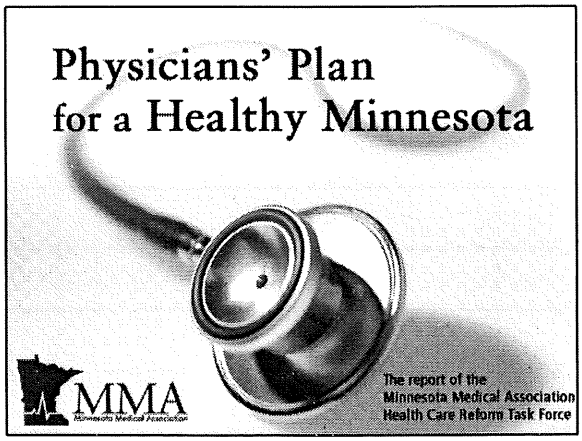
The MMA mission is to

- promote excellence in health care,
- ensure a healthy practice environment, and
- preserve the professionalism of medicine

...through advocacy, education, information, and leadership.



Physicians' Plan for a Healthy Minnesota



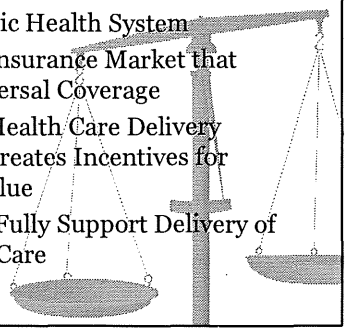
MMA

Minnesota Medical Association

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

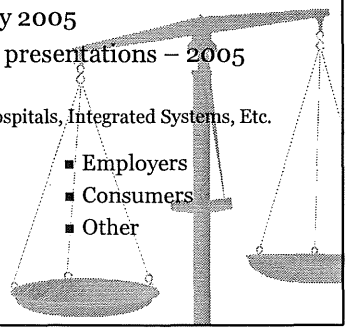
A New Model for Minnesota:
4 Interconnected Features

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



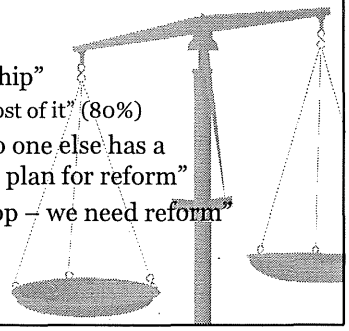
Physicians' Plan for a Healthy Minnesota

- Completed early 2005
- Over 70 formal presentations – 2005
  - Providers
    - Physicians, Hospitals, Integrated Systems, Etc.
  - Government
  - Health Plans
  - Labor
  - Employers
  - Consumers
  - Other



Physicians' Plan for a Healthy Minnesota

- "Great Plan"
- "Great Leadership"
  - "We (I) like most of it" (80%)
- "At this time no one else has a comprehensive plan for reform"
- "Don't let it drop – we need reform"

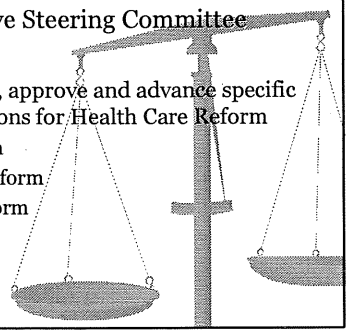


Physicians' Plan for a Healthy Minnesota

- Options reviewed
- Situation is urgent
- Federal solutions are not emerging
- States- increased role in leading reform
- Advance Proposal
  - Private/Public partnership most desirable
  - Engage public over time
  - Create Health Care Reform Steering Committee
- Healthy Minnesota: A Partnership for Reform

Healthy Minnesota: A Partnership for Reform

- Senior Executive Steering Committee
- Charge
  - Oversee, guide, approve and advance specific recommendations for Health Care Reform
    - Public Health
    - Insurance Reform
    - Delivery Reform
    - Quality

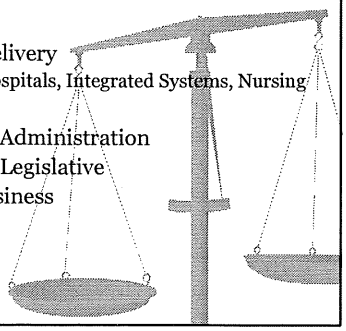


Healthy Minnesota: A Partnership for Reform

- Marketplace & Legislative Reforms
- Bold, meaningful reform
- Not "tweaking around the edges"
- "Doing" not "Talking about doing"
- 25 member Steering Committee
- Anticipate 4 Subcommittees
- March 2006 through 2007 Legislative Session

Healthy Minnesota: A Partnership for Reform

- Membership
  - Health Care Delivery
    - Physicians, Hospitals, Integrated Systems, Nursing
  - Health Plans
  - Government – Administration
  - Government – Legislative
  - Employers/Business
  - Consumers
- Staff



Dr. Robert Meicher

Healthy Minnesota: A Partnership for Reform

Background

The Minnesota Medical Association's health care reform proposal, "Physicians' Plan for A Healthy Minnesota," provides a unique opportunity to bring together health care and other community leaders to develop strategies to improve Minnesota's health care system. The plan, which was published in early 2005, is based on four interconnected features:

- **A strong public health system**, including an increased emphasis on prevention and creating incentives for healthy behavior.
- **A reformed insurance market**. This includes ensuring universal coverage for essential benefits, building a fairer system of spreading risk and sharing cost, and helping employers make coverage options available.
- **A reformed health care delivery market**, including increasing emphasis on consumer education and "health literacy," and on the provider side, creating incentives that focus on creating value rather than shifting costs.
- **Systems that fully support the delivery of high quality care**, including the use of evidence-based guidelines, more effective management of chronic conditions, electronic medical information systems, preventive care, coverage for behavioral health services, and a medical home with a personal physician for every Minnesotan.

The Physicians' Plan can be viewed online at www.mmaonline.net/taskforce.

Goal

The goal of the Healthy Minnesota Project is to develop and initiate implementation of specific, actionable strategies to improve Minnesota's health care system. Physicians' Plan for a Healthy Minnesota is the starting point for the project.

Process

A project steering committee and several work groups are being assembled and will convene in the near future. The work groups will develop and forward recommendations to the steering committee, which will prepare a final report and recommendations.

Partners

The Healthy Minnesota Steering Committee will include physicians and other providers, employers and consumers, as well as representatives of health systems, hospitals, health plans, state government, and higher education.

Timeline

Most of the work will be accomplished by the end of 2006, with a possible extension into early 2007. The final report may call for legislative action in 2007.

For more information, contact:

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612-362-3735
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2/15/06

Physicians' Plan for a Healthy Minnesota

The Minnesota Medical Association's Proposal for Health Care Reform

MMA
Minnesota Medical Association

The Report of the Minnesota Medical Association Health Care Reform Task Force
A Supplement to *Minnesota Medicine* | March 2005

Acknowledgments

The Minnesota Medical Association wishes to thank the following members of the Health Care Reform Task Force who generously provided their time, insight, and expertise. Without their significant contributions, this report would not have been possible.

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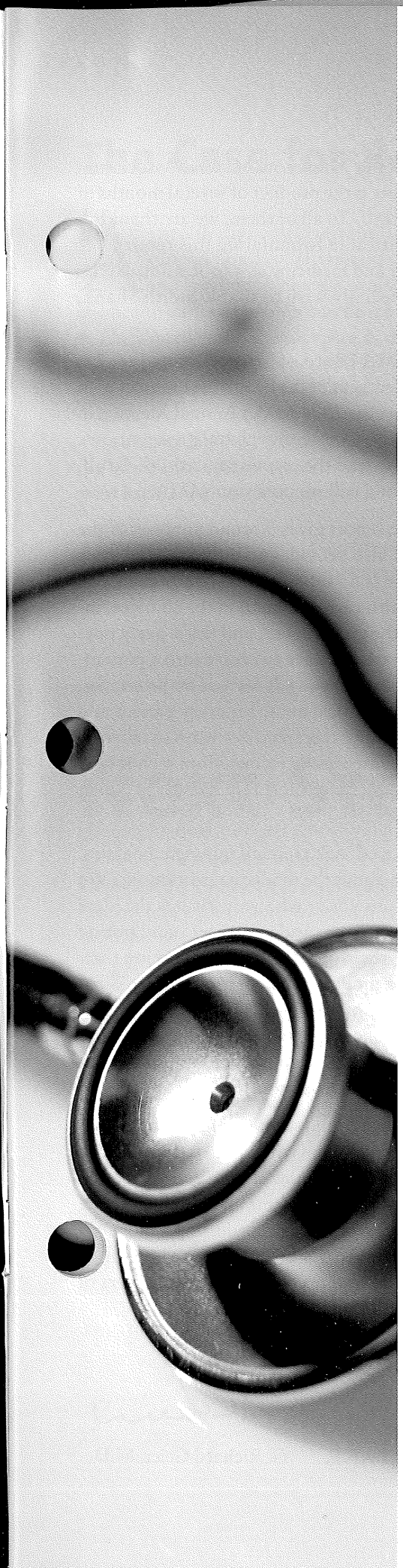
Minnesota Medical Association



Physicians' Plan for a Healthy Minnesota

The Minnesota Medical Association's Proposal for Health Care Reform

The Report of the MMA Health Care Reform Task Force

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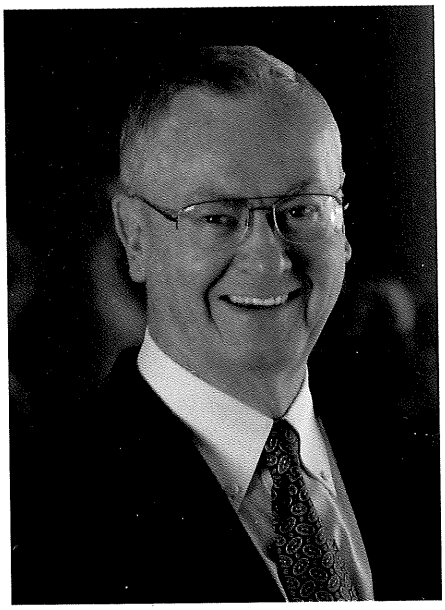
J. Michael Gonzalez-Campoy, M.D., Ph.D., F.A.C.E.
MMA President



G. Richard Geier, M.D.
Chair, Board of Trustees

Dear Colleagues:

It is a pleasure to present the report of our Minnesota Medical Association Health Care Reform Task Force. This report is the product of several months of work by task force members and MMA staff. To all of them, we are thankful. Not only was their collective wisdom critical in formulating this report, their commitment to physician leadership and medicine as a profession carries through their recommendations. We especially wish to thank Judith Shank, M.D., who chaired the task force.

This report was approved by the MMA Board of Trustees at its Jan. 22, 2005, meeting. For many of you, the key features of the health care reform plan will be familiar. A preview was presented at the 2004 MMA Annual Meeting in Duluth last September, and the MMA has given several regional presentations. For others, this will be your first chance to read the recommendations. To all, we hope you'll see the value of this work, and will support your MMA.

Our Health Care Reform Task Force report gives a broad analysis of the state of medical practice in Minnesota. It also provides an outline of the steps that need to be taken to improve it. There is no other plan as comprehensive. This report calls for all players in the health care system to make changes, including physicians, patients, employers, the government, and third-party payers. The ultimate goal is for the current system of care to evolve into a patient-centered model that ensures participation by everyone. It focuses on promoting health and preventing disease. It calls for a medical home for every patient and a return to a strong doctor-patient relationship. It emphasizes ways to enhance quality while controlling costs, such as greater use of information technology and continuous systems improvement. But perhaps most importantly, it places physicians in a position to lead health care.

Our MMA has been careful to elicit feedback from all interested parties. Some of our colleagues have strong views about the inadequacy of the current system of care. Some have definite opinions about what constitutes the ideal model of care that should replace the one we have. And yet others stand behind the current models of care, highlighting their benefits and minimizing their faults. Clearly, there is never going to be a model that pleases everyone. What the task force has created is a collective vision of how medical care in Minnesota should evolve. This vision represents many compromises. It values the good things we have accomplished. But it challenges us to continue to improve what is currently recognized as the best health care in the nation.

Change is often difficult. Many of us feel complacent and fear change. But over time, our association has realized that change will come one way or another and that fighting it is fruitless. We have, by virtue of this report, asserted our right to move beyond merely being a part of the process and have placed the MMA in the lead. Our MMA is proud of its work and its leadership. Above all, our MMA is pleased to continue to be of value to our profession. We hope all you will embrace the concepts in this report and become ardent supporters of the process of change that it will help bring about in Minnesota.

Sincerely,

J. Michael Gonzalez-Campoy, M.D., Ph.D., F.A.C.E.

G. Richard Geier, M.D.

The Case for Reform

As health care costs continue to rise and exert pressure on families, physicians, businesses, and state and local governments, consensus is building that the health care system needs to be reformed.

- The United States spends twice as much per person on health care as any other country.
- In Minnesota, the average annual cost of health care per family is about $11,000—an amount that is expected to double by 2010. Wages are not growing fast enough to absorb such cost increases.
- At least 275,000 Minnesotans don't have health insurance.
- Opportunities to improve quality and reduce costs exist—especially in the treatment of chronic illnesses.

The MMA's Response

The MMA Board convened the Health Care Reform Task Force in January of 2004 after recognizing the growing momentum for a more fundamental debate about health care. The MMA's last major health care reform initiative was in 1992.

The 21-member task force met 11 times during a nine-month period to grapple with the complex problem of health care reform. The goal of every task force member was to make a set of recommendations that would result in bold and fundamental change. The report was unanimously approved by the MMA Board of Trustees on Jan. 22, 2005.

The task force members hope Minnesota's physicians will unite around this reform vision and use it to lead the state to a better and more affordable health care system.

Next Steps ...

Some of the recommendations in the Physicians' Plan for a Healthy Minnesota require long-term efforts and collaboration with other stakeholders. In the next several months, MMA staff and members will build support for the plan by holding about 200 meetings with health care stakeholders such as physicians, health plans, legislators, consumers, employers, the governor's administration, and community groups. The goal of these meetings is to refine the plan and fill in details.

Other recommendations, such as those below, can be undertaken immediately or are already part of the MMA's action plan:

- Advocate for stronger public health policies and systems
- Help physicians deliver evidence-based care
- Support a medical home for every Minnesotan through changes in administrative and payment policies
- Support efforts to improve care delivery and payment for patients with chronic and complex conditions
- Advocate for including behavioral health care as part of basic medical benefits
- Support an information infrastructure that would allow collection, reporting, and dissemination of the information needed to measure and improve quality and help patients make choices about cost and quality
- Advocate for reductions in administrative complexity
- Support a $1 per pack increase in the tobacco tax to help preserve Minnesota's health care programs and move toward universal insurance coverage
- Advocate for a statewide ban on smoking in bars and restaurants
- Explore legislative options regarding specific reforms such as an individual insurance requirement, an essential benefit set, and insurance market reform

Judith Shank, M.D., chair of the MMA Health Care Reform Task Force

The Right Plan at the Right Time

Former MMA President Judith F. Shank, M.D., led the 21-member MMA Health Care Reform Task Force through months of deliberations on how to reshape Minnesota's health care system. Shank is a strong believer in the vision of providing insurance for all Minnesotans and improving the quality of care—while at the same time holding down health care costs. Here are some of her thoughts about why Minnesota needs the Physicians' Plan for a Healthy Minnesota.

Q. Why is reform needed now?

A. The Legislature is grappling with budget shortfalls and finding that more and more of the state's budget is taken up by health care costs. Employers are seeing double-digit increases in the cost of their health care premiums. Employees' portion of health care costs is rising three times faster than wages. So there's recognition that health care is tremendously important to everyone and costing more and more every year.

Q. What is at the heart of the task force's vision?

A. The vision is essentially that all Minnesotans should have health care insurance [and that we] can improve quality because we have much more information to work with now.

Q. How could a new system promote quality and save money?

A. Hopefully, the new system would provide incentives for physicians to do more counseling and prevention and disease management. We know that 30 percent of the population uses 70 percent of health care dollars. And 5 percent of the population uses 50 percent of health care dollars. By giving both patients and physicians incentives to work on primary and secondary prevention and using better systems to manage chronic disease, we can keep more people healthy and out of these high cost groups. Improvi chronic disease management should improve quality of life and prevent expensive hospitalizations.

Q. Can you give an example?

A. We can improve quality by getting more patients to have colonoscopies in a timely fashion. Colon cancer, in most cases, is a preventable illness. So it would cost more for the colonoscopies, but you would save a lot of money on therapy and surgery later on. Another good example was a lo project that used a team ap proach to help patients manage their congestive heart failure (CHF). Physicians collaborated with nurses, nutritionists, pharmacists, even physical therapists to provide care for a group of patients that had had numerous hos-

pitalizations for CHF. The result was a dramatic improvement in health status and thousands of dollars in savings. Right now, there is no way to finance such programs without a grant.

Q. How does public health fit into this vision?

A. There certainly needs to be more dollars spent on public health. We only spend about 5 percent of health care dollars on public health. For instance, if we could keep people from smoking, we could save lots and lots of dollars. Lung cancer and COPD are nearly always related to smoking, and they are very expensive to treat.

Q. Why reform the insurance market?

A. At present, insurance companies work very hard to prevent adverse selection. They don't want to be attractive to people who have medical problems and could cost them money. If everyone's [insurer] was required to provide health insurance for anybody [who wants it], it would stop that adverse selection and the inefficient cost shifting that goes with it.

Q. Why is an individual mandate necessary?

A. It is unfair for people who assume they are young and healthy to opt out of the program. The idea of insurance is to spread risk. And it should be spread as broadly as possible.

Q. Doesn't that create another burden for the poor?

A. There would have to be subsidies for people who cannot afford it. We're already subsidizing health care for many poor people. We think we could do that more efficiently with a different insurance market.

Q. Who will determine the essential set of benefits?

A. What we're proposing is that there be a community group led by physicians that determines the essential set of benefits. It would be evidence based where possible. There isn't a lot of evidence about some things. In those cases, it would have to be based on expert opinion and existing guidelines.

Q. Will it be a bare-bones set of benefits?

A. I don't think we envisioned bare bones. I think we envisioned a process where many of the things that are covered now would still be covered. We would not, however, advocate for big copayments for preventive services. We want to give people incentives to use preventive services.

Q. How would this work?

A. One example might be prescribing a generic drug versus a brand-name one. Probably, generic drugs for hypertension would be fully covered, but if you want a new high-tech, fancy drug you only have to take once a day, you might have to pay more for that one.

Q. How will prices be determined?

A. Physicians would set their own fees, presumably based on real costs. Insurance companies would determine what is a reasonable amount to pay for a service. Then, patients would be responsible for deciding whether or not they were willing to pay more for a specific procedure, physician, or hospital.

There also must be some mechanism to make sure that people without discretionary dollars still have adequate access to the services they need.

Q. Will this change the way the government buys health care?

A. Government programs set prices. Many of their prices are far below the cost of care, though some prices actually exceed the cost of care. That creates an incentive for hospitals to concentrate on profitable care and to minimize care that is poorly compensated. This is why we have so few psychiatric beds and so many cardiac centers. The other thing that happens is that the costs get shifted onto employers and other purchasers.

The MMA can't make the government do anything. But we would hope, through the power of persuasion and by employers recognizing how much of this cost they're bearing, we could end the discriminatory pricing.

Q. What needs to happen to make this plan a reality?

A. We need to get buy-in from employers. We need buy in from and we need to educate consumers. And we need the government to think more long term.

Q. How soon could change occur?

A. There are a lot of pieces that could happen quickly.

Q. Which ones?

A. It might take the Legislature a year or two to change the laws relating to insurance. That's a matter of will more than anything else. We can all start working on understanding what high-quality care is and developing systems to help with that.

Q. How significant is this plan?

A. It is very significant. Employers see health care costs are harming their ability to compete in a global market. They are eager for ideas about how to do a better job of providing better health care for their employees at lower costs. I think they are eager for something like this.

Health Insurance for All Minnesotans

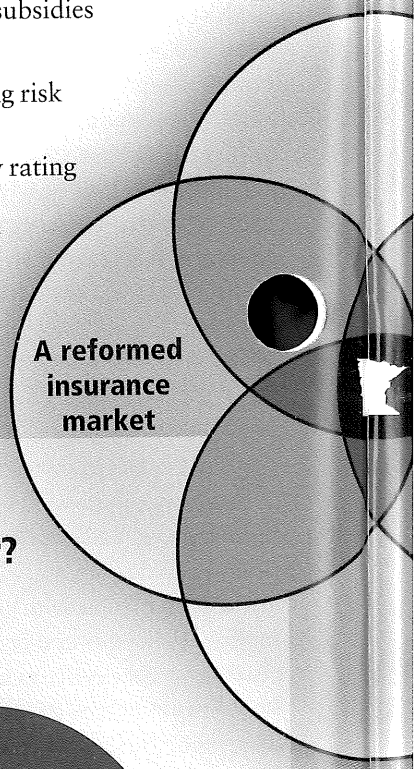
Achieving universal coverage is a key step to creating a better, more affordable health care system in Minnesota. Under the plan, all Minnesotans will be required to have insurance for essential health care services. A communitywide, physician-led discussion will lead to the creation of an essential set of benefits that will be continuously updated.

Under the proposal, all health plans will sell this essential benefit set. Pricing will be based on a community average, rather than an individual's age or health. People will be able to buy supplemental insurance for services outside the essential benefit set. The state will subsidize the cost of basic coverage for those who cannot afford it.

Universal insurance coverage will result in a healthier population and lower health care costs, as having insurance will encourage people to get preventive care and avoid more serious illness. Also, when everyone has insurance, the risk pool is broader and insurance is more affordable. Universal coverage will also eliminate inefficient cost shifting to employers and health care providers.

Recommendations

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



Best of Both Worlds

Competition and Coverage

Minnesotans are divided. They want universal coverage, and they want a private health care system. The MMA proposal gives them both. The government will require all Minnesotans to have health insurance, but medical services will be delivered in a competitive market.

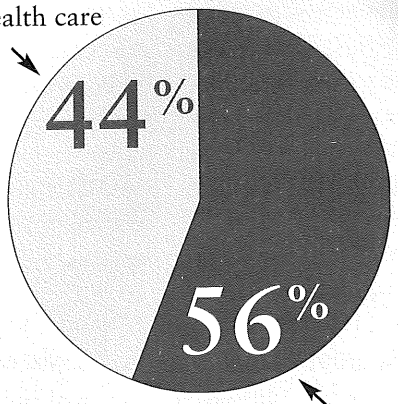
Under the plan, patients, not large payers or the government, will control health care spending. Physicians, not insurance companies, will set prices. Patients will have unlimited choice and a stake in getting the best value for their health care dollars. Overpriced health care providers will lose patients.

Health plans will compete by offering supplemental products covering additional services or reducing patients' out-of-pocket expenses.

A combination of universal health care coverage and a competitive market will slow rapidly rising health care costs, improve the quality of care, and result in Minnesotans receiving the best value for their health care dollar.

Which would you prefer?

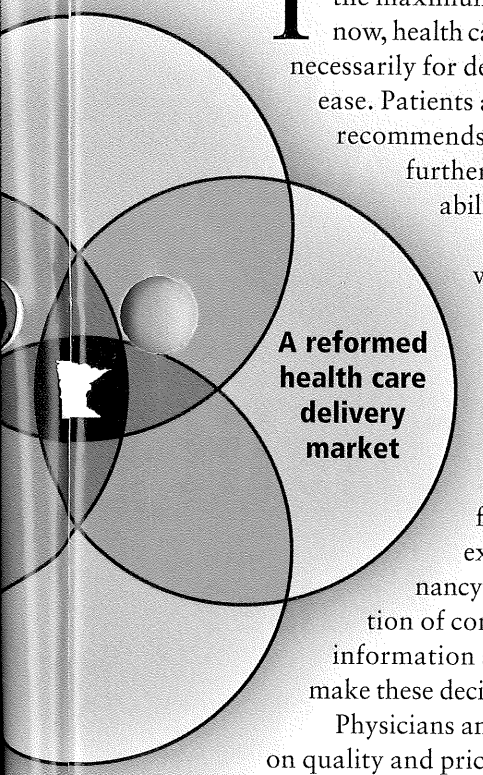
A private system that relies on individuals and employers to provide for their own health care needs.



A universal system in which the government ensures that everyone has coverage.

Source: Minnesota Citizens Forum on Health Care Costs

A Competitive Market that Improves Value and Engages Consumers



The task force concluded that Minnesotans are not getting the maximum value for their health care dollars. Right now, health care providers are rewarded for volume—not necessarily for delivering quality care or for preventing disease. Patients are often oblivious to costs. The task force recommends changing the current payment system to further engage patients and support physicians' ability to deliver the highest quality care.

Under the plan, patients, not large payers, will control health care spending. Patients will decide where to receive care and how much they are willing to pay for it. They can choose to pay extra to be cared for by higher-cost providers, to use a brand-name drug rather than a generic, or to receive care that is not needed but is preferred, such as frequent ultrasound examinations during an uncomplicated pregnancy or repeated imaging procedures for evaluation of common conditions. Patients will have more information available at the point of care to help them make these decisions.

Physicians and other health care providers will compete on quality and price. Physicians will set their own prices, and barriers to competition, such as limited networks, will be eliminated. Encouraging health care providers to compete on price will keep the price of services in line with value.

Health insurers will compete by helping enrollees make the best use of their money. They may also offer supplemental insurance that will limit out-of-pocket risk for patients and/or cover services outside the essential benefit set. Though everyone must have insurance, employers will still have an incentive to offer insurance benefits as a way to recruit future employees or to keep existing ones.

The state and federal governments will buy health care services the same way private purchasers do. Government will stop arbitrarily setting prices below actual costs because this results in inefficient cost shifting to the private sector. This will lead hospitals, physicians, and clinics to use their capital and resources more efficiently.

Recommendations

- Engage patients through greater accountability for medical decision making.
- Create a fundamentally different economic model for medical care service
  - End discriminatory government pricing policies.

What do Minnesotans want?

69% say health insurance should pay for any kind of medical treatment, regardless of the cost.

62% say our health care system should spend as much money as necessary to try to save a person's life.

But...

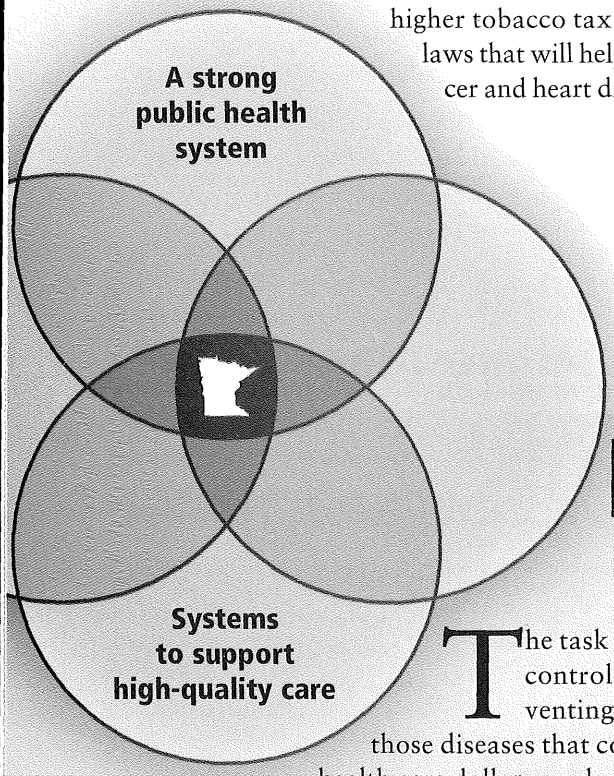
72% say the cost of treatment, along with the chance of success, is a factor that should be considered when making treatment decisions.

82% say people have the responsibility not to overuse health care services because it increases insurance costs for everyone.

SOURCE
Minnesota Citizens Forum on Health Care Costs

A Strong Public Health System

There should be more emphasis on preventing illness and strengthening our public health system. The public health system reduces risk factors for disease by protecting the food and water supply, ensuring highway and workplace safety, and promoting changes in social norms and behaviors such as reducing tobacco use. It also promotes immunization, controls disease outbreaks, and coordinates disaster response. Public health must be considered an integral part of the health care system. Minnesota should adopt policies such as a higher tobacco tax and clean-air laws that will help prevent cancer and heart disease.

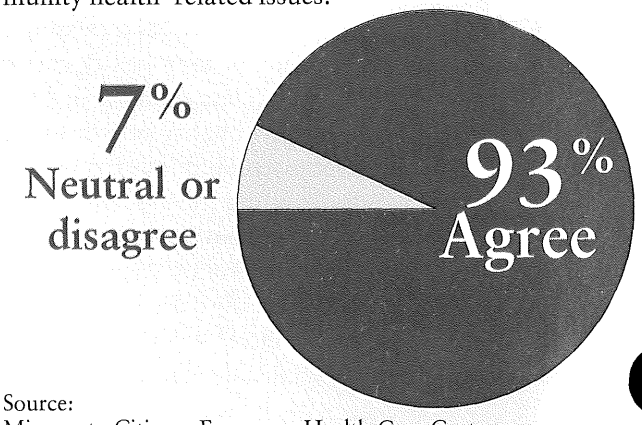


Recommendations

- Make public health more prominent.
- Coordinate action to address modifiable risk factors.

Do you agree or disagree?

I think it's a good idea that the government spends money on prevention, early detection of disease, and other community health–related issues.



Source:
Minnesota Citizens Forum on Health Care Costs

Promoting Quality

The task force found that attempts to control costs should focus on preventing and managing the care of those diseases that consume most of Minnesota's health care dollars, such as heart disease and diabetes. The emphasis will shift from trying to control costs in the generally healthy population to preventing and managing serious illness in the 30 percent of patients who generate 70 percent of health care spending.

The plan calls for policies and incentives that encourage the use of evidence-based guidelines, disease management, and preventive care. Investments should be made in electronic medical information systems that can improve care and eliminate errors. And the health care system should help each Minnesotan find a "medical home" with a personal physician. Behavioral health services will be covered in the same way as care for other illnesses. The task force supports initiatives that provide patients with cost and quality information they can use to make smart health care choices.

True or False?

The MMA is calling for a government-run single-payer health care system.

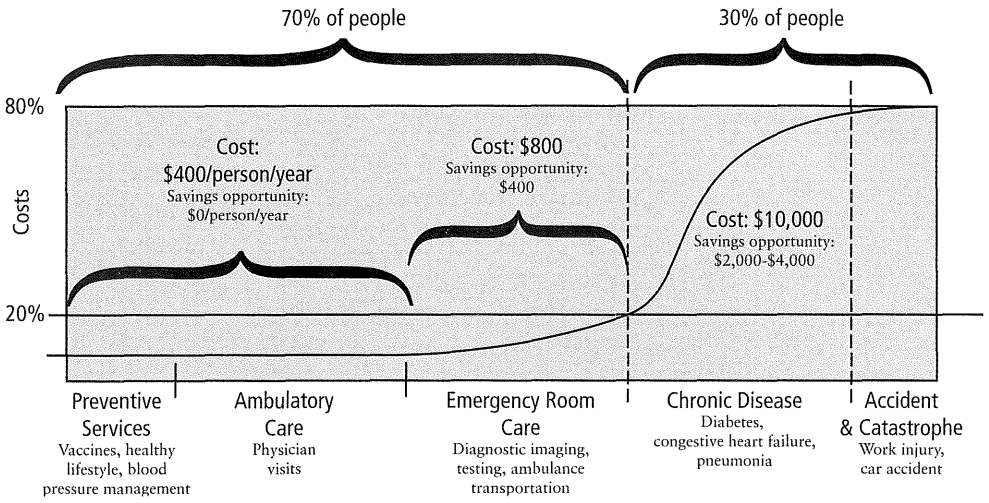
The essential set of benefits will be bare bones.

The plan encourages employers to stop providing health insurance.

The plan has no room for health savings accounts.

Health Care Costs

Only 5 percent of patients generate more than 50 percent of health care costs. Today's system tries to save money primarily by extracting deep discounts from primary care. This is counterproductive and discourages preventive medicine. Cost-control efforts should focus on chronically ill patients or those with complex diseases who generate the vast majority of costs.



Average annual per household health care costs in Minnesota: $11,000

Sources: Fischer M, Avorn J. JAMA 2004;291:1850-1856; McGlynn E, et al. New Engl J Med. 2003;348:2635-45; and Milagra VG, Ahmed T. Health Affairs 2004;23:255-266.

Health Care

False The MMA supports a more competitive, market-oriented health care system than exists today.

False Essential benefits will likely resemble those offered by employers today.

False Health benefits will still provide a powerful way for employers to attract and keep employees.

False The plan embraces a competitive market in which health savings accounts still make sense.

Recommendations

- Further increase the amount of effective care that is provided
  - Support physician-developed guidelines.
  - Support expansion of improved information infrastructure.
  - Support every Minnesotan having a medical home.
  - Place the emphasis for cost control where the greatest opportunity exists—chronic care
- Provide useful quality information
  - Support transparency in quality measurement and reporting of system capability.
  - Support simplified quality measurement and reporting transactions.
- Develop payment systems to support quality practice
  - Support payment processes that financially reward the implementation of guidelines, registries, and other efforts to improve quality of care.
- Ensure the safety and quality of health care
  - Leverage existing quality-improvement work.
  - Ensure the competency of heath care professionals and institutions.

Current and Future Stakeholder Roles in

	Patient/Consumer	Physician/Provider	Employer
Current	• Chooses plan based on coverage levels, provider access, premium price • Seeks service • Pays co-pay (if any) • Feels entitled to covered services • Pays nothing or full price (no discounts) if uninsured • Pays higher co-pays for behavioral health services • Chooses physicians based on referrals or word of mouth	• Provides service • Is paid primarily at negotiated (imposed) rate • Provides care to uninsured either charged at full rate or as uncompensated care (occasional individual arrangements negotiated with selected providers)	• Selects plan(s) and produc • Determines contribution levels • Can restrict or opt out of behavioral health coverage
Future	• Chooses plan based on price, quality of administrative services, availability of information to support provider choice, shared treatment decision making, prevention, and care management • Seeks services from any provider with no plan restrictions • Chooses physicians based on quality and cost information (may face cost differentials based on level of coverage and physicians' prices)	• Advises patient on treatment options • Provides service • Sets same price for all patients (percent of bill paid by patient versus plan may vary among plans) • Strives to improve safety, effectiveness, efficiency of care • Competes on improved outcomes and expertise • Provides information about cost and quality	• Selects plan(s) to administer essential benefits • Chooses whether to offer additional coverage • Determines contribution levels • Provides incentives and p grams for health risk reduction/wellness (eg, employer pays enrollee and physician to complete a health risk appraisal and rewards both for improvement over time) • Provides information to employees to help them maximize value for dollars spent

How the MMA Proposal Compares with t

The MMA proposal includes many of the same recommendations made by Gov. Tim Pawlenty's Minnesota Citizens Forum on Health Care Costs (2004). That forum conducted numerous public hearings and a public opinion survey to chart a course for health care reform in Minnesota.

Recommendations	MMA Plan	Citizens Forum Plan
Allow patients to control payment and choose providers	Yes	Yes
Create payment systems that support preventive care	Yes	Yes
Encourage patients to choose treatments based on value	Yes	Yes
Disclose cost and quality information	Yes	Yes
Reduce costs through better quality	Yes	Yes
Change payment systems to reward quality	Yes	Yes
Strengthen public health efforts	Yes	Yes
Commit to universal coverage	Yes	Yes

in Creating Value

Health Plan

- Designs multiple benefit packages
- Sets coverage criteria
- Determines provider network
- Effectively sets provider's price/payment
- Is primarily concerned with control of unit prices
- Supports independent behavioral health pricing, access and service limits, and co-pays

Government

- Focuses on setting artificially low prices per unit cost
- Shifts costs to other payers
- Adds layers of regulation
- Adopts benefit mandates

- Administers essential benefit set
- Uses standard clinical guidelines
- Does not define provider network but helps consumers find a medical home and maximize the value of their dollars
- Negotiates payment rates to providers but doesn't limit provider prices
- Shifts payment toward episodes of care or care for ongoing conditions
- Provides information and other support for providers to improve care
- Charges a community-rated premium for essential benefits
- Continues to design and offer supplemental products
- Participates in a statewide reinsurance pool for all its products
- Provides information to enrollees to help them maximize value for dollars spent

- Ensures a well-functioning market
- Protects against anti-trust violations
- Provides tax incentives for coverage
- Pays plans and providers a reasonable rate
- Subsidizes coverage for people with low incomes and ensures access
- Supports the information infrastructure with funding, incentives, regulations
- Promotes streamlined reporting
- Does not impose mandates for ineffective care
- Ensures a strong public health system
- Uses policy tools to reduce health risks

h the Citizens Forum Plan

Recommendations	MMA Plan	Citizens Forum Plan
Require individuals to have health insurance	Yes	No
Use community average to price insurance	Yes	No
Develop an essential benefits set	Yes	Yes
Reduce the cost of overhead and administration	Yes	Yes
Eliminate cost shifting for uncompensated care	Yes	Yes
Persuade government to buy health care like private parties do	Yes	No
Provide incentives for healthy behavior	Yes	Yes

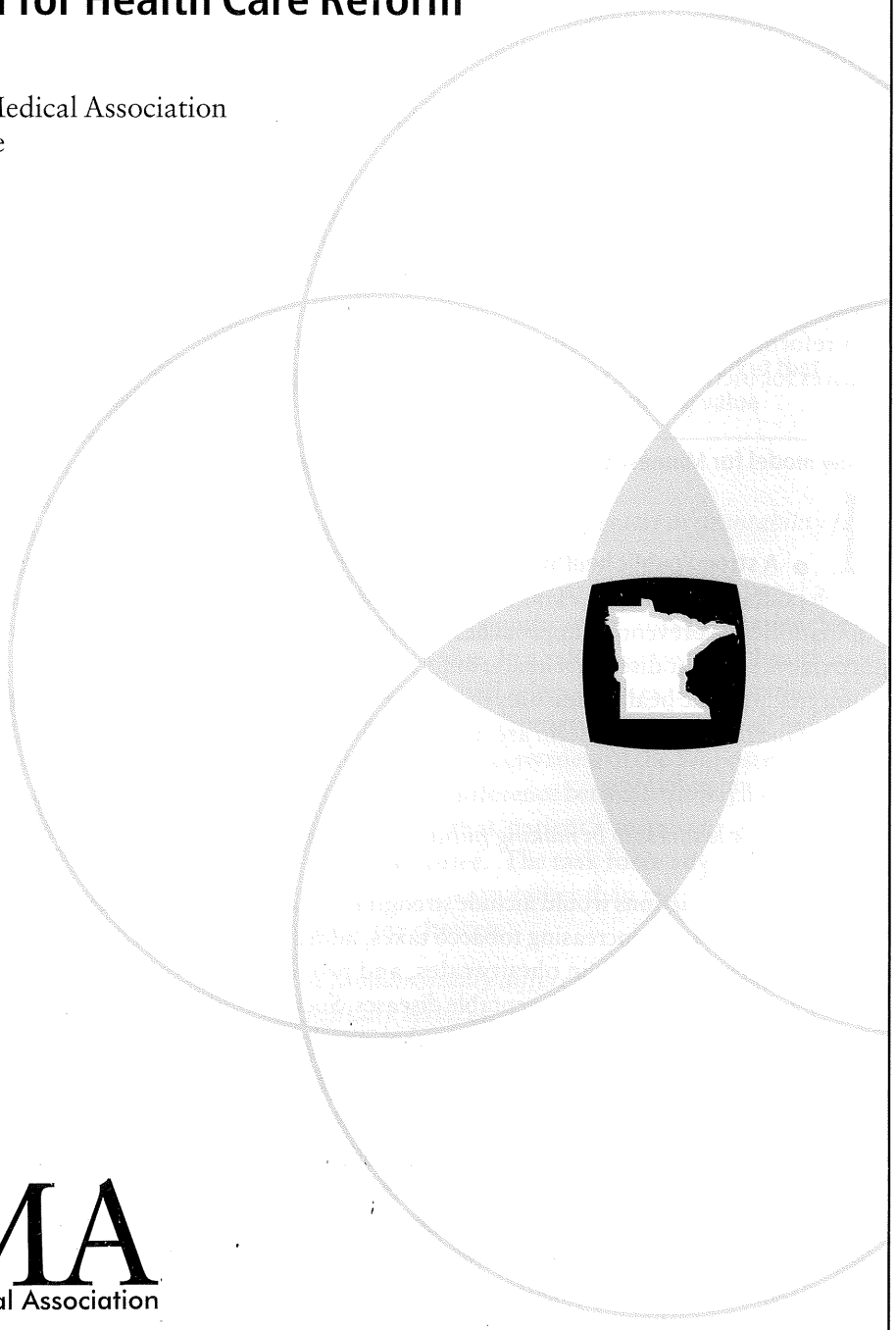
Note: For a more extensive comparison see pg 39.

Physicians' Plan for a Healthy Minnesota

The MMA's Proposal for Health Care Reform

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

Approved January 2005



MMA
Minnesota Medical Association

Executive Summary

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

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

1. A strong public health system,

2. A reformed insurance market that delivers universal coverage,

3. A reformed health care delivery market that creates incentives for increasing value,

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

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

Why health care reform again?

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

A new model for Minnesota: Four interconnected features

1 • A strong public health system

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

Recommendations:

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

Coordinate action to address modifiable risk factors.
Although many organizations have a genuine interest in supporting prevention, current activities across the state are fragmented. The MMA should urge the creation of a more coordinated and strategic action agenda to address the leading modifiable risk factors.

2 • A reformed insurance market that delivers universal coverage

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

Recommendations:

Ensure universal coverage for essential benefits.

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

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

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

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

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

Build a fairer system of spreading risk and sharing cost.

- *Require statewide community rating, guaranteed issuance, and a high-cost case reinsurance pool.*
  In the current system, health plans compete to a significant degree by seeking to avoid insuring the groups of people that have the highest medical costs through their product designs, underwriting criteria, and rating policies. To create a more stable and fair system, the task force calls for a return to statewide community rating for the essential benefits set. Plans would charge everyone the same premium for the essential benefit set regardless of their age or health status. The plan also calls for the creation of a mandatory reinsurance pool for all types of health plans and all products. Under the new model, policies would be available to all who wish to buy them—guaranteed issue.

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

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

Recommendations:

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

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

individuals and small-group purchasers.

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

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

Recommendations:

Further increase the amount of effective care that is provided.

- *Support physician-developed guidelines.*
  The appropriate use of evidence-based, clinical guidelines is important for clinical and shared decision-making. Although numerous guidelines exist, they must be developed in an open, multispecialty process. All guidelines should also be readily available to patients so they can better understand how to approach common health problems and what to expect from physicians and other health care providers.

- *Support expansion of an improved information infrastructure.*
  Interconnected health information systems are needed to support more efficient care and to support a heightened commitment to measurement and improvement. To fully engage patients in making informed, value-based decisions, real-time benefit determination systems will be required. Building and sustaining such systems will require leadership by the federal and state governments and the active partnership of private-sector purchasers and health care providers.

- *Support a "medical home" for every adult and child in Minnesota anchored in a continuous relationship with a personal physician.*
  The relationship between patient and physician is the central leverage point for improving quality and value. If these relationships are allowed to continue long term without the disruption caused by health plan and network changes, the benefits of a medical home are further increased.

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

Provide useful information about quality.

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

Develop payment systems to support quality practice.

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

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

Ensure the safety and quality of health care.

- *Leverage existing quality-improvement work.*
  A tremendous amount of quality-improvement activity is already underway in Minnesota. Enough money is being spent already to fund an aggressive quality-improvement agenda for the state. Much more could be accomplished if the activities were more efficiently organized and connected, and if duplicative efforts were reduced.

- *Ensure the competency of heath care professionals and institutions.*
  Current limitations in methods preclude the use of statistical quality measures at the individual physician level. Instead, physician competency is assessed by methods such as state licensure and board certification. Board certification, in particular, is undergoing significant transformation. More emphasis is being placed on ongoing demonstration of performance rather than knowledge alone. As the new market system evolves, the role of various stakeholders in assuring competency will need to be re-evaluated.

Financing the health care system

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

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

Achieve efficiencies and redirect expenditures.
Much of the money spent on health care now is wasted. Capturing those lost dollars will require administrative simplification in the insurance, billing, and claims adjudication processes. It will also require the elimination of the waste and extra expense created by overuse of resources and current variations in quality.

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

Moving reform forward

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

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

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

Task Force Charge and Process

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

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

More than 50 physicians responded to the memberwide call for volunteers to serve on the task force. G. Richard Geier, M.D., MMA board chair, selected members from diverse specialties and from various parts of the state. Former MMA President Judith Shank, M.D., was asked to chair the group. The task force met 11 times over the course of nine months.

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

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

Key Assumptions

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

1. Regardless of the mechanism of financing (whether a competitive market model or a government-funded and regulated model), it is critical that the delivery of effective health care be improved, including reducing the utilization of services that are driven more by the preference of the patient and/or physician (preference-sensitive care), as well as those that are driven more by availability (supply-sensitive care), rather than by evidence of appropriateness.

2. The task force recognized that the current system of health care financing creates severe economic distortions for all users and that federal payment policy is a significant contributing factor. The current system of "administered pricing" by Medicare and Medicaid shifts costs to other users, thereby increasing costs for other consumers. Complete reform will require federal action, but it is possible for Minnesota, and neighboring states working with Minnesota, to make changes that will improve health care quality and value and slow the rate of increase in health care spending. The Institute of Medicine in its Leadership by Example report has suggested that there is a greater likelihood for reform when whole states or regions undertake efforts to improve health care quality and value. Minnesota has an opportunity to lead the nation in such efforts. The recommendations outlined in this report should serve as a blueprint for the combined efforts of physicians, other health care providers, consumers, payers, and government to move forward in a coordinated and effective manner.

3. The task force recognized that Minnesota is not an island and could not, even if we wished to, make fundamental changes in the nature of the current employer-based private insurance system absent federal policy changes. The task force did look briefly at other international models of health care financing and wondered whether, especially

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

The vast majority of task force members concluded that a private, competitive market model is preferable to a government-controlled model primarily because of its superior ability to promote innovation and advancement. Many task force members did, however, place a high value on the equity and potential administrative simplicity of a more centrally financed and managed system. Members generally agreed that appropriate health policy should strive to find the optimal mix of competitive and regulatory approaches, and the recommendations in this report do propose a balance of both.

The Case for Change

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

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

Cost

Per capita health care costs have increased at an average of 3.6 percent per year since 1960, versus GDP growth of only 1.4 percent per year. The share of the national economy spent on health care, education, and defense was 6 percent for each in 1960. By 2003, education was still at 6 percent and defense had fallen to 4 percent, but health care was at 16 percent of all spending. The imbedded cost of health care in the goods and services produced by American companies puts us at a growing disadvantage with global competitors.[2] The average annual health care cost for a family in Minnesota is about $11,000, and this is projected to double by 2010 if current trends continue.[1] Real wages are not growing fast enough to absorb this cost increase. If unabated, these trends portend a reduction in access to and quality of care, and adverse economic effects for individuals, companies, and government.

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

A recent study by Thorpe et al. in *Health Affairs* broke down the component parts of the cost increase for the 15 health conditions that account for the majority of the health spending increase from 1987 to 2000. The researchers found that for about half the conditions total cost increases were driven principally by increases in the cost per case (ie, the increased intensity of care), which were driven in turn by new technologies and new treatment approaches. For the other conditions, an increase in the number of people being treated was the main factor. Notably, two of the top cost drivers in this analysis are diabetes and pulmonary diseases, the causes of which are environmental or related to personal behaviors (especially smoking and obesity) and are almost entirely preventable.[3]

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

Access

The United States is alone among developed nations in failing to guarantee universal health care coverage to its people. During the booming economy and tight labor markets of the 1990s, employer-provided coverage grew, although even then about 15 percent of people, most of whom were employed, were left without coverage. After a decade of fairly steady progress toward insuring more people, coverage levels are falling in the nation and in Minnesota, as employers have a harder time offering coverage, employees have a harder time affording it even when offered, and government programs tighten eligibility requirements as budgets are cut. Forty-five million Americans are uninsured on any given day of the year, and 82 million are uninsured at some point in the year.[4] The last official estimate for the number of uninsured Minnesotans was 275,000, although new data are expected soon that will likely show an increase.[5] Given cost trends and projected budget deficits, the number of uninsured is likely to continue to increase, absent policy changes. For thousands of other Minnesotans, high-deductible policies or limited coverage options may limit access to necessary and appropriate medical care.

Given that health care providers work hard to provide charity care and that public policy requires that people not be refused care for inability to pay, public opinion hasn't always equated lack of insurance with lack of needed care. The evidence is now clear, however, that coverage correlates strongly to health, productivity, and even mortality. Approximately 18,000 people die each year in the United States because they are uninsured, according to the Institute of Medicine. Others suffer unnecessary consequences of their disease and lack of treatment, and the indirect costs to the economy in lost productivity (including both absenteeism and impaired performance of people who continue to work despite their illness and limitations) are increasing.[6]

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

Quality

Quality of health care is now understood to be highly variable. An estimated 30 percent of all health care spending nationally goes for care that is either not indicated, not effective, or not up to current community standards. A 2003 study by McGlynn et al. published in the *New England Journal of Medicine* constitutes the most thorough review to date of actual care received against well-accepted clinical standards. The researchers reached the startling conclusion that Americans receive effective care (defined as appropriate care based on medical evidence and practice guidelines) for acute and chronic conditions only about half the time.[7] Dartmouth researchers (Fisher et al.) reported in the *Annals of Internal Medicine* that for the Medicare program, the highest quality of care is actually delivered in the lowest-cost regions of the country.[8] Medicare data show Minnesota to be a low-cost, high-quality state. But current Medicare payment policy essentially penalizes rather than rewards this.

The evidence is mounting that "more care is not always better care" and that sometimes, in fact, more care is downright dangerous. The seminal Quality Chasm series from the Institute of Medicine not only documents the impact of suboptimal care on the public's health but suggests a blueprint for solutions.[9] Although many analyses suggest that Minnesota performs significantly better than national averages, there are also clear indications that quality variation is an issue and an opportunity here as well. These sources include the Institute for Clinical Systems Improvement, Stratis Health (the Medicare Quality Improvement Organization), and the recent results from the Council of Health Plans' Community Measurement Project. The task force is convinced that the Institute of Medicine and the Citizens Forum had it right: Higher-quality care need not always cost more; in fact, when it comes to cost containment, quality improvement is a big part of the answer.

Health status

It is increasingly clear that despite spending twice as much or more per capita than most other countries on health care, the United States lags far behind them on broad measures of population health. The World Health Organization ranks the United States as 29th in life expectancy. The United States has fallen in the rankings on such basic measures as both male and female life expectancy and infant mortality in the last 20 years.[2] The reasons for the disparity in spending and outcome are complex. Indeed, researchers believe that differences in access to medical services per se account for perhaps 10 percent of those gaps. The most powerful determinants of population health are personal behaviors and the physical, economic, and social conditions of the communities in which people live.[10]

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

are quite different in that society as well.[11] Some might suggest that this comparison is much too simplistic. But it does raise a provocative challenge: Shouldn't the health we are producing for our population for the dollars we invest be the truest measure of our health policy?

From a state standpoint, part of Minnesota's past performance on measures of health care cost and quality come from its historically strong public health system and the relatively healthier habits of the population. More recently, however, local health behavior trends should give us cause for alarm. Smoking rates, for example, have not fallen in Minnesota as rapidly as in the nation as a whole. Youth smoking rates increased more rapidly during the years we were not funding aggressive prevention efforts, and obesity rates are increasing faster in Minnesota than in some areas. Despite the high health status rankings of the majority population, some key health status measures among African Americans and American Indians are worse than their counterparts in other states.[12] Public health research suggests that the causes of these disparities have a great deal to do with social and economic conditions in the communities in which minority populations are concentrated. Given the forecasted growth of these populations in coming decades, these disparities are even more significant.

Broad solutions across all sectors are needed

The medical profession should step up and acknowledge that it can and will make improvements in the areas it can influence. However, addressing the root causes of these deep challenges lies far outside the capability of individual physicians, hospitals, or health care delivery systems. Health care costs and quality are determined by the financing systems and market conditions in which health professionals do their work. The determinants of public health have everything to do with public policy choices in the spheres of economics, community design, and the like. Policy solutions are needed across a broad range of issues, if we want to see results.

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

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

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

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

Vision for a New Health System

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

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

Principles for Reform

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

A. The community has a responsibility

1. *To ensure affordable access to basic care.*
2. *To broadly share the risk and cost of medical needs.*
3. *To assist the population in using health care resources wisely.*
4. *To provide the conditions and environment in which people can be healthy and make healthy choices.*
5. *To maximize the proportion of health spending that goes to effective care for all who need it.*
6. *To secure the future capacity of the health care system to provide sustained high-quality and affordable health care through investments in prevention, medical education, and medical research, and improvements in the system's infrastructure.*

B. Individuals have a responsibility to the community

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

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

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

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

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

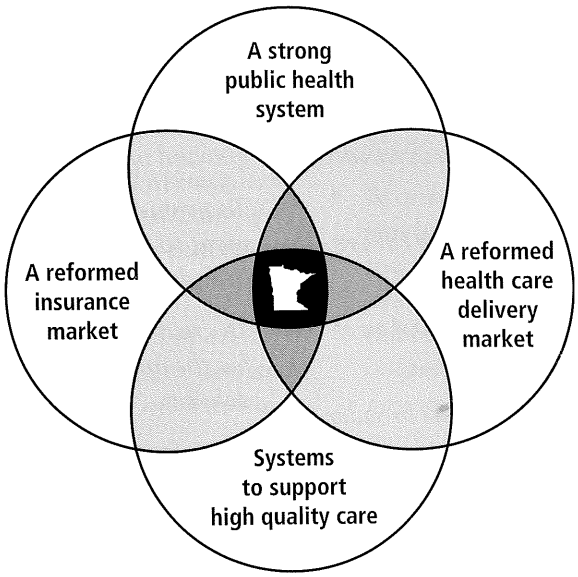
E. Health plans/insurers have responsibilities as members of the community

1. *To create payment systems that foster efficient care and improved health.*
2. *To coordinate care management systems with physicians and care teams and to provide the needed information and infrastructure supports for high-quality programs.*
3. *To correct business practices that lead to health care fragmentation, such as carved-out behavioral health benefits.*
4. *To minimize the complexity of the system and the cost of administration, and to assist patients/members in navigating the system.*
5. *To share in the needed investments in prevention strategies and infrastructure improvement.*
6. *To provide tools and resources and foster an environment to help beneficiaries achieve and physicians deliver desirable results.*
7. *To create and foster continuous learning environments for the improvement of health care administration and delivery.*

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

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

A Model for a New System



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

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

1 ● A strong public health system

Despite the overwhelming influence of environmental factors and behavioral choices on personal and population health status, the nation spends only about 5 percent of its total health budget addressing these issues.[10] The vast majority of this health budget is devoted to individual clinical interventions, which often occur after illness is already present. The state and the nation need to invest much more heavily in primary and secondary prevention efforts both to intervene in the process of disease and to reduce costs. Primary prevention—those efforts undertaken long before there is any clinical evidence of disease—can provide long-term benefits that are difficult to measure in short economic horizons. Intervention to prevent the worsening of a condition undertaken after disease is present (secondary prevention) can show more dramatic results in the short term and more quantifiable economic results. For example, it is known that individuals who are overweight or who have hypertension use about 30 percent more resources each year than people with normal weights and blood pressure levels. Lifestyle modifications to eliminate tobacco use and effective use of drugs to prevent recurrent heart attacks and heart failure can reduce the need for hospitalizations and expensive interventions such as angioplasty and stenting. Limiting smoking in public places and reducing tobacco use can curb the incidence of asthma and cardiovascular events, even in the very short term for patients with existing disease.

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

tion strategies are largely responsible for the majority of the phenomenal gains in lifespan during the past century.

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

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

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

Recommendations:

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

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

2. • A reformed health insurance market

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

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

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

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

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

Recommendations:

Ensure universal coverage for essential benefits.

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

- *Identify an essential benefits package that is adequate to protect health.*
  A single, standardized set of health services, which are essential for the protection of individual and public health, should be identified and established as the required floor of coverage for all individuals (the required level of coverage for the individual mandate). Services beyond the standardized set should be available in a competitive market but would not be subsidized by the broader community (either directly or through tax policy). The design of the benefits floor should not be based on either a catastrophic policy with a high deductible or on first-dollar coverage with a simple dollar cap for coverage. Essential benefits should be based on health status impact and evidence of effective interventions. Age-appropriate health risk assessment should be provided for all patients. Behavioral health services should be covered on the same basis as any other clinical service.

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

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

Build a fairer system of spreading risk and sharing cost.

- *Require statewide community rating and guaranteed issuance for the essential benefits package.*
  In the current system, health plans compete to a significant degree not over their ability to manage costs or improve health but by seeking to avoid the groups of people that generate the greatest cost through their product design, underwriting criteria, and rating policies. To create a more stable and fair system, each insurer or health plan should set one statewide community rate for the benefit package. The community rate set by each plan would not vary from one market segment to another (the rate for the benefit package would not vary whether sold to a large employer, a small employer, or an individual). There should be no adjustments for age or

other factors to the community rate. The only allowed variation should be for health-improvement incentives (eg, discounts for positive behaviors). In a mandatory universal coverage system, all insurance products must be available to all who wish to buy them—guaranteed issuance of policies.

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

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

3 • A reformed health care delivery market

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

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

Researchers have described two distinct categories of care that contribute significantly to the variation in rates of service use and cost across the country and within market regions: preference-sensitive and supply-sensitive care.[13]

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

Supply-sensitive care is care that is driven by the availability of services rather than by scientific evidence or guidelines. It also increases overall costs. Fisher et al. have demonstrated that the difference in Medicare costs between Minneapolis-St. Paul and Miami is related to the greater supply of intensive care and medical specialty resources in the latter, with no difference in patient need or outcomes.[8] From a patient care standpoint, it is not necessary that every hospital in a relatively small geographic area have a cardiac surgical program, an orthopedic program, a high-risk obstetrical program, and a comprehensive cancer program, each with marginal patient volumes. Such a diffusion of capacity is economically inefficient and undermines quality as well. The current situation is driven in large part, the task force believes, by the artificial payment system now used by Medicare and others in which the price for services is often unrelated to the clinical value delivered and to the cost of providing the service. Government program payments now are vastly below cost for many clinical services but also are significantly above cost for others. The task force believes that the recommendations for a reformed health care delivery market that are proposed below would lead hospitals, physicians, clinics, and health systems to better allocate capital and resources.

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

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

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

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

Recommendations:

Engage patients through greater accountability for medical decision making.
Today, the cost of a service and the possible incremental or marginal benefit of that service are not significant factors in determining patients' perception of value. In a reformed system in which patients have access to information and are more health literate, patients will select health care services of value based on three things: 1) the patient's condition and risk factors; 2) the strength of the evidence on the effectiveness of the proposed intervention; and, 3) any difference between the payment rate negotiated by that patient's insurance plan and the provider's price.

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

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

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

New market dynamics—a few key differences

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

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

4 ● Systems that fully support the delivery of high-quality care

Analyses of claims costs at both the national and state level and by various health plans all confirm that health care spending is highly concentrated in a small percentage of patients. The task force found the visual display of costs and savings opportunities (see Figure 1, p. 30) to be very helpful in understanding the opportunities for cost control in the system. The graphic portrays both the type of care and the potential for cost savings at various points along the spectrum.

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

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

Recommendations:

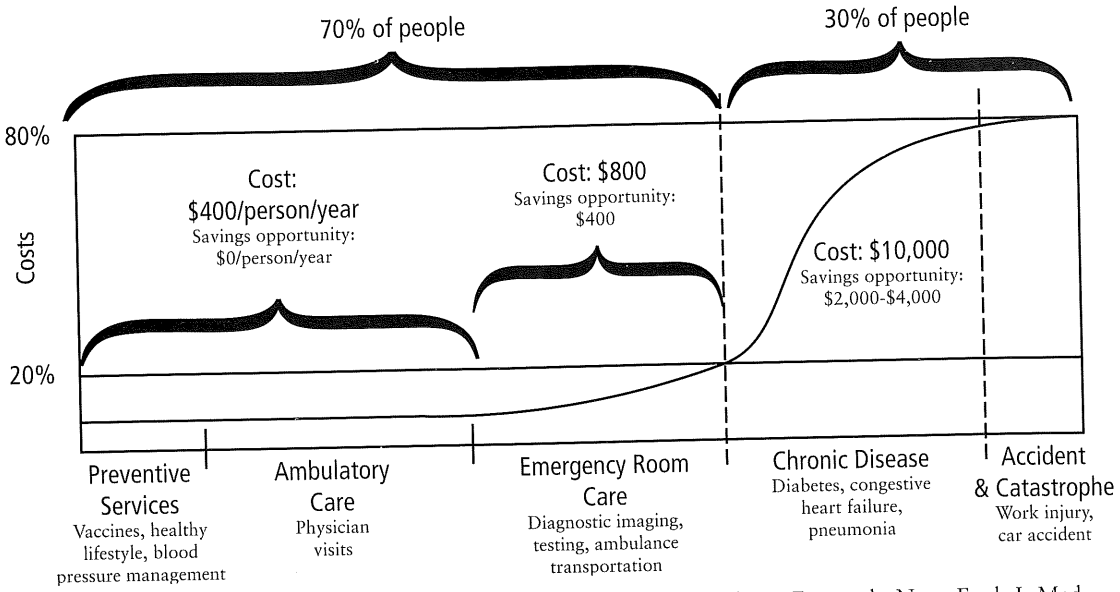
Further increase the amount of effective care that is provided.

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

Figure 1

Health Care Costs

Average Annual per Household Health Care Costs in Minnesota: $11,000



Sources: Fischer M, Avorn J. JAMA 2004;291:1850-56; McGlynn E, et al. New Engl J Med. 2003;348:2635-45; and Villagra VG, Ahmed T. Health Affairs 2004;23:255-66.

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

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

- *Support every adult and child in Minnesota having a "medical home" anchored in a continuous relationship with a personal physician.*
  To promote continuous healing relationships and to better coordinate care through continuity of person, place, and information, every Minnesotan should have a medical "home." Physician practices that are organized for ea patient access will facilitate greater patient us of the medical home as opposed to emergency or urgent care centers. In collaboration with others, the task force recommends that the MMA work to educate patients and payers about the importance of this concept. Significant evidence shows that having a personal physician improves quality, improves health outcomes, and controls costs. Employers, government, and plans should be encouraged to adopt payment plans and enrollment policies that increase the likelihood that patients can identify and sustain a relationship with a personal physician. Payment methods must be built to support the functions provided by a medical home, such as patient education and case management. Those services would be covered as part of the essential set of services.

- *Place the emphasis for cost control where the greatest opportunity exists—chronic care.*
  More than 70 percent of health care costs are incurred by about 30 percent of patients. In fact, only 5 percent of patients generate more than 50 percent of all costs. Today's system largely tries to save money by extracting deep discounts for most primary care. The task force believes that system is inefficient and counterproductive. It keeps physicians and other health professionals

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

Provide useful quality information.

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

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

  Performance measurement tends to evoke strong reaction from many physicians and for good reason. The implications of measurement and public reporting can be significant both in terms of business/economic impact and professional reputation. In addition, it is no easy task to explain the value and limitations of performance measurement at each of the three levels (ie, population, facility, and individual). The selection of appropriate measures is critical. Appropriate performance measures must be statistically valid, and they should measure things over which the object of the measurement has some control. Given both the large number of patients needed to meet statistical standards and the environmental influences on health status (ie, factors often outside of the physician's control), outcome measures should only be used to assess progress in whole populations of people.[ii] Process measures are appropriate for evaluating a clinic, hospital, or health system's performance (assuming adequate patient population size). For example, process measures could assess whether a clinic has systems in place to ensure that immunizations, screening tests, or hemoglobin A1Cs for diabetics are offered and tracked.

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

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

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

ii. Methodological challenges are real; consider this telling example from David Eddy: "The low frequency of certain outcomes has big implications for the sample size needed to measure a meaningful difference in outcomes across plans. If breast cancer mortality were to be used as a measure of breast cancer screening, a population of about 2 million women would be needed to find that size difference in mortality. The median-size health maintenance organization (HMO) has fewer than 10,000 women over age 50, which makes this measure impossible to use for comparing the quality of breast cancer care." (Eddy D. Performance Measurement: Problems and Solutions. Health Affairs. 1998;July/August:7-25.)

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

Develop payment systems to support quality practice.

- *Support payment processes that financially reward the implementation of guidelines, registries, and other efforts to improve quality of care.*
  Significant national and local attention is being paid to the notion of "pay for performance." The intent of this concept is to financially reward those health care providers who are delivering care (for some subset of selected diseases or conditions) above some level identified, generally by health plans or purchasers. The task force notes that despite the rush to adopt such techniques, there is little or no evidence to indicate whether they will achieve the desired improvements in quality that all seek.

  The task force believes that its model for the future will eventually make the concept of pay-for-performance moot because patients will decide for themselves about the value offered in terms of performance and cost. However, in the short-term, employers and third-party payers appear to see the need to make value-based decisions on behalf of consumers and are moving to adopt some pay-for-performance models. Until the desired health care system that is described in this paper is achieved, the task force recommends that the MMA advocate for pay-for-performance models that reward near-term provider actions that would build their capacity and systems for efficient, effective care—the installation of electronic medical records, computerized pharmacy order-entry systems, clinical decision-support systems, disease and case management, team-based care, etc. The task force also believes that it is reasonable for the MMA, in the interim, to support models that appropriately reward process improvements (eg, documentation of appropriate recommendations made to patients). Given the limitations outlined earlier, the task force does not believe that the MMA should support pay-for-performan[illegible] models that link payment with patie[illegible] outcomes.

Ensure the safety and quality of health care.

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

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

Financing the Future System

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

- *In general, the financing mechanisms must be broad-based, including reliance on progressive taxation systems.*
- *The cost of financing the needed subsidies for low-income Minnesotans could be partially recovered by capping the tax deductibility of health benefits at the essential benefit set level.*
- *Much more transparency in the system is needed to track where savings are being generated and captured.*
- *Cost savings from quality and efficiency improvements could at least partially be redirected into expanded access, system infrastructure needs, and prevention efforts with much longer-term payoff.*
- *Competition among health insurers could redirect some administrative spending into investments to improve care processes and system infrastructure.*
- *Government could redirect some of its current investments in capital improvement to prioritize building the information infrastructure.*
- *Although the issue was discussed only briefly, most task force members expressed more support for market influences determining the distribution of supply rather than regulatory forces.*
- *Mechanisms to directly and adequately fund the costs of medical and other health professional education and medical research, must be developed. The cross-subsidies and market disadvantages are now borne disproportionately by certain health systems that we rely on to provide these essential public goods. The more competitive market model advocated by the task force will exacerbate these problems unless a new financing method is developed.*
- *Taxes on products with correlations to health risks could be raised (eg, tobacco, alcohol, snack foods, fast food). Such taxes not only generate revenue but also create price disincentives for use or overuse and help consumers to appreciate the connection between their own behavioral choices and the cost of health care.*

Issues Outstanding and Needing Development

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

- *The mechanics of the new payment model(s) for physicians, facilities, and other providers. Much more specific work is needed to translate the task force's general ideas on what to do differently into how to do it. This will be of major concern to other stakeholders.*
- *Implications of the model on underserved communities, including low-income and vulnerable populations. How will access be ensured for these groups? Even in a competitive system, physician prices will always be too high for some simply because the demand is high, supply is limited, and the need is immediate. The task force talked generally about requirements that could be placed on plans and/or providers to ensure that care would be available to these populations, but this issue needs to be addressed with other stakeholders from the outset.*

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

Recommendations for Moving Reform Forward

Communicating vision and building consensus for a new model

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

- *Convene discussions on the mutual responsibilities/principles framework.*
- *Convene discussions on how the proposed new model would change the role of key constituencies (physicians, care systems, professional organizations, health care consumer/advocate groups, employers, health plans, government, patients).*
- *Further explore the essential benefit set concept in partnership with others. Study emerging literature on the topic, talk to other states, etc. Explore how such a model could be built and kept updated through a physician-led discussion.*
- *Build coalitions to press for the needed fundamental changes.*
- *Seek waivers of federal laws that impede reform (ERISA, etc.) and seek changes in federal government tax and payment policy that distorts the market (includes Medicare geographic equity).*

Immediate MMA action

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

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

Conclusion

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

Summary of Recommendations

A strong public health system

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

A reformed health insurance market

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

A reformed health care delivery market

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

Systems that fully support the delivery of high-quality care

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

Appendix A

Health Care Reform Task Force Charter

January 24, 2004

MMA Board of Trustees

Summary

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

Charge

A Health Care Reform Task Force will be created to:

Develop and recommend a set of principles to guide the MMA's positions/actions on health care reform.

Recommend next steps for MMA involvement in health care reform.

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

Scope of work

Phase I

Understand current MMA policies and previous reform work.

Understand AMA policies and reform work.

Understand external viewpoints/data/recommendations on reform.

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

Develop principles to guide the MMA.

Phase II

Recommend next steps, including

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

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

With whom should we collaborate?

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

Should the MMA develop a full reform proposal?

How should MMA principles be communicated to physicians/patients?

What education of physicians and/or patients should occur?

Task force membership

12 to 14 MMA members

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

Communication

The task force will provide regular updates to the board, prepare a report for the 2004 MMA House of Delegates, and complete work prior to the end of 2004.

Authority

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

Appendix B

Task Force Recommendations Compared with Other Proposals

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

Appendix C

Current and Future (Potential) Stakeholder Roles in Creating Value

	Current	Future (Potential)
Patient/Consumer	• Chooses plan based on coverage levels, provider access, premium price • Seeks service • Pays co-pay (if any) • Feels entitled to covered services • Pays nothing or full price (no discounts) if uninsured • Pays higher co-pays for behavioral health services • Chooses physicians based on referrals or word of mouth	• Chooses plan based on price, quality of administrative services, availability of information to support provider choice, shared treatment decision making, prevention and care management • Seeks services from any provider with no plan restrictions • Chooses physicians based on quality and cost information (may face cost differentials based on level of coverage and physicians' prices)
Physician/Provider	• Provides service • Is paid primarily at negotiated (imposed) rate • Provides care to uninsured either charged at full rate or as uncompensated care (occasional individual arrangements negotiated with selected providers)	• Advises patient on treatment options • Provides service • Sets same price for all patients (percent of bill paid by patient versus plan may vary among plans) • Strives to improve safety, effectiveness, efficiency of care • Improves outcomes and develops expertise on which to compete • Provides information about cost and quality
Employer	• Selects plan(s) and products • Determines contribution levels • Restricts or opts out of behavioral health coverage	• Selects plan(s) to administer essential benefits • Chooses whether to provide additional coverage • Determines contribution levels • Provides incentives and programs for health risk reduction/wellness (eg, employer pays enrollee and physician to complete a health risk appraisal and rewards both for improvement over time)
Health Plan	• Designs multiple benefit packages • Sets coverage criteria • Determines provider network • Effectively sets provider's price/payment • Is primarily concerned with control of unit prices • Supports independent behavioral health pricing, access and service limits, and co-pays	• Administers standard benefit set • Uses standard clinical guidelines • Does not define provider network, but assists consumers in finding a medical home and in maximizing the value of their dollars • Negotiates payment rates to providers but doesn't limit prices • Shifts payment toward episodes of care or care for ongoing conditions • Provides information and other support for providers to improve care • Charges a community-rated premium for essential benefits • Continues to design and offer supplemental products • Provides information to enrollees to help them maximize value • Participates in statewide reinsurance pool for all its products
Government	• Focus on setting artificially low prices per unit cost • Shifts costs to other payers • Adds layers of regulation • Adopts benefit mandates	• Ensures a well-functioning market • Protects against anti-trust violations • Provides tax incentives for coverage • Pays plans and providers a reasonable rate • Subsidizes coverage for people with low incomes and ensures access • Supports the information infrastructure with funding, incentives, regulations • Promotes streamlined reporting • Does not impose mandates for ineffective care • Ensures a strong public health system • Uses policy tools to reduce health risks

Appendix D

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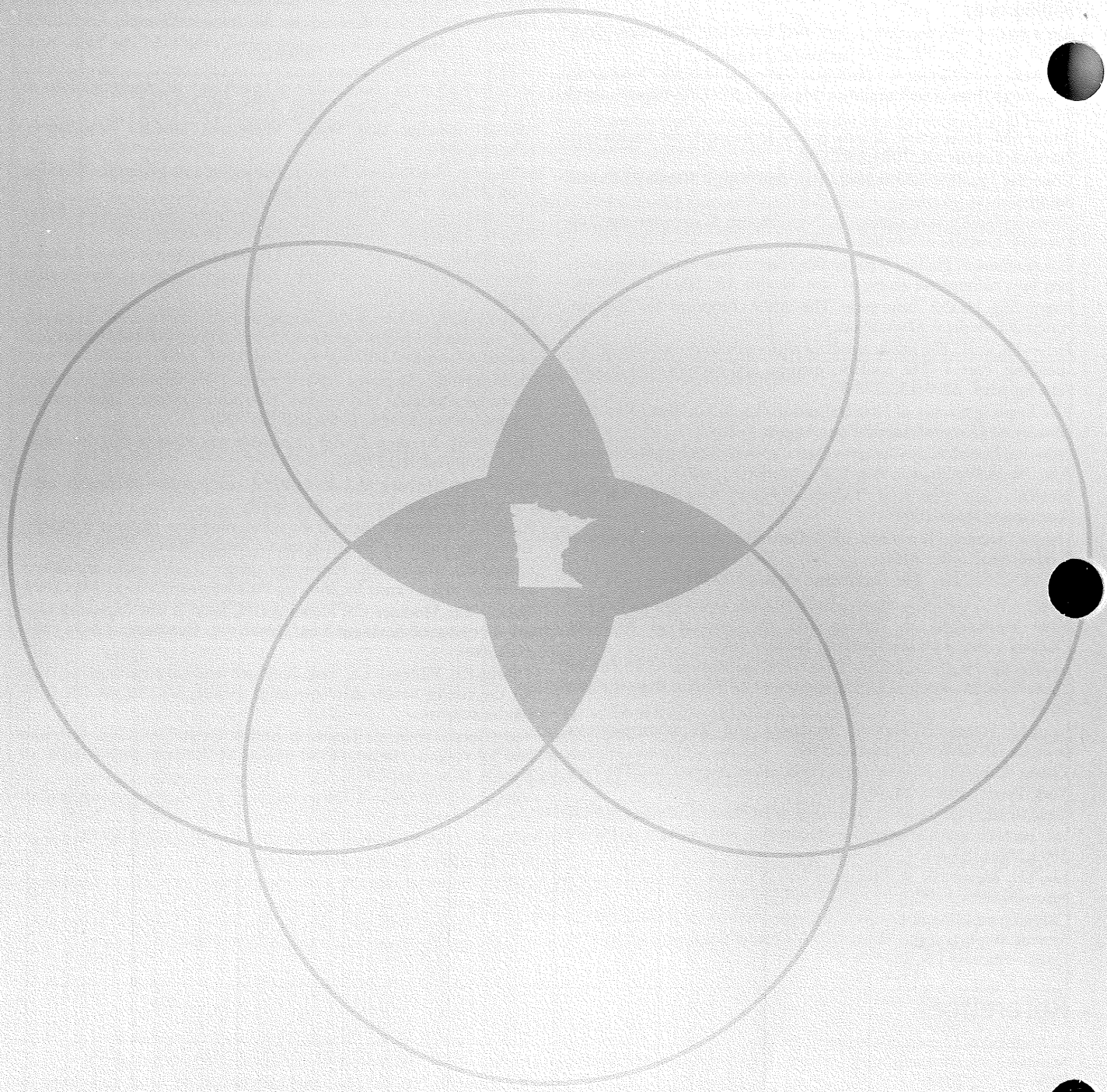

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Jim Abeler
State Representative

District 48B
Cities of Anoka and Ramsey
Anoka County

Minnesota House of Representatives

COMMITTEES: **CHAIR**, HEALTH CARE COST CONTAINMENT DIVISION
EDUCATION POLICY AND REFORM
HEALTH POLICY AND FINANCE
HIGHER EDUCATION FINANCE
WAYS AND MEANS

February 16, 2006

Dear Members and Staff of the HCCC Division and other interested Parties,

Attached you will find copies of the bills to be pre-filed on the topics of allowing employers and public entities to join together to purchase insurance (reform of PEIP and MEIP) and the creation of a state health reinsurance association on the order of WCRA. PEIP is in dire need of treatment and MEIP and the existing state health reinsurance association are in mothballs.

Questions, comments, and clarifications on any of this are invited. I really think there is somewhere to go with these reforms and recommissionings.

I was hoping to get a draft of what I am proposing on other topics ready for pre-filing, but that has hit a few logistical snags, so stay tuned.

By the way, if you have bills or amendments you would like the Division to look into, please let my LA or I know so they can be considered before our short deadlines hit us.

Jim Abeler, Division Chair
Rep.jim.abeler@house.mn

Tentative HCCC Division Schedule:
February 28, 10am-1pm
March 1, 2:30pm
March 8, 4:30pm
March 9, 4:30pm

600 E Main, Anoka, Minnesota 55303
State Office Building, 100 Rev Dr Martin Luther King Jr Blvd, St. Paul, Minnesota 55155-1298
(612) 245-3764
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FAX: (651) 296-1478 TTY: (651) 296-9896 Email: rep.jim.abeler@house.mn

HOUSE RESEARCH

Bill Summary

FILE NUMBER: H.F. (not yet introduced)
Version: bill draft TP 102

DATE: February 14, 2006

STATUS: Type Committee name here Committee

Authors: Abeler

Subject: health reinsurance pool

Analyst: Thomas R. Pender, 651-296-1885

Overview

This bill creates a new health coverage reinsurance pool, modeled somewhat on the reinsurance pool for small employer health coverage, now in chapter 62L but currently dormant.

Section

1 **Minnesota statewide health reinsurance association.** Creates the new reinsurance association to provide voluntary reinsurance and stop-loss coverage for health coverage provided to Minnesota employers, both public and private. Exempts the association from certain state laws, but not from the MCHA assessment. Specifies its powers. Specifies the oversight role of the commissioner of commerce for financial solvency.

2 **Board of directors.** Provides that the board will have nine members appointed by the governor, consisting of four public directors, four representatives of employers, and one representative of employees. Specifies the duties and procedures of the board.

3 **Compliance by insureds.** Requires that participating employers and other entities comply with the association's rules. Permits termination of coverage for failure to do so.

4 **Administration of association.** Requires the association to contract with a qualified entity to administer the association's reinsurance operations. Specifies the administrator's duties and the contracting process. Provides for audits.

5 **Participation in reinsurance association.** Requires the board to establish and enforce minimum claims processing and managed care for the underlying health coverage. Requires

Section

the board to develop and use underwriting standards appropriate and customarily used for reinsurance. Requires participation to be for two-year periods.

6 **Ceding of risk.** Requires an employer to enroll its entire employee group, unless the board grants an exception. Provides that the program is not responsible for administering the underlying health coverage.

7 **Allowed reinsurance benefits.** Permits reinsurance only of benefit approved by the board for reinsurance.

8 **Transfer of risk.** Specifies various administrative procedures for reinsurance.

9 **Reinsurance premiums.** Provides that the board will determine the reinsurance premiums.

10 **Financial management and assessments.** Provides for the board to assess participants retrospectively if premiums are insufficient. Permits the board access to loans on an as-needed basis from the health care access fund for start-up and initial financial stability up to a maximum of $10,000,000. The loans must be repaid with interest over a ten-year period.

11 **Educational programs and services.** Permits service cooperatives to participate in the reinsurance pool.

12 **Participation in reinsurance pool permitted.** Permits local governments that are fully-insured to participate in the pool if their insurance arrangements can be structured that way.

13 **Participation in reinsurance pool permitted.** Permits local government employers with health coverage self-insured on their own or in a self-insured pool to participate in the reinsurance association.

14 **Appropriation.** Appropriates money for the loans available from the health care access account under section 10.

HOUSE RESEARCH

Bill Summary

FILE NUMBER: H.F. (not yet introduced)
Version: bill draft TP100

DATE: February 14, 2006

STATUS: Type Committee name here Committee

Authors: Abeler

Subject: Two health insurance pools (PEIP and MEIP)

Analyst: Thomas R. Pender, 651-296-1885

Overview

This bill makes various changes in the Public Employees Insurance Program, now administered by the Department of Employee Relations, and the Minnesota Employees Insurance Program, now in statute but not now in operation. These are both voluntary health insurance pooling programs, the former for local government employees and the latter for private sector employees.

Section

1 **Public employees insurance program.**

Subd. 1. Intent. Eliminates life insurance as a required offering, making it optional. Makes other language changes.

Subd. 2. Definitions. Eliminates the responsibility of the commissioner of employee relations from the program and substitutes the commissioner of commerce for more limited function. Makes changes to conform to the program being run by a board instead of by the department of employee relations (DOER).

Subd. 3. Public employees insurance program. Permits the board to contract with an organization to administer the program on the board's behalf. Permits variations from the health plan offered to state employees, including different levels of enrollee cost-sharing.

Subd. 4. Labor-Management Board. Converts what has been an advisory committee to DOER to an independent board appointed by the governor.

Section

Subd. 5. Public employee participation. Makes conforming changes. Requires the employers who withdraw from the insurance pool pay to the pool a share of its net deficits and requires payment of premiums for the entire required period.

Subd. 6. Coverage. Makes technical and conforming changes. Requires that coverage comply with state requirements.

Subd. 6a. Choice of providers. Requires that the plan permit choice of type of health care provider, within a provider's licensed scope of practice.

Subd. 7. Premiums. Permits the program to rate certain employers separately for premium purposes, if doing so would benefit the program.

Subd. 8. Continuation of coverage. Makes conforming changes. Permits reenrollment of participants who leave the pool.

Subd. 9. Insurance trust fund. Permits the board, in its first few years, to borrow money from the health care access fund as needed for start-up costs and initial financial stability, up to a maximum of $2,000,000. These loans would bear interest and be repaid within five years.

Subd. 10. Exemption. Limits the program's current exemptions from state law, conforming to an earlier provision on state coverage requirements and limits the program's exemption from the MCHA assessment.

Subd. 11. Reinsurance. Permits the program to participate in an insured or self-insured reinsurance pool.

Subd. 12. Commissioner of commerce. Requires that the pool's financial solvency be overseen by the commissioner of commerce.

2 **Minnesota Employees Insurance Program**

Subd. 1. Intent. No changes.

Subd. 2. Definitions. Change to reflect program being administered by a board.

Subd. 3. Entity status and administration. Creates a board to be in charge of the program instead of DOER.

Subd. 4. Board of directors. Provides that the board will have ten members appointed by the governor, consisting of five representing employers, two representing employees, and three public members.

Subd. 5. Employer eligibility. Requires that employers that enter the pool make a two-year commitment. Requires that employers have at least 50 percent of their employees working in Minnesota, but permits enrollment of in-state employees only, if that requirement is not met. Makes technical and conforming changes. Prohibits a participating employer to offer other employee health coverage, except with

Section

permission.

Subd. 6. Individual eligibility. Makes conforming changes.

Subd. 7. Coverage. Permits coverage to be insured or self-insured, or through a combination. Permits participation in an insured or self-insured reinsurance association. Eliminates references to the plan offered to state employees. Permits choice of type of provider, subject to scope of practice.

Subd. 8. Premiums. Makes conforming changes. Permits rating certain employers separately for premium purposes.

Subd. 9. Reserves. Eliminates reference to state board of investment. Permits the board to borrow from the health care access account up to $2,000,000, repayable with interest over five years, for start-up and initial financial stability.

Subd. 10. Program status. Conforming and technical changes.

Subd. 12. Status of agents. No change.

3 **Appropriations.** Appropriates money for the loans referenced in sections 1 and 2.

4 **Revisor's instruction.** Instructs the revisor to move sections 1 and 2 out of the DOER chapter and into a new chapter of statute.

A bill for an act

relating to insurance; reforming two employer health coverage pooling programs; recodifying them; appropriating money; amending Minnesota Statutes 2004, sections 43A.316; 43A.317.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 43A.316, is amended to read:

43A.316 PUBLIC EMPLOYEES INSURANCE PROGRAM.

Subdivision 1. **Intent.** The legislature finds that the creation of a statewide program to provide public employees and other eligible persons with ~~life insurance and~~ hospital, medical, and dental benefit coverage ~~through provider organizations~~ would result in a ~~greater utilization~~ more efficient use of government resources and would advance the health and welfare of the citizens of the state.

Subd. 2. **Definitions.** For the purpose of this section, the terms defined in this subdivision have the meaning given them.

(a) **Commissioner.** "Commissioner" means the commissioner of ~~employee relations~~ commerce.

(b) **Employee.** "Employee" means:

(1) a person who is a public employee within the definition of section 179A.03, subdivision 14, who is insurance eligible and is employed by an eligible employer;

(2) an elected public official of an eligible employer who is insurance eligible;

(3) a person employed by a labor organization or employee association certified as an exclusive representative of employees of an eligible employer or by another public employer approved by the ~~commissioner~~ board, so long as the plan meets the requirements of a governmental plan under United States Code, title 29, section 1002(32); or

(4) a person employed by a county or municipal hospital.

(c) **Eligible employer.** "Eligible employer" means:

(1) a public employer within the definition of section 179A.03, subdivision 15, that is a town, county, city, school district as defined in section 120A.05, service cooperative as defined in section 123A.21, intermediate district as defined in section 136D.01, Cooperative Center for Vocational Education as defined in section 123A.22, regional management information center as defined in section 123A.23, or an education unit organized under the joint powers action, section 471.59; or

(2) an exclusive representative of employees, as defined in paragraph (b);

(3) a county or municipal hospital; or

(4) another public employer approved by the ~~commissioner~~ board.

(d) **Exclusive representative.** "Exclusive representative" means an exclusive representative as defined in section 179A.03, subdivision 8.

(e) **Labor-Management ~~Committee~~ Board.** "Labor-Management ~~Committee~~ Board" means the ~~committee~~ board established by subdivision 4.

(f) **Program.** "Program" means the statewide public employees insurance program created by subdivision 3.

Subd. 3. **Public employee insurance program.** The ~~commissioner~~ board shall be the administrator of the public employee insurance program and may determine its funding arrangements. The board may contract with a qualified entity to perform the administrative functions. The ~~commissioner~~ board shall model the program after the plan established in section 43A.18, subdivision 2, but may ~~modify~~ adopt variations from that plan~~, in consultation with the Labor-Management Committee~~. The variations may include different deductibles, coinsurance, co-pays, or other enrollee cost-sharing provisions.

Subd. 4. **Labor-Management ~~Committee~~ Board.** The Labor-Management ~~Committee~~ Board consists of ten members appointed by the ~~commissioner~~ governor. The Labor-Management ~~Committee~~ Board must comprise five members who represent employees, including at least one retired employee, and five members who represent eligible employers. ~~Committee~~Board members are eligible for expense reimbursement in the same manner and amount as authorized by the commissioner's plan adopted under section 43A.18, subdivision 2. ~~The commissioner shall consult with the labor-management committee in major decisions that affect the program.~~ The ~~committee~~ board shall ~~study issues~~ evaluate and make decisions relating to the insurance program including, but not limited to, flexible benefits, utilization review, quality assessment, and cost efficiency. The ~~committee~~ board continues to exist while the program remains in operation.

Subd. 5. **Public employee participation.** (a) Participation in the program is subject to the conditions in this subdivision.

(b) Each exclusive representative for an eligible employer determines whether the employees it represents will participate in the program. The exclusive representative shall give the employer notice of intent to participate at least 30 days before the expiration date of the collective bargaining agreement preceding the collective bargaining agreement that covers the date of entry into the program. The exclusive representative and the eligible employer shall give notice to the ~~commissioner~~ board of the determination to participate in the program at least 30 days before entry into the program. Entry into the program is governed by a schedule established by the ~~commissioner~~ board.

(c) Employees not represented by exclusive representatives may become members of the program upon a determination of an eligible employer to include these employees in the program. Either all or none of the employer's unrepresented employees must participate. The eligible employer shall give at least 30 days' notice to the ~~commissioner~~ board before entering the program. Entry into the program is governed by a schedule established by the ~~commissioner~~ board.

(d) Participation in the program is for a two-year term. Participation is automatically renewed for an additional two-year term unless the exclusive representative, or the employer for unrepresented employees, gives the ~~commissioner~~ board notice of withdrawal at least 30 days before expiration of the participation period. A group that withdraws must wait two years before rejoining. An exclusive representative, or employer for unrepresented employees, may also withdraw if premiums increase 50 percent or more from one insurance year to the next.

(e) The exclusive representative shall give the employer notice of intent to withdraw ~~to the commissioner~~ at least 30 days before the expiration date of a collective bargaining agreement that includes the date on which the term of participation expires.

(f) Each participating eligible employer shall notify the ~~commissioner~~ board of the names of individuals who will be participating within two weeks ~~of~~ after the ~~commissioner receiving~~ board receives notice of the parties' intent to participate. The employer shall also submit other information as required by the ~~commissioner~~ board for administration of the program.

(g) An exclusive representative or employer that withdraws from the program must pay to the board, for deposit into the insurance trust fund created in subdivision 9, an assessment by the board for its pro rata share of any net losses accrued within the program during the employer's participation in the program. The pro rata share is determined based upon the premiums paid by that employer as a percentage of total premiums paid by all

employers in the program during that employer's participation, as determined by the board. An employer that withdraws from the program under circumstances that do not permit withdrawal under this subdivision is liable to the board for premiums payable by the employer until the time that the employer is eligible to withdraw and the employer shall pay those premiums voluntarily and no later than their due date. If the premiums or pro rata assessments are not paid voluntarily, the board has authority to collect these premiums under any method permitted by law for a nongovernmental creditor of the employer, and shall do so.

Subd. 6. **Coverage.** (a) ~~By January 1, 1989,~~ The ~~commissioner~~ board shall announce the benefits of the program. The program shall include employee hospital, medical, and dental~~, and life~~ insurance for employees and ~~hospital and medical benefits for~~ dependents. Health maintenance organization options and other delivery system options may be provided if they are available, cost-effective, and capable of servicing the number of people covered in the program. Participation in optional coverages may be provided by collective bargaining agreements. For employees not represented by an exclusive representative, the employer may offer the optional coverages to eligible employees and their dependents provided in the program.Health coverage must include at least the benefits required of a health plan company regulated under chapters 62A, 62C, or 62D.

(b) The ~~commissioner, with the assistance of the~~ Labor-Management ~~Committee~~ Board, shall periodically assess whether it is financially feasible for the program to offer or to continue an individual retiree program that has competitive premium rates and benefits. If the ~~commissioner~~ board determines it to be feasible to offer an individual retiree program, the ~~commissioner~~ board shall announce the applicable benefits, premium rates, and terms of participation. Eligibility to participate in the individual retiree program is governed by subdivision 8, but applies to retirees of eligible employers that do not participate in the program and to those retirees' dependents and surviving spouses.

Subd. 6a. ~~**Chiropractic services**~~ **Choice of providers.** All benefits provided by the program ~~or a successor program~~ relating to expenses incurred for medical treatment or services of a ~~physician~~ health care provider must also include ~~chiropractic~~ treatment and services of ~~a chiropractor~~ any other licensed, certified or registered health care provider to the extent that the ~~chiropractic~~ services and treatment are within the scope of ~~chiropractic licensure~~ the provider's licensure, certification, or registration.

~~This subdivision is intended to provide equal access to benefits for program members who choose to obtain treatment for illness or injury from a doctor of chiropractic, as long as the treatment falls within the chiropractor's scope of practice. This subdivision is not intended to change or add to the benefits provided for in the program.~~

Subd. 7. **Premiums.** The proportion of premium paid by the employer and employee is subject to collective bargaining or personnel policies. If, at the beginning of the coverage period, no collective bargaining agreement has been finalized, the increased dollar costs, if any, from the previous year is the sole responsibility of the individual participant until a collective bargaining agreement states otherwise. Premiums, including an administration fee, shall be established by the ~~commissioner~~ board. The board may decide to rate specific employers separately for premium purposes, if the board determines that doing so is in the best interests of the program. Each employer shall pay monthly the amounts due for employee benefits including the amounts under subdivision 8 to the ~~commissioner~~ board no later than the dates established by the ~~commissioner~~ board. If an employer fails to make the payments as required, the ~~commissioner may~~ board shall cancel program benefits and pursue other civil remedies, as provided in subdivision 5, paragraph (d).

Subd. 8. **Continuation of coverage.** (a) A former employee of an employer participating in the program who is receiving a public pension disability benefit or an annuity or has met the age and service requirements necessary to receive an annuity under chapter 353, 353C, 354, 354A, 356, 422A, 423, 423A, or 424, and the former employee's dependents, are eligible to participate in the program. This participation is at the person's expense unless a collective bargaining agreement or personnel policy provides otherwise. Premiums for these participants must be established by the ~~commissioner~~ board.

The ~~commissioner~~ board may provide policy exclusions for preexisting conditions only when there is a break in coverage between a participant's coverage under the employment-based group insurance program and the participant's coverage under this section. An employer shall notify an employee of the option to participate under this paragraph no later than the effective date of retirement. The retired employee or the employer of a participating group on behalf of a current or retired employee shall notify the ~~commissioner~~ board within 30 days of the effective date of retirement of intent to participate in the program according to the rules established by the ~~commissioner~~ board.

(b) The spouse of a deceased employee or former employee may purchase the benefits provided at premiums established by the ~~commissioner~~ board if the spouse was a dependent under the employee's or former employee's coverage under this section at the time of the death. The spouse remains eligible to participate in the program as long as the group that included the deceased employee or former employee participates in the program. Coverage under this clause must be coordinated with relevant insurance benefits provided through the federally sponsored Medicare program.

(c) The program benefits must continue in the event of strike permitted by section 179A.18, if the exclusive representative chooses to have coverage continue and the employee pays the total monthly premiums when due.

~~(d) A participant who discontinues coverage may not reenroll.~~

(d) Persons participating under ~~these paragraphs~~ this subdivision shall make appropriate premium payments in the time and manner established by the ~~commissioner~~ board.

Subd. 9. **Insurance trust fund.** (a) The insurance trust fund in the state treasury consists of deposits of the premiums received from employers participating in the program and transfers before July 1, 1994, from the excess contributions holding account established by section 353.65, subdivision 7. All money in the fund is appropriated to the ~~commissioner~~ board to pay insurance premiums, approved claims, refunds, administrative costs, and other related service costs. Premiums paid by employers to the fund are exempt from the taxes imposed by chapter 297I. The ~~commissioner~~ board shall reserve an amount of money to cover the estimated costs of claims incurred but unpaid. The State Board of Investment shall invest the money according to section 11A.24. Investment income and losses attributable to the fund must be credited to the fund.

(b) If the board determines that the funds in the insurance trust fund are inadequate to meet the board's obligations, the board may access additional funds as needed in the form of loans from the health care access fund, not to exceed a total indebtedness of $2,000,000 at any one time. Such loans accrue interest at three percent per annum simple interest and must be repaid in installments beginning no later than two years after the board first provides coverage and must be fully repaid no later than five years after that date. The monthly repayment installments must be reamortized as needed to reflect repayments and additional loan amounts accessed, so that monthly installments will be sufficient to repay the existing balance, including accrued interest, at the end of that five-year period. The $2,000,000 amount is available until the end of that five-year period. Amounts of principal repaid are available to be accessed for new loans within that period.

Subd. 10. **Exemption.** The public employee insurance program and, where applicable, the employers participating in it, are exempt from chapters 60A, 62A, 62C, 62D, 62E, and 62H, section 471.617, subdivisions 2 and 3, and the bidding requirements of section 471.6161, except:

(1) as otherwise provided in subdivision 6, paragraph (a); and

(2) that the program is subject to the assessment for the Minnesota Comprehensive Health Association under section 62E.11, if the type of coverage provided would be subject to that assessment if provided by a contributing member of that association.

Subd. 11. **Reinsurance.** The board may, on behalf of the program, participate in an insured or self-insured reinsurance pool.

Subd. 12. **Commissioner of commerce.** The program's premiums and other decisions relevant to financial solvency must be submitted to the commissioner of commerce for prior approval. The premiums and other decisions are deemed approved if not disapproved within 60 days of their submission to the commissioner.

Sec. 2. Minnesota Statutes 2004, section 43A.317, is amended to read:

43A.317 MINNESOTA EMPLOYEES INSURANCE PROGRAM.

Subdivision 1. **Intent.** The legislature finds that the creation of a statewide program to provide employers with the advantages of a large pool for insurance purchasing would advance the welfare of the citizens of the state.

Subd. 2. **Definitions.** (a) **Scope.**For the purposes of this section, the terms defined have the meaning given them.

(b) ~~**Commissioner**~~ **"Board".**~~"Commissioner" means the commissioner of employee relations.~~ "Board" means the board of directors created under subdivision 4.

(c) **Eligible employee.** "Eligible employee" means an employee eligible to participate in the program under the terms described in subdivision 6.

(d) **Eligible employer.** "Eligible employer" means an employer eligible to participate in the program under the terms described in subdivision 5.

(e) **Eligible individual.** "Eligible individual" means a person eligible to participate in the program under the terms described in subdivision 6.

(f) **Employee.** "Employee" means an employee of an eligible employer. "Employee" includes a sole proprietor, partner of a partnership, member of a limited liability company, or independent contractor.

(g) **Employer.** "Employer" means a private person, firm, corporation, partnership, limited liability company, association, or other entity actively engaged in business or public services. "Employer" includes both for-profit and nonprofit entities.

(h) **Program.** "Program" means the Minnesota employees insurance program created by this section.

Subd. 3. **Entity status and administration.** ~~After consulting with the chairs of the senate Governmental Operations and Veterans Committee and the house of representatives Governmental Operations and Veterans Affairs Policy Committee, the commissioner may determine when the program provided under this section is available. When the commissioner makes the program available,~~ The board is created and may operate as an unincorporated association and may incorporate as a Minnesota nonprofit corporation

under chapter 317A. The board shall have all powers available under that chapter, except to the extent inconsistent with this section. The ~~commissioner~~ board shall, consistent with the provisions of this section, administer the program and determine its coverage options, funding and premium arrangements, contractual arrangements, and all other matters necessary to administer the program. ~~The commissioner's contracting authority for the program, including authority for competitive bidding and negotiations, is governed by section 43A.23.~~

Subd. 4. ~~**Advisory committee**~~ **Board of directors.** ~~After the commissioner consults as required in subdivision 3 and then determines to make the program available,~~ The ~~commissioner~~ governor shall ~~establish a~~ appoint an intial ten-member ~~advisory committee~~ board of directors that includes five members who represent eligible employers ~~and five~~, two members who represent eligible individuals. ~~The committee shall advise the commissioner on issues related to administration of the program. The committee is governed by sections 15.014 and 15.059, and continues to exist while the program remains in operation~~, and three public members, for initial terms of two years for five directors and three years for the other five directors. Subsequent board members shall be appointed by the governor to serve staggered three-year terms.

Subd. 5. **Employer eligibility.** (a) **Procedures.** All employers are eligible for coverage through the program subject to the terms of this subdivision. The ~~commissioner~~ board shall establish procedures for an employer to apply for coverage through the program.

(b) **Term.** The initial term of an employer's coverage ~~may~~ must be for ~~up to~~ at least two years from the effective date of the employer's application. After that, coverage will be automatically renewed for an additional term of two years unless the employer gives notice of withdrawal from the program according to procedures established by the ~~commissioner~~ board or the ~~commissioner~~ board gives notice to the employer of the discontinuance of the program. The ~~commissioner~~ board may establish conditions under which an employer may withdraw from the program prior to the expiration of a term, including by reason of an increase in health coverage premiums of 50 percent or more from one insurance year to the next. An employer that withdraws from the program may not reapply for coverage for ~~a period of time equal to its initial term of coverage~~ two years.

(c) **Minnesota work force.** An employer is not eligible for coverage through the program if ~~five~~ 50 percent or more of its eligible employees work primarily outside Minnesota, except that an employer that either does or does not meet that requirement may apply to the program on behalf of only those employees who work primarily in Minnesota, and the board may accept or reject the application.

(d) **Employee participation; aggregation of groups.** An employer is not eligible for coverage through the program unless its application includes all eligible employees who work primarily in Minnesota, except employees who waive coverage as permitted by subdivision 6. Private entities that are eligible to file a combined tax return for purposes of state tax laws are considered a single employer, except as otherwise approved by the ~~commissioner~~ board.

(e) **Private employer.** A private employer is not eligible for coverage unless it has two or more eligible employees who live in the state of Minnesota. If an employer has only two eligible employees and one is the spouse, child, sibling, parent, or grandparent of the other, the employer must be a Minnesota domiciled employer and have paid Social Security or self-employment tax on behalf of both eligible employees.

(f) **Minimum participation.** The commissioner must require as a condition of employer eligibility that at least 75 percent of its eligible employees who have not waived coverage participate in the program. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of coverage. For purposes of this section, waiver of coverage includes only waivers due to coverage ~~under another group health benefit plan~~ eligible for waiver under section 62L.03, subdivision 3, paragraph (a). An employer may not offer any employee coverage other than that offered by the board, expect with prior approval of the board.

(g) **Employer contribution.** The ~~commissioner~~ board must require as a condition of employer eligibility that the employer contribute at least 50 percent toward the cost of the premium of the employee and may require that the contribution toward the cost of coverage is structured in a way that promotes price competition among the coverage options available through the program.

(h) **Enrollment cap.** The ~~commissioner~~ board may limit employer enrollment in the program if necessary to avoid exceeding the program's reserve capacity.

Subd. 6. **Individual eligibility.** (a) **Procedures.** The ~~commissioner~~ board shall establish procedures for eligible employees and other eligible individuals to apply for coverage through the program.

(b) **Employees.** An employer shall determine when it applies to the program the criteria its employees must meet to be eligible for coverage under its plan. An employer may subsequently change the criteria annually or at other times with approval of the ~~commissioner~~ board. The criteria must provide that new employees become eligible for coverage after a probationary period of at least 30 days, but no more than 90 days.

(c) **Other individuals.** An employer may elect to cover under its plan:

(1) the spouse, dependent children, and dependent grandchildren of a covered employee;

(2) a retiree who is eligible to receive a pension or annuity from the employer and a covered retiree's spouse, dependent children, and dependent grandchildren;

(3) the surviving spouse, dependent children, and dependent grandchildren of a deceased employee or retiree, if the spouse, children, or grandchildren were covered at the time of the death;

(4) a covered employee who becomes disabled, as provided in sections 62A.147 and 62A.148; or

(5) any other categories of individuals for whom group coverage is required by state or federal law.

An employer shall determine when it applies to the program the criteria individuals in these categories must meet to be eligible for coverage. An employer may subsequently change the criteria annually, or at other times with approval of the ~~commissioner~~ board. The criteria for dependent children and dependent grandchildren may be no more inclusive than the criteria under section 43A.18, subdivision 2. This paragraph shall not be interpreted as relieving the program from compliance with any federal and state continuation of coverage requirements.

(d) **Waiver and late entrance.** An eligible individual may waive coverage at the time the employer joins the program or when coverage first becomes available. The ~~commissioner~~ board may establish a preexisting condition exclusion of not more than 18 months for late entrants as defined in section 62L.02, subdivision 19.

(e) **Continuation coverage.** The program shall provide all continuation coverage required by state and federal law.

Subd. 7. **Coverage.** Coverage ~~is available through the program beginning on July 1, 1993. Until an arrangement is in place to provide coverage~~ may be provided through a transfer of risk to one or more carriers regulated under chapter 62A, 62C, or 62D, ~~the commissioner shall solicit bids under section 43A.23, from carriers regulated under chapters 62A, 62C, and 62D, to provide coverage of eligible individuals. The commissioner shall provide coverage through contracts with carriers, unless the commissioner receives no reasonable bids from carriers~~ through a group self-insured arrangement under chapter 62H, or through a combination of those methods. The board may participate in an insured or self-insured reinsurance pool provided under sections 62L.24 to 62L.33.

(a) **Health coverage.** Health coverage is available to all employers in the program. The ~~commissioner~~ board shall attempt to establish health coverage options that have

strong care management features to control costs and promote quality and shall attempt to make a choice of health coverage options available. Health coverage for a retiree who is eligible for the federal Medicare program must be administered as though the retiree is enrolled in Medicare parts A ~~and~~, B, and D. ~~To the extent feasible as determined by the commissioner and in the best interests of the program, the commissioner shall model coverage after the plan established in section 43A.18, subdivision 2.~~ Health coverage must include at least the benefits required of a carrier regulated under chapter 62A, 62C, or 62D for comparable coverage. ~~Coverage under this paragraph must not be provided as part of the health plans available to state employees.~~

(b) **Choice of providers.** All benefits provided by the program relating to expenses incurred for medical treatment or services of a health care provider must also include treatment and services of any other licensed, certified or registered health care provider to the extent that the services and treatment are within the scope of the provider's licensure, certification, or registration.

(c) **Optional coverages.** In addition to offering health coverage, the ~~commissioner~~ board may arrange to offer dental or other health-related coverage through the program. Employers with health coverage may choose to offer dental or other health-related coverage according to the terms established by the ~~commissioner~~ board.

~~(c)~~ (d) **Open enrollment.** The program must meet all underwriting requirements of chapter 62L and must provide periodic open enrollments for eligible individuals for those coverages where a choice exists.

~~(d)~~ (e) **Technical assistance.** The ~~commissioner~~ board may arrange for technical assistance and referrals for eligible employers in areas such as health promotion and wellness, employee benefits structure, tax planning, and health care analysis services as described in section 62J.2930.

Subd. 8. **Premiums.** (a) **Payments.** Employers enrolled in the program shall pay premiums according to terms established by the ~~commissioner~~ board. If an employer fails to make the required payments, the ~~commissioner~~ board may cancel coverage and pursue other civil remedies.

(b) **Rating method.** The ~~commissioner~~ board shall determine the premium rates and rating method for the program. The rating method for eligible small employers must meet or exceed the requirements of chapter 62L. The rating methods must recover in premiums all of the ongoing costs for ~~state~~ administration and for maintenance of a premium stability and claim fluctuation reserve. ~~On June 30, 1999, after paying all necessary and reasonable expenses, the commissioner must apply up to $2,075,000 of any remaining balance in the Minnesota employees' insurance trust fund to repayment of any amounts drawn or~~

~~expended for this program from the health care access fund.~~ The board may decide to rate specific employers separately for premium purposes, if the board determines that doing so is in the best interests of the program.

(c) **Taxes and assessments.** To the extent that the program operates as a self-insured group, the premiums paid to the program are not subject to the taxes imposed by chapter 297I, but the program is subject to a Minnesota Comprehensive Health Association assessment under section 62E.11.

Subd. 9. ~~**Minnesota employees insurance trust fund.** (a) **Contents.** The Minnesota employees insurance trust fund in the state treasury consists of deposits received from eligible employers and individuals, contractual settlements or rebates relating to the program, investment income or losses, and direct appropriations.~~

~~(b) **Appropriation.** All money in the fund is appropriated to the commissioner to pay insurance premiums, approved claims, refunds, administrative costs, and other costs necessary to administer the program.~~

~~(c)~~ **Reserves.** (a) For any coverages for which the program does not contract to transfer full financial responsibility, the ~~commissioner~~ board shall establish and maintain reserves:

(1) for claims in process, incomplete and unreported claims, premiums received but not yet earned, and all other accrued liabilities; and

(2) to ensure premium stability and the timely payment of claims in the event of adverse claims experience. The reserve for premium stability and claim fluctuations must be established according to ~~the~~ sound actuarial standards ~~of section 62C.09, subdivision 3, except that the reserve may exceed the upper limit under this standard until July 1, 1997~~.

~~(d) **Investments.** The State Board of Investment shall invest the fund's assets according to section 11A.24. Investment income and losses attributable to the fund must be credited to the fund.~~

(b) If the board determines that its reserves are inadequate, the board may access additional funds as needed in the form of loans from the health care access fund, not to exceed a total indebtedness of $2,000,000 at any one time. Such loans accrue interest at three percent per annum simple interest and must be payable in monthly installments beginning no later than two years after the board first provides coverage and must be fully repaid no later than five years after that date. The monthly repayment installments must be reamortized as needed to reflect repayments and additional loan amounts accessed, so that monthly installments will be sufficient to repay the existing balance, including accrued interest, at the end of that five-year period. The board may make additional repayments of principal and interest at any time. The $2,000,000 amount is available until the end of

that five-year period. Amounts of principal repaid are available to be accessed for new loans within that period.

Subd. 10. **Program status.** The Minnesota employees insurance program is a state program to provide the advantages of a large pool to ~~small~~ employers for ~~purchasing~~ providing health coverage, other coverages, and related services from insurance companies, health maintenance organizations, and other organizations. The program is not an insurance company. Coverage under this program shall be considered a certificate of insurance or similar evidence of coverage and is subject to all applicable requirements of chapters 60A, 62A, 62C, 62E, 62H, 62L, and 72A, and ~~is~~ the coverage, premiums, and reserves are subject to regulation by the commissioner of commerce to the extent applicable.

Subd. 12. **Status of agents.** Notwithstanding sections 60K.49 and 72A.07, the program may use, and pay referral fees, commissions, or other compensation to, agents licensed as insurance producers under chapter 60K or licensed under section 62C.17, regardless of whether the agents are appointed to represent the particular health carriers or community integrated service networks that provide the coverage available through the program. When acting under this subdivision, an agent is not an agent of the health carrier or community integrated service network, with respect to that transaction.

Sec. 3. **APPROPRIATIONS.**

(a) $2,000,000 is appropriated from the health care access fund to the insurance trust fund for the purpose of the as-needed loans to the Public Employees Insurance Program, as provided in section 43A.316, subdivision 9, paragraph (b).

(b) $2,000,000 is appropriated from the health care access fund to the commissioner of commerce for the as-needed loans to the Minnesota Employees Insurance Program, as provided in Minnesota Statutes, section 43A.317, subdivision 9, paragraph (b).

Sec. 4. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall recode:

(1) Minnesota Statutes, section 43A.316, as Minnesota Statutes, section 62U.15; and

(2) Minnesota Statutes, section 43A.317, as Minnesota Statutes, section 62U.16.

A bill for an act

relating to insurance; creating an employee health coverage reinsurance pool for businesses and political subdivisions; appropriating money; amending Minnesota Statutes 2004, sections 123A.21, subdivision 7; 471.61, by adding a subdivision; 471.617, by adding a subdivision; proposing coding for new law as Minnesota Statutes, chapter 62U.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[62U.01] MINNESOTA STATEWIDE HEALTH REINSURANCE ASSOCIATION.**

Subdivision 1. **Creation.** The Minnesota Statewide Health Reinsurance Association may operate as a nonprofit unincorporated association, but is authorized to incorporate under chapter 317A.

Subd. 2. **Purpose.** The association is established to provide a voluntary private reinsurance and stop-loss pool for health coverage provided to employees and dependents by Minnesota employers. Public sector and private sector employers are eligible to apply for reinsurance through the pool, regardless of whether the underlying health coverage is insured or self-insured.

Subd. 3. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Eligible entity" means an insured or self-insured public or private sector employer, a self-insured group of public or private sector employers, the public employees insurance program, the Minnesota employees insurance program, a service cooperative, or a multiple employer welfare arrangement.

(c) "Reinsurance" means reinsurance or stop-loss coverage.

(d) "Insured" means an eligible entity that obtains reinsurance through the association.

Subd. 4. **Exemptions.** The association, its transactions, and all property owned by it are exempt from taxation under the laws of this state or any of its subdivisions, including, but not limited to, premiums taxes imposed under chapter 297I, income tax, sales tax, use tax, and property tax. The association may seek exemption from payment of all fees and taxes levied by the federal government. Except as otherwise provided in this chapter, the association is not subject to the provisions of chapters 13, 13D, 60A, and 62A to 62H. Reinsurance or stop-loss insurance premiums received by the board are subject to the assessment of the Minnesota Comprehensive Health Association under chapter 62E to the same extent as other reinsurance or stop-loss coverage. The association is not a public employer and is not subject to the provisions of chapters 179A and 353. Members of the board of directors and entities that obtain coverage through the association are exempt from sections 325D.49 to 325D.66 in the performance of their duties as directors and as insureds of the association.

Subd. 5. **Powers of association.** The association may exercise all of the powers of a corporation formed under chapter 317A, including, but not limited to, the authority to:

(1) establish operating rules, conditions, and procedures relating to the reinsurance of members' risks;

(2) assess insureds in accordance with the provisions of this section and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses;

(3) sue and be sued, including taking any legal action necessary to recover any assessments;

(4) enter into contracts necessary to carry out the provisions of this chapter;

(5) establish operating, administrative, and accounting procedures for the operation of the association; and

(6) borrow money against the future receipt of premiums and assessments up to the amount of the previous year's assessment, with the prior approval of the commissioner of commerce.

The provisions of this chapter govern if the provisions of chapter 317A conflict with this chapter. The association may operate under the plan of operation approved by the board and shall be governed in accordance with this chapter and may operate in accordance with chapter 317A. If the association incorporates as a nonprofit corporation under chapter 317A, the filing of the plan of operation meets the requirements of filing articles.

Subd. 6. **Role of commissioner.** The commissioner of commerce shall supervise the association in accordance with this chapter. The commissioner of commerce may examine the association. The association's reinsurance policy forms, contracts, premium rates, and assessments are subject to the approval of the commissioner of commerce. The association's policy forms, contracts, and premium rates are deemed approved if not disapproved by the commissioner of commerce within 60 days after the date of filing them with the commissioner of commerce. The association's assessments are deemed approved if not disapproved by the commissioner of commerce within 15 business days after filing them with the commissioner of commerce. The association shall notify the commissioner of all board meetings, and the commissioner or the commissioner's designee may attend all board meetings. The association shall file an annual report with the commissioner on or before July 1 of each year, beginning July 1, 2008, describing its activities during the preceding calendar year. The report must include a financial report, a summary of claims paid by the association, and full information regarding compensation and reimbursements paid by the association to the directors. The annual report must be available for public inspection.

Sec. 2. **[62U.02] BOARD OF DIRECTORS.**

Subdivision 1. **Composition of board.** The association shall exercise its powers through a board of nine directors appointed by the governor. Four directors must be public members who are deeply committed to the success of the association. Four of the nonpublic directors must be representatives of employers or other organizations that are eligible to obtain reinsurance or stop-loss through the association, including at least one governmental employer. The ninth board member must represent employees.

Subd. 2. **Appointment of board.** On or before July 1, 2006, the governor shall appoint an interim board of directors of the association who shall serve until December 31, 2007. Thereafter the governor shall appoint board members to serve staggered three-year terms, so that one-third of the terms expire each year.

Subd. 3. **Term of office.** Each director shall hold office until expiration of the director's term or until the director's successor is duly appointed and qualified, or until the director's death, resignation, or removal.

Subd. 4. **Resignation and removal.** A director may resign at any time by giving written notice to the governor. The resignation takes effect at the time the resignation is received unless the resignation specifies a later date. If a vacancy occurs for a director, the governor shall appoint a new director for the duration of the unexpired term.

Subd. 5. **Quorum.** A majority of the directors constitutes a quorum for the transaction of business. If a vacancy exists by reason of death, resignation, or otherwise, a majority of the remaining directors constitutes a quorum.

Subd. 6. **Duties of directors.** On or before January 1, 2007, the board or the interim board shall develop a plan of operation and reasonable operating rules to ensure the fair, reasonable, and equitable administration of the association. The plan of operation must include the development of procedures for selecting an administering entity, establishment of the powers and duties of the administering entity, and establishment of procedures for collecting assessments from insureds, including the imposition of interest penalties for late payments of assessments. The plan of operation must be submitted to the commissioner for review and a determination that the plan is consistent with the requirements of this section. The board of directors may subsequently amend, change, or revise the plan of operation with the same review and determination by the commissioner. The original plan and proposed amendments to it are deemed to be consistent with the requirements of this section unless objected to by the commissioner within 60 days.

Subd. 7. **Compensation.** Directors may be reimbursed by the association for reasonable and necessary expenses incurred by them in performing their duties as directors and may be compensated by the association at a rate determined by the board per day spent on authorized association activities.

Subd. 8. **Officers.** The board may elect officers and establish committees as provided in the bylaws of the association. Officers have the authority and duties in the management of the association as prescribed by the bylaws and determined by the board of directors.

Subd. 9. **Majority vote.** Approval by a majority of the directors present is required for any action of the board.

Sec. 3. **[62U.03] COMPLIANCE BY INSUREDS.**

All insureds shall comply with the provisions of this chapter, the association's bylaws, the plan of operation developed by the board of directors, and any other operating, administrative, or other procedures established by the board of directors for the operation of the association. The board may terminate the coverage of an insured that violates this section.

Sec. 4. **[62U.04] ADMINISTRATION OF ASSOCIATION.**

Subdivision 1. **Administrator.** The association shall contract with a qualified entity to operate and administer the association. If there is no available qualified entity, or in

the event of a termination under subdivision 2, the association may directly operate and administer the reinsurance program. The administrator shall perform all administrative functions required by sections 62U.01 to 62U.10. The board of directors shall develop administrative functions required by those sections and written criteria for the selection of an administrator. The administrator must be selected by the board of directors.

Subd. 2. **Term.** The administrator shall serve for a period of three years, unless the administrator requests the termination of its contract and the termination is approved by the board of directors. The board of directors shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within 90 days is considered an approval.

Subd. 3. **Duties of administrator.** The association shall enter into a written contract with the administrator to carry out its duties and responsibilities. The administrator shall perform all administrative functions required by sections 62U.01 to 62U.10, including the:

(1) preparation and submission of an annual report to the commissioner;

(2) preparation and submission of monthly reports to the board of directors;

(3) calculation of all assessments and the notification thereof of insureds;

(4) payment of claims to insureds following the submission by insureds of acceptable claim documentation;

(5) provision of claim reports to insureds as determined by the board of directors;

(6) recommendation to the board of reinsurance coverages, premiums, and underwriting standards;

(7) marketing of the reinsurance program; and

(8) other duties as determined by the board.

Subd. 4. **Bid process.** The association shall issue a request for proposal for administration of the reinsurance association and shall solicit responses from qualified entities. Methods of compensation of the administrator must be a part of the bid process. The administrator shall substantiate its cost reports consistent with generally accepted accounting principles. The contract for administration must be rebid every three years.

Subd. 5. **Audits.** The board of directors may conduct periodic audits to verify the accuracy of financial data and reports submitted by the administrator. The board may establish in the plan of operation a uniform audit program.

Subd. 6. **Records of association.** The association shall maintain appropriate records and documentation relating to the activities of the association. All individual patient-identifying claims data and information are confidential and not subject to disclosure of any kind, except as necessary to resolve claims, provided that an employer must not be given access to such data regarding a person covered by that employer. All

records, documents, and work product prepared by the association or by the administrator for the association are the property of the association. The commissioner shall have access to the data for the purposes of carrying out the supervisory functions provided for in sections 62U.01 to 62U.10.

Subd. 7. **Indemnification.** The association shall indemnify directors, officers, employees, and agents to the same extent that persons may be indemnified by corporations under section 317A.521.

Sec. 5. **[62U.05] PARTICIPATION IN REINSURANCE ASSOCIATION.**

Subdivision 1. **Minimum standards.** The board of directors or the interim board shall establish minimum claim processing and managed care standards which must be met by the underlying health coverage in order to have its risk reinsured by the association. Adherence to these standards must be subject to audit by the association.

Subd. 2. **Underwriting standards.** The board shall develop and use underwriting standards for determining whether to reinsure an eligible entity, and on what terms. The standards must be similar to those customarily used in the health reinsurance and stop-loss markets and must avoid subjecting the association to undue risk, in the opinion of the board.

Subd. 3. **Length of participation.** An insured's initial participation in the reinsurance pool is for a period of two years. Subsequent elections of participation are also for two-year periods.

Sec. 6. **[62U.06] CEDING OF RISK.**

Subdivision 1. **Prospective ceding.** An employer or other eligible entity may prospectively reinsure its entire employer group and may exclude certain employees only with the approval of the administrator, subject to the association's operating rules.

Subd. 2. **Reinsurance termination.** An insured may terminate reinsurance through the association for an entire group on the anniversary date of coverage for that group, with a 60-day written notice, subject to the two-year participation requirement of section 62U.05, subdivision 3.

Subd. 3. **Continuing insureds responsibility.** An eligible entity transferring risk to the association is completely responsible for administering its health benefit plans. An eligible entity shall apply its case management and claim processing techniques consistently between reinsured and nonreinsured business.

Sec. 7. **[62U.07] ALLOWED REINSURANCE BENEFITS.**

An eligible entity may reinsure through the association only those benefits permitted to be reinsured by the board. The board may establish guidelines to clarify what coverage is included.

Sec. 8. **[62U.08] TRANSFER OF RISK.**

Subdivision 1. **Reinsurance threshold.** An eligible entity participating in the association may transfer up to a percentage of the risk above a reinsurance threshold. The board shall determine the percentage and the threshold.

Satisfaction of the reinsurance threshold must be determined by the board of directors based on discounted eligible charges. The board may establish an audit process to assure consistency in the submission of charge calculations by eligible entities to the association. The association shall determine the amount to be paid to the eligible entity for claims submitted based on discounted eligible charges. The board may also establish upper limits on the amount paid by the association based on a usual and customary determination. The board shall establish in the plan of operation a procedure for determining the discounted eligible charge.

Subd. 2. **Conversion factors.** The board shall establish a standardized conversion table for determining equivalent charges for eligible entities that use alternative provider reimbursement methods. If an eligible entity establishes to the board that the health carrier's conversion factor is equivalent to the association's standardized conversion table, the association shall accept the health carrier's conversion factor.

Subd. 3. **Board authority.** The board shall establish criteria for changing the threshold amount or retention percentage. The board shall review the criteria on an annual basis. The board shall provide the insureds with an opportunity to comment on the criteria at the time of the annual review.

Subd. 4. **Notification of transfer of risk.** An insured must notify the association, within 90 days of receipt of proof of loss, of satisfaction of a reinsurance threshold. After satisfaction of the reinsurance threshold, an eligible entity continues to be liable to its providers, eligible employees, and dependents for payment of claims in accordance with the underlying benefit plan. Eligible entities shall not pend or delay payment of otherwise valid claims due to the transfer of risk to the association.

Subd. 5. **Periodic studies.** The board shall, on a biennial basis, prepare and submit a report to the commissioner of commerce on the effect of the reinsurance association on the insurance market. The first study must be presented to the commissioner no later than January 1, 2009. After two years of operation, the board shall study the composition of the board and determine whether the initial appointments reflect the types of interests and

backgrounds appropriate to the reinsurance association and recommend any desirable changes.

Sec. 9. **[62U.09] REINSURANCE PREMIUMS.**

Subdivision 1. **Monthly premium.** An eligible entity ceding a group to the reinsurance association shall be assessed a monthly reinsurance coverage premium determined by the board. The board may consider benefit levels in establishing the reinsurance coverage premium.

Subd. 2. **Adjustment of premium rates.** The board of directors shall establish operating rules to allocate adjustments to the reinsurance premium charge of no more than minus 25 percent of the monthly reinsurance premium for eligible entities that can demonstrate administrative efficiencies and cost-effective handling of equivalent risks. The adjustment must be made monthly, unless the board provides for a different interval in its operating rules. The operating rules must establish objective and measurable criteria which must be met by an eligible entity in order to be eligible for an adjustment. These criteria must include consideration of efficiency attributable to case management, but not consideration of such factors as provider discounts.

Subd. 3. **Liability for premium.** An eligible entity is liable to the board for the cost of the reinsurance premium and may not transfer or purport to transfer this liability to the persons covered by the reinsurance.

Sec. 10. **[62U.10] FINANCIAL MANAGEMENT AND ASSESSMENTS.**

Subdivision 1. **Assessment by board.** For the purpose of providing the funds necessary to carry out the purposes of the association, the board of directors shall assess insureds as provided in subdivisions 2, 3, and 4 at the times and for the amounts the board of directors finds necessary. Assessments are due and payable on the date specified by the board of directors, but not less than 30 days after written notice to the insured. Assessments accrue interest at the rate of six percent per year on or after the due date.

Subd. 2. **Initial capitalization.** The board of directors shall determine the initial and ongoing capital operating and reserve requirements for the association. If the board determines that it needs funds in addition to those otherwise available to the board, to meet the board's obligations, the board may access additional funds as needed in the form of loans from the health care access fund, not to exceed a total indebtedness of $10,000,000 at any one time. Such loans accrue interest at three percent per annum simple interest and must be repaid in installments beginning no later than two years after the board first provides coverage and must be fully repaid no later than ten years after that date. The

monthly repayment installments must be reamortized as needed to reflect repayments and additional loan amounts accessed, so that equal monthly installments will be sufficient to repay the existing balance, including accrued interest, at the end of that ten-year period. The $10,000,000 amount is available until the end of that ten-year period. Amounts of principal repaid are available to be accessed for new loans within that period.

Subd. 3. **Retrospective assessment.** On or before July 1 of each year, the administering carrier shall determine the association's net loss, if any, for the previous calendar year, the program expenses of administration, and other appropriate gains and losses. If reinsurance premium charges are not sufficient to satisfy the operating and administrative expenses incurred or estimated to be incurred by the association, the board of directors shall assess each insured in proportion to each insured's respective share of the total reinsurance premiums. The board of directors may provide for interim assessments as it considers necessary to appropriately carry out the association's responsibilities. The board of directors may establish operating rules to provide for changes in the assessment calculation.

Subd. 4. **Refund.** The board of directors may refund to insureds, in proportion to their contributions, the amount by which the assets of the association exceed the amount the board of directors finds necessary to carry out its responsibilities during the next calendar year. A reasonable amount may be retained to provide funds for the continuing expenses of the association and for future losses.

Subd. 5. **Appeals.** An insured may appeal to the commissioner of commerce within 30 days of notice of an assessment by the board of directors. A final action or order of the commissioner is subject to judicial review in the manner provided in chapter 14.

Sec. 11. Minnesota Statutes 2004, section 123A.21, subdivision 7, is amended to read:

Subd. 7. **Educational programs and services.** The board of directors of each SC shall submit annually a plan to the members. The plan shall identify the programs and services which are suggested for implementation by the SC during the following year and shall contain components of long-range planning determined by the SC. These programs and services may include, but are not limited to, the following areas:

(1) administrative services;

(2) curriculum development;

(3) data processing;

(4) distance learning and other telecommunication services;

(5) evaluation and research;

(6) staff development;

(7) media and technology centers;

(8) publication and dissemination of materials;

(9) pupil personnel services;

(10) planning;

(11) secondary, postsecondary, community, adult, and adult vocational education;

(12) teaching and learning services, including services for students with special talents and special needs;

(13) employee personnel services;

(14) vocational rehabilitation;

(15) health, diagnostic, and child development services and centers;

(16) leadership or direction in early childhood and family education;

(17) community services;

(18) shared time programs;

(19) fiscal services and risk management programs. A risk management program may involve participation in a reinsurance arrangement offered by the Minnesota Statewide Health Reinsurance Association;

(20) technology planning, training, and support services;

(21) health and safety services;

(22) student academic challenges; and

(23) cooperative purchasing services.

Sec. 12. Minnesota Statutes 2004, section 471.61, is amended by adding a subdivision to read:

Subd. 6. **Participation in reinsurance pool permitted.** A political subdivision providing insured health coverage to its employees and their dependents may obtain reinsurance coverage from the Minnesota Statewide Health Reinsurance Association created in chapter 62U to coordinate with the underlying health coverage.

Sec. 13. Minnesota Statutes 2004, section 471.617, is amended by adding a subdivision to read:

Subd. 7. **Participation in reinsurance pool permitted.** A political subdivision self-insuring health coverage it provides to its employees and dependents, whether self-insuring on its own or as part of a group self-insurance arrangement, may obtain excess or stop-loss coverage through the Minnesota Statewide Health Reinsurance Association created under chapter 62U.

Sec. 14. **APPROPRIATION.**

$10,000,000 is appropriated from the health care access fund to the commissioner of commerce for disbursement as as-needed loans to the Minnesota Statewide Health Reinsurance Association, as provided in Minnesota Statutes, section 62U.10.

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Health Tracking

MARKETWATCH

Health Savings Accounts: Early Estimates Of National Take-Up

Roger Feldman, Stephen T. Parente, Jean Abraham, Jon B. Christianson and Ruth Taylor

Abstract

The 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA) approved tax-advantaged health savings accounts (HSAs) for certain high-deductible health insurance plans. We predict that MMA could lead to approximately 3.2 million HSA contracts among Americans ages 19–64 who are not students, not enrolled in public health insurance plans, and not eligible for group coverage as a dependent. We simulate the effect of several additional tax subsidies for HSAs. We predict that the Bush administration's refundable tax-credit proposal would double HSA take-up and reduce the number of uninsured people by 2.9 million, at an annual cost of $8.1 billion.

Consumer-directed health plans are attracting attention from consumers, employers, and policymakers. These are high-deductible health insurance plans coupled with a tax-advantaged account that can be used to pay for eligible medical expenses. Enrollees who spend all of their health spending accounts in a given year then spend their own money until they meet the deductible requirement. The benefit design can be tailored to cover all or part of spending amounts that exceed the deductible. To facilitate informed decision making, enrollees are given information about health care providers, prices, and quality ratings.[1]

Until recently, these plans typically were offered to employees of large, self-insured employers, often as an optio alongside traditional health insurance products.[2] Early indications are that they are a viable alternative to existing plan designs.[3] They also were available to employees of small businesses and the self-employed through a 199 federal demonstration project. That demonstration never caught on, because either the employer or employee, b

not both, could contribute to the account and because the number of policies that could be sold under the demonstration was limited to 750,000, which dampened suppliers' interest in selling such products.

Recently, however, consumer-directed plans received a boost from the Medicare Prescription Drug, Improvemer and Modernization Act (MMA) of 2003. Section 1201 of MMA (and subsequent guidance by the Treasury Department) approved a new form of plan known as a health savings account (HSA). Beginning 1 January 2004, anyone could purchase a health plan with an annual deductible of at least $1,000 for an individual and $2,000 fo family, coupled with a tax-advantaged account to which both the employer and enrollee may contribute. Total an contributions can be as large as the plan's deductible (up to $5,000 for an individual and $10,000 for a family). U previous designs, the HSA is fully portable, so a person may use it without being dependent on the provisions of particular employer.

Mainstream insurers such as Blue Cross Blue Shield plans and UnitedHealth Group are selling these tax-advantaged HSAs.[4] To facilitate its entry into this market, in November 2004 UnitedHealth Group purchased Defi Health of Minneapolis, an early leader in marketing consumer-directed plans. United-Health had previously purchased Golden Rule Insurance Company of Indianapolis, which sold health plans with non-tax-preferred savi accounts to individuals and employers.

HSAs might receive another boost if Congress enacts a Bush administration proposal to create a refundable tax credit for people under age sixty-five to purchase health insurance plans with HSAs. In one form of this proposal, credit would provide a subsidy of up to 90 percent of the insurance premium.[5] The maximum credit for low-incom taxpayers would be $1,000 per adult and $500 per child (up to two children). The subsidy would phase out as inc increases.

Policy analysts have sharply conflicting opinions about the wisdom of this tax credit. Some critics are concerned a further tax subsidy for individual coverage might lead to the "hollowing out" of the market for group coverage as low-risk enrollees leave group insurance pools.[6] Others, however, believe that more favorable tax treatment wou spur the development of a mass market for individual coverage that would make it more broadly attractive.[7]

The purpose of our research is to examine the potential of individual HSAs for increasing the number of insured Americans, especially those with low incomes. In particular, how much HSA take-up is expected from MMA? Wh the additional impact of the administration's proposed tax credit and other possible subsidies? By how much will these proposals reduce the number of uninsured people? And how much will the subsidies cost?

Data And Analytic Approach

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We addressed these questions by estimating a health plan choice model for employees of three large companies that offer consumer-directed plans. Results were then used to simulate how many people in a nationally representative survey would choose HSAs. For each simulation, we predicted the number of people taking up HSAs and the cost of the proposal.

Data sources. We used three data sources for our analysis: the Medical Expenditure Panel Survey (MEPS); hea plan choice data from three large employers; and data for individual HSA policies from the eHealth insurance.cor Web site.

MEPS is an annual survey of the U.S. non-institutionalized, civilian population. We used two files from the 2001 MEPS (the latest data available). The first is the Household Component (MEPS-HC), which contains detailed demographic, employment, and insurance information on a nationally representative sample of individuals. We restricted our attention to people ages 19–64 who were not enrolled in public insurance programs and not full-tir students. For reasons explained later, we also excluded adults who were not offered insurance by their employe who could be covered by someone else's group insurance plan. When weighted to produce population estimates sample used in this study corresponds to 121,535,688 nonelderly Americans.

The second file is the MEPS-HC-Insurance Component (IC), in which a random sample of people who reported being employed and offered health insurance in Round 1 of MEPS-HC were asked to provide contact informatior their place of employment. Their employers were surveyed regarding the number and types of plans offered to eligible workers.

We had access to data on the 2002 health plan choices of employees, representing about 80,000 covered lives (including dependents), of three large employers.[8] Each employer offered a consumer-directed plan that receive first-year take-up rate of 4–15 percent. The type of plan offered by these employers was a health reimbursement account (HRA) in which the employer places tax-free credits (not real dollars) in an account that the employee ca use to pay for eligible medical expenses. The account rolls over from year to year, but, unlike for an HSA, the employee does not own it, and it is not portable.

Our data for individual policies came from two surveys conducted by the Health Insurance Association of Americ (HIAA) in 2002 and 2003, plus current information on individual HSA policies from eHealthinsurance.com, which provides an estimated monthly premium cost based on county, enrollee's age, family size, and health history.[9]

These data sources were used for three major analysis steps: model estimation; choice set assignment/predictio and policy simulation.

Model estimation. In the first step, using pooled data from the three employers that offer consumer-directed plai we estimated a conditional logistic plan choice model, similar to our earlier work.[10] This step produced coefficient estimates that represent the utility of each plan attribute to the employee.[11]

Prediction of plan choices. In the second step we used the estimated choice-model coefficients to predict healt plan choices for individuals in MEPS-HC. To complete this step, it was necessary to assign the number and type health insurance choices that are available to each respondent in MEPS-HC. For this purpose, we turned to the smaller but more detailed MEPS-HC-IC file, which contained the needed information. We summarize the details this process and direct interested readers to a longer version of the paper on our Web site, www.ehealthplan.org

The process can be described as a "crosswalk" between the two MEPS files. To use a specific example, governr employees in the linked MEPS file are offered more plans by their employers than are other workers, on average Suppose the average government employee had three offers. We "walked" back to MEPS-HC and assigned thre plans to each government employee in that data set. The actual crosswalk was done by multivariate regression models.

Next, in the linked MEPS file, we identified the types of plans that had the maximum probability among the optior that were offered. For example, those who were offered three plans were most likely to have a choice of high- an low-coverage preferred provider organizations (PPOs) and one health maintenance organization (HMO). We assigned these choices to government employees in MEPS-HC.

To predict the premiums associated with these choices, we estimated "hedonic" premium equations from the link MEPS file as a function of hospital and physician coinsurance (or copayment) rates and the plan's annual deduct We used the estimated coefficients and the characteristics of the two PPOs and one HMO to predict premiums fc the plans that were offered to our typical government worker.

To obtain employees' out-of-pocket premiums, we multiplied total premiums by the average proportion paid by employees for single or family coverage from the linked MEPS data. Out-of-pocket premiums were adjusted by 1 minus the employee's estimated federal tax rate for employees who paid their share of the premium with pretax income.[12]

Consumer-directed plans were not available in 2001, and tax-advantaged HSAs were not available until 2004, sc had to use a different strategy to assign consumer-directed plans to some workers in MEPS-HC. Because large employers have shown the most interest in consumer-directed plans, we assumed that all workers in firms with n

than 500 employees will be offered two consumer-directed plans.[13] One of these was modeled on the HRAs offe by the three employers for which we had data in 2002. Another was a less-generous HRA with cost-sharing characteristics typical of an HSA. We did not assign a consumer-directed plan to employees in establishments w fewer than 500 workers.

Our approach has three potential shortcomings. First, because our employer data were collected before 2004, th did not include HSA offers. We assumed that employees' preferences for an HSA could be simulated by their preferences for the less generous HRA. This assumption no doubt affects the accuracy of our simulations but se the most reasonable strategy available.[14] Second, the simulations could be affected if consumer-directed plans prove to be less popular among large employers than we assumed. Thus, our estimates may be an " upper bour of consumer-directed plan enrollment in employer-sponsored health benefit programs. Third, the "crosswalk" we used can be applied only to people in MEPS-HC with an offer of employer coverage. Those who were not offere such coverage but who could be covered as dependents by someone else's (usually a spouse's) group insuranc plan had to be excluded.

We used a different algorithm to assign plans to individuals in MEPS-HC who did not have an employer's covera offer and were not eligible for coverage as a dependent. Before 2004, we assumed that such people had four choices: high-, medium-, and low-coverage PPOs and no insurance. The plan characteristics used to define thes options were taken from the 2003 HIAA survey of plans purchased in the individual market. We used the 25th, 5(and 75th percentiles of the distribution of plan attributes to define the coverage levels.

Because health insurance premiums in the individual market vary by a person's age, we created an index using information from the 2002 HIAA survey. The index was set equal to 1.0 for the age group corresponding to the median age of adults in MEPS-HC. Older people, who had higher premiums, had index values greater than 1.0. Younger people had index values less than 1.0. After developing these indices and applying them to 2002 data, scaled all premiums to 2005 prices.

Starting in 2004, we assumed that all people in the nongroup market would have access to an HSA. We relied o eHealthinsurance .com for current information on two HSA policies offered in the largest two cities in every state. Next, we estimated a hedonic premium equation to predict the premium for different HSA designs. For all of the simulations except one (described below), we used an HSA with a $1,000 spending account and $3,500 deductil for single coverage and $2,000/$7,000 for families.[15] The average monthly premium for our prototype HSA for a forty-year-old, non-smoking, single male was $102.78 per month; the same person with a spouse and two childre under age ten would pay $226.97 per month. The total cost of the prototype HSA is equal to the premium plus th enrollee's contribution to the tax-advantaged account.

Finally, our health insurance choice model did not include alternatives for turning down the employer's offer or fo being uninsured in the individual market. To account for these possibilities, we added a "turndown" choice to the model for workers with an offer and scaled the utility of that choice so that a nationally representative 15 percent employees with an offer would refuse it.[16] For people without an offer, we added an "uninsurance" option that wo be chosen by a nationally representative 57 percent of this group. Because uninsurance and turndown rates vary greatly by income and we wanted to determine whether HSAs would appeal to the low-income uninsured, we performed these estimates separately by income quartile.

Simulations. The third step in our analysis was to specify and perform the simulations. All of the simulations wer conducted in relation to the MMA "baseline." The first simulation is the administration's proposal to provide a refundable tax credit of up to 90 percent of the insurance premium, with a maximum credit of $1,000 per adult for single taxpayers with no dependents and annual adjusted gross income (AGI) less than $15,000.[17] The subsidy would be phased down to 50 percent at $20,000 and zero at $30,000. These parameters were used to develop a sliding scale of tax credits with kinks at $15,000 and $20,000. We also modeled the tax credit applying to dependents, starting at $500 per dependent (limit of two children) for families with annual incomes less than $25, and declining according to the higher income kinks ($40,000 and $60,000) associated with families.

Given that one of the objectives of the tax-credit proposal is to reduce the number of uninsured people, we simul an even more generous policy that subsidizes part or all of the insurance premium for lower-income individuals a families. Specifically, we set the HSA premium at zero for taxpayers with incomes of $15,000 or less, 50 percent the premium for those with incomes of $15,000–$40,000, and 75 percent of the premium for those with incomes $40,000–$60,000.[18]

In the third simulation, we simply set the total price of an HSA (premium and savings account) at zero. In effect, t proposal is a complete subsidy for the prototype HSA. As a final policy targeted at people without jobs, we create simulation in which anyone not employed received a full subsidy for the premium and HSA, regardless of income

Study Results

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Each simulation begins with a comparison to the 2005 baseline situation. In Exhibit 1, for example, we see a take-up of 9 percent for HSAs in the nonoffered market without any additional change in policy. We attribute this impact to the relatively lower premium of the HSA in our simulations, compared with a PPO, and the high price elasticity associated with coinsurance. However, the market for employer-sponsored HSAs remains small as long as the employee can select a PPO or HMO with an employer premium contribution.

View this table: [in this window] [in a new window] **EXHIBIT 1 Effects Of Various Health Plan Options, Baseline And Administration's Proposal (Simulation 1)**

Simulation 1: administration's tax-credit proposal. We predict that the tax credit will reduce the number of uninsured people in the nonoffered market by 10.7 percent to 24,348,069, at an annual cost of approximately $6. billion (Exhibit 1). The subsidy also will increase the number of people who turn down an employer's offer in fav of an individual HSA by 159.3 percent to 861,387, at a cost of $1.2 billion. However, this is only 1 percent of the employer-offered market.

Simulation 2: low-income buy-in subsidy. Under this proposal, a greater share of the previously uninsured population would take up coverage (Exhibit 2). However, the cost is much higher: $10.8 billion per year for the offered population and $1.4 billion for the offered population, in which slightly more than one million people turn c their employer's offer in favor of an individual HSA.

View this table: [in this window] [in a new window] **EXHIBIT 2 Low-Income Buy-In Subsidy For Health Coverage (Simulation 2)**

Simulation 3: full subsidy for the prototype HSA. This proposal achieves a 47 percent reduction in the numbe uninsured people (Exhibit 3). However, the annual cost in the nonoffered market is $52.3 billion. In addition, thi proposal begins to erode the employer-sponsored health insurance market by attracting almost 5.7 million peopl from that market to individual HSAs, at an annual cost of approximately $16.9 billion.

View this table: [in this window] [in a new window] **EXHIBIT 3 Full Subsidy For Two Health Savings Account (HSA) Designs (Simulation 3)**

Given that we are simulating a complete subsidy for the health insurance premium and also are contributing $1,C per year to an individual's HSA ($2,000 for a family), it is surprising that the simulated take-up is not larger. One possible explanation is that the HSA in our simulations has a $2,500 "doughnut hole" for single coverage (and $5,000 for a family). Thus, individuals still face large financial risk under this plan. Medicaid could be a more attractive option for many low-income, uninsured people. It is also possible that our simulations, being based on model of health insurance choice within a fairly limited range of plan designs, could be less accurate when the de is pushed to the extreme—for example, with "free" coverage.

When we changed the design of the HSA to a $2,500 deductible for single coverage and $5,000 for families (witl doughnut holes of $1,500 and $3,000, respectively), the premiums are higher, but the take-up rate for a "free" HS of this type is much greater, with only 3.8 million people remaining uninsured (Exhibit 3). In other words, a generous "free" HSA could nearly eliminate uninsurance among the population considered in our simulations. However, the annual cost of the subsidy would be approximately $211 billion, much of it incurred in a "buy-out" o employer health insurance sector.[19]

This example points to a trade-off between HSA generosity and the cost of the subsidy. More generous designs example, with smaller doughnut holes) will increase the take-up rate but also increase the cost of the subsidy. Al as some have feared, a full subsidy for a generous HSA would have a strong impact on the group market.

Simulation 4: full subsidy for non-workers. One possible approach to prevent the erosion of employer covera would be to exclude the working population from the HSA subsidy. To explore the consequences of this approac our final simulation was a full subsidy targeted at people without jobs, regardless of income. The result is more ta up than with the administration's proposal, but the subsidy cost, at $11.2 billion, is higher (Exhibit 4).

View this table: [in this window] [in a new window] **EXHIBIT 4 Full Subsidy For Health Coverage Buy-In For Nonworking Adults (Simulation 4)**

Comparative "efficiency" in reducing the number of uninsured people. We next compared the simulations i terms of their overall "efficiency" in reducing the number of uninsured Americans, which we measured by the cos additional person covered.[20] The administration's proposal and the low-income buy-in subsidy are almost equall efficient, with per capita costs of $2,761 and $2,718, respectively (Exhibit 5).

View this table: [in this window] [in a new window] **EXHIBIT 5 Efficiency Of Simulated Subsidies For Health Coverage**

A full subsidy for the nonworking population, at a higher per capita cost of $3,574, appears to be less efficient tha either the administration's proposal or the low-income buy-in. The free HSA also was less efficient than the other proposals. However, it did accomplish larger reductions in the uninsured population: almost thirteen million with t prototype design and more than twenty-three million with the more generous design.

Comparative attractiveness to the low-income uninsured. Another standard for comparing the subsidy propc is to assess their attractiveness to the low-income uninsured, a group that might have the most difficulty finding affordable health insurance. Approximately 42 percent of those taking up insurance under the administration's proposal would come from the lowest quartile of the income distribution, and 75 percent would come from the lov half (Exhibit 6). However, the take-up rate among the upper half of the income distribution would be somewhat higher. The free HSA is the most attractive policy for the low-income uninsured, with 95 percent of the take-up coming from the lower half of the income distribution. This subsidy works better for low-income people because c the strong association between low income and not working.

View this table: [in this window] [in a new window]
EXHIBIT 6 Take-Up Of Health Coverage Among Low-Income People, Under Various Simulations

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HSA take-up rates. Using a combination of public and private data, we find that widespread national adoption of individual HSA plans is possible. Untouched, MMA could lead to approximately 3.2 million individual HSA contracts among U.S. adults ages 18–64 who are not students, not enrolled in public health insurance programs, and not eligible for group coverage as a dependent. On the other hand, we predict that HSAs will not be popular among employees with an employer's he insurance offer, primarily because the employer's premium subsidy reduces the attractiveness of HSAs. It is pos that HSAs will remain a "niche product" unless employers reduce their premium contributions—in which case the lower total premiums of HSAs could make them more attractive to covered workers. The take-up of employer-ba HSAs also could increase if small and medium-size employers begin to offer them, but this aspect of employer adoption of HSAs is beyond the scope of our study. The popularity of individual HSAs will increase further under simulations considered here.

Impact of subsidies on coverage and costs. The Bush administration's proposed tax-credit plan would double individual HSA take-up and reduce the number of uninsured people by 2.9 million, at an annual tax cost of $8.1 billion—an average of $2,761 per person. A low-income buy-in subsidy would reduce the number of uninsured people by 16.5 percent (about 4.5 million people) at a cost of $12.2 billion annually, or an average of $2,718 per person. Offering "free" individual HSAs could, in theory, almost eliminate uninsurance but at a much higher per c cost.

In addition to higher costs, "free" individual HSAs could greatly erode the market for employer-sponsored health insurance, with reductions of almost 5.7 million covered employees for the prototype HSA and 31.6 million for the more generous design.

Offering a free HSA to the nonworking, non–publicly insured population would not erode the employer coverage market. This simulation reduces the number of uninsured people, but less efficiently than a combination of other subsidies.

At least 70 percent of the take-up for the subsidies considered here would come from the lower half of the U.S. income distribution. The "free" HSA for nonworkers is the most attractive policy for the low-income uninsured.

Further HSA design considerations. Our work shows that people are sensitive to the size of the doughnut hole with much larger take-up of the more generous HSA compared with the prototype design. Further variation of the doughnut hole, as well as simulating the effect of various coinsurance rates for coverage above it, would be warranted. Risk-adjusted subsidies tied to health status might also be considered if health-related selection were found to be a problem.

Although our study does not consider possible behavioral responses, such as workers moving from jobs with insurance offers to those without offers as a consequence of the subsidy, it does indicate that a subsidy for HSAs can be simulated and that the effects of a subsidy might be important for expanding health insurance coverage ir United States.

Editor's Notes

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11. We wanted to include employee (or family) health status in the choice model, but, unfortunately, we did nc have these data. However, in our previous work (see Note 10), we found that health status was not a significant predictor of enrollment in a consumer-directed plan. Therefore, we do not believe that this is a serious omission.
12. Because state identification codes are not available in the MEPS-HC data, we could not adjust the out-of-pocket premium by the employee's state income tax rate if applicable.
13. Mercer, "U.S. Health Benefit Cost."
14. The most likely bias from this approach is that we will underestimate the attractiveness of an HSA, which features employee "ownership" of the account.
15. Additional details about the HSA policies used in the simulations are available from the authors. Contact Roger Feldman, feldm002@umn.edu .
16. We do not attempt to predict the ultimate insurance choices of workers who turn down an employer offer b do not buy an individual HSA. Some will obtain insurance through a spouse's policy, but others will remair uninsured.
17. Under the administration's proposal, the tax credit would apply only to the insurance premium, not to the h account. However, MMA lets consumers fund their accounts with pretax dollars, and this subsidy would st in place.
18. These subsidies applied both to single people with no dependents and to families. We did not attempt to "spline" the subsidies as in the administration's proposal.
19. The $211 billion for the full subsidy of a generous HSA was derived by adding the subsidy in the individua market ($98.7 billion) to the subsidy for those who turn down employer coverage ($122.4 billion).
20. The subsidy claimed by those already insured could be viewed as a reward for "doing the right thing."

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Health Tracking

MARKETWATCH

A Report Card On The Freshman Class Of Consumer-Directed Health Plans

Meredith Rosenthal, Charleen Hsuan and Arnold Milstein

Abstract

We used a series of case studies of first-generation consumer-directed health plans to investigate their early experience and the suitability of their design for reducing the growth in health benefit spending and improving the value of that spending. We found three fundamental but correctible weaknesses: Most plans do not make available comparative measures of quality and longitudinal cost-efficiency in enough detail to help consumers discern higher-value health care options; financial incentives for consumers are weak and insensitive to differences in value among the selections that consumers make; and none of the plans made cost-sharing adjustments to preserve freedom of choice for low-income consumers.

In the wake of the backlash against managed care, U.S. health benefit programs are undergoing a transformation.[1] The fulcrum for management of costs and quality has shifted from insurers and physicians toward consumers. Consumer-directed health plans, the result, vary in multiple dimensions but share (1) enhanced tools to support informed choice of providers and treatments; (2) expansion of programs to enable consumers to manage their health and health care; and (3) stronger financial incentives for consumers to control spending.[2]

Proponents of consumer-directed plans argue that they will catalyze health system reform by making enrollees better consumers of health care. They forecast that such plans will curb consumers' demand for low-value health services and stimulate their preferenc more-affordable and higher-quality providers and treatments.[3] Skeptics suggest that the plans amount to Trojan horses carrying camouflaged reductions in risk protection and financial access to care.[4] They are concerned that consumer-directed plans offered alongside other plans will skim off the healthier members of the risk pool, resulti

in a redistribution of resources from the sick to the healthy.[5]

In this paper we evaluate the early experience and design of fourteen first-generation consumer-directed health plans. We examine six design features that relevant health services research suggests will be required for such plans to reduce spending growth and increase value substantially. In addition, we reflect on early estimates of im reported by the industry and independent researchers. We examined both spending-account and tiered consume directed plan models.

Spending-account models. Spending-account plans now come as health reimbursement accounts (HRAs) or health savings accounts (HSAs) and offer consumers a fund to spend on some or all categories of health care. C the consumer has depleted the account, and for some expenses not eligible to be reimbursed out of the account, high deductible must usually be met before preferred provider organization (PPO)–style coverage applies. HSAs, created by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, must be accompanied by a high-deductible health plan that conforms to Internal Revenue Service (IRS) guidelines and ai portable for a person's lifetime. In HRAs, unspent balances are also carried forward by the beneficiary for future u but usually revert to the employer when the beneficiary changes employers.

Tiered models. Tiered models are more heterogeneous. They vary along several key dimensions: the scope an timing of consumer cost sharing. We label as "premium-tiered" those models that vary consumers' premium contributions based on annual selections, such as network size or health care delivery model. The most flexible forms of premium-tiered models are "customized-benefit-design" models that also allow consumers, at enrollmer customize cost-sharing parameters such as size of deductible or coinsurance, as well as network scope and moc Another type of tiered model is "point-of-care." These models vary consumers' cost sharing for each provider cor at the point of service, based on the provider's quality, price, or cost-efficiency tier.

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With an advisory team of five senior health services researchers, we identified fourteen consumer-directed health plans for study. We included the full range of new consumer-directed employee health benefit "solutions," except HSAs, which had newly entered the market. We prioritized plans with larger market share and those operating for at least a year, to allow sufficient operating experience. We included plans serving large employers (mostly self-insured) and small employers (mostly fully insured) because of likely differences in benefit design and implementation.

Among the fourteen plans were seven spending-account models, three premium-tiered models, one premium-tie customized-benefit-design model, and three point-of-care tiered models. To obtain candid information from respondents, we agreed to not identify specific companies or products and to label them as Plans 1–14.[6] Becaus there are few insurers with large enrollments in spending-account models and point-of-care tiered networks, the seven spending-account models we studied accounted for nearly 85 percent of 2003 U.S. enrollment in such mo while the three point-of-care tiered models accounted for nearly 80 percent of 2003 U.S. enrollment in such mode

For each selected model, we focused on a specific employer's implementation of that model. In late 2003 and ea 2004, we conducted a series of recorded telephone interviews with health plans' medical directors or marketing executives and the employer's human resource or health benefits director. We asked health plans questions in si categories: (1) targeted purchasers, including self- or fully insured; (2) benefit design; (3) consumer decision sup and health/health care management; (4) quality of care/financial protections; (5) observed risk segmentation effe among enrollees; and (6) impact, if measured, on enrollees' satisfaction, re-enrollment rates, service use, plan-pa costs, out-of-pocket costs, and provider behavior. With health benefit purchasers, we explored instead integratio the consumer-directed plan with any other health plan options, including the employer's contributions toward plai premiums.

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Rigorous analysis of the actual impact of consumer-directed plans is key to assessing the value of these new models. Because these plans are relatively new to the market, however, almost all of the evidence on savings comes from the plans themselves or their consultants, and thus it should be regarded as preliminary until independently confirmed. The impact of favorable selection among enrollees, empirically demonstrated in some studies, remains the largest unknown.[7] Also, findings relate to specific populations and plan designs and might not be generalizable.

Service use and spending. Most of the spending-account plans reported internal estimates of reduced service u and total spending because of the introduction of the new models. One premium-tiered plan also reported that its introduction caused enrollees to buy less generous plan designs and to reduce use compared with the previous y

Reported savings are difficult to generalize because they are relative to a variety of comparison plans, and, in ma cases, it is unclear how much were attributable to coverage reductions rather than behavioral change. The larges savings estimate suggested an 11 percent absolute reduction in total spending in the first year, while other plans the market were growing at double-digit rates. Most plans reported a reduced rate of positive spending growth, a some had no data. Several plans reported that consumers' out-of-pocket spending grew more slowly than comparison plans, as well. Plans attributed most savings to service substitutions by consumers rather than reductions in overall rates of service use. Substitutions included generic for brand-name drugs and office visits fo emergency room visits. One spending account and one premium-tiered plan (Plans 2 and 9) found that use of preventive care increased relative to comparison groups. Some point-of-care tiered plans observed slight behavi modification among enrollees. Plan 13 reported "modest but measurable" switching among enrollees to providers the preferred tier, while Plan 14 will increase the out-of-pocket cost differentials and add a fourth tier because of negligible switching among enrollees.

Independent evaluations of consumer-directed plans are now under way. The largest evaluation, and the only on report savings, assesses spending accounts offered by Definity in comparison to health maintenance organizatio (HMO) and PPO plans offered to the same risk pools.[8] In this setting, drug spending greatly decreased for spend account enrollees and remained below that of other plans throughout the study. Hospital admission rates were al initially lower but then surpassed those of the comparison plans. These findings might be explained by the fact th later years, many enrollees had accrued enough in their accounts to offset all or most of the deductible.

Consumer satisfaction. Finally, several spending-account plans reported annual renewal frequency above 90 percent for both employers and employees with a choice of plans. This, and survey results cited by the same pla suggests that satisfaction with the spending-account models is relatively high. Published survey data provide a somewhat different insight. In one employer setting, consumers who chose a consumer-directed plan offered alongside HMO and PPO options were somewhat less satisfied with their plan than other employees and were m likely to have switched plans at the end of the year.[9] Recall, however, that these findings relate to a single plan a might not be generalizable.

The Grading System For Judging Consumer-Directed Plan Designs

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We used principles derived from relevant health services research to score the plans on the following six design features likely to be pivotal to a plan's ability to greatly curb per capita spending and ameliorate quality failure.

Low-spender incentives. Because tiered plans are primarily attempting to influence choice of providers, to test the adequacy of their low-spender

incentives, we sought evidence on the amount of incremental cost sharing required to encourage enrollees to select a provider other than their natural choice. Survey research by David Meltzer and colleagues on consumers' acceptance of inpatient care by hospitalists rather than by their personal physicians showed that $200 will cause 85 percent of U.S. patients to select a hospitalist.[10] Only half of the prem tiered models required consumers to pay at least $200 more per year for selecting a lower provider tier. Two-thir the point-of-care tiered models required copayment differences of at least $200 if they received the modal annua amount of care from lower-tier physicians or hospitals.

Spending-account plans require consumers to pay dollar for dollar out of their accounts or out of pocket up to $1,000–$1,750 for single coverage. Because all of the accounts we examined had rollover provisions, we assum that enrollees typically treat account dollars as having high opportunity costs and will therefore try to conserve th for uses perceived as being of higher value.[11] Thus, all of the spending-account models passed our test of adeq of low-spender incentives (Exhibit 1).

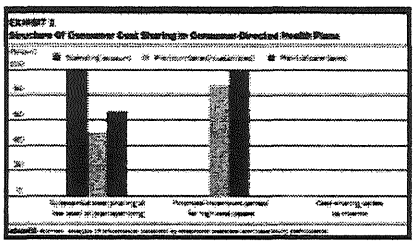

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EXHIBIT 1 Structure Of Consumer Cost Sharing In Consumer-Directed Health Plans

High-spender incentives. The principal factor driving growth in health spending is the use of high-cost technologies.[12] If consumer financial incentives rather than managed care preauthorization controls are to be reli upon for cost control, they must influence consumers with high levels of spending. To test for this, we examined whether consumer-directed plans use financial incentives to influence consumers' selections after combined spending exceeds $5,000.[13] For premium-tiered and point-of-care tiered models, we again looked for expected annual out-of-pocket payment differences of at least $200 between the most and least preferred hospitals and physicians, but at higher levels of plan spending. For spending accounts, we looked at the coinsurance rate to determine the consumer's share of spending after $5,000 and compared this to 20 percent, the modal coinsuran rate faced by current PPO or point-of-service (POS) enrollees for physician services.

We judged that all four premium-tiered plans offered sizable high-spender incentives based on the following logic a high-spending consumer responded to the premium differences among plan options by selecting a narrower network or higher cost sharing (or both), then the marginal incentives intrinsic to that selection would persist for tl entire year, until the consumer exceeded the out-of-pocket maximum. The three point-of-care tiered plans also influence consumers' selections at relatively high levels of spending because each time a person visits a nonpreferred physician or hospital, an additional copayment is required. For most patients at $5,000 of combinec plan spending, the out-of-pocket limit will not have been reached. The spending-account models required coinsurance of 10 percent or less once the deductible had been met. Thus, incentives to reduce spending were v or absent once a person reached $1,500–$2,500 in cumulative plan spending.

We note, however, that cost sharing is inherently a limited mechanism for influencing high spenders because out pocket maximums, which are needed to protect against catastrophic financial risk, ultimately desensitize enrollee the cost-efficiency of their selections, unless positive incentives are used.

Low-income incentive adjustments. Although cost sharing needs to be adequate to encourage higher-value selections, it is counterproductive if it discourages use of valuable services by lower-income enrollees or offers

choice in theory only.[14] POS cost sharing, coverage bonuses, out-of-pocket limits, or premium contributions that sensitive to enrollees' income all might protect lower-income people. Among all types of consumer-directed plans examined, none of the employers or plans used these forms of income-sensitivity.

Value-tailored incentives. We looked separately at whether cost sharing favors higher-quality and more cost-efficient plan selections (rather than just those with lower unit prices) of physicians, hospitals, and major treatmer options. For quality, we further differentiated between measures used that represent only service quality; narrowl defined clinical quality; or multidimensional, broadly defined quality. For treatment options, we examined whethe cost sharing varies based on cost-efficiency and any measure of quality.

Because most spending accounts rely on deductibles and traditional coinsurance, cost sharing is not sensitive to quality of provider selections (Exhibit 2). However, three of the seven spending accounts made some concessi quality by providing first-dollar coverage or subsidies for preventive services, and one plan offered a reward prog to encourage healthy behavior, including appropriate primary prevention. One spending-account model also favo high-value care by providing more generous coverage for maintenance drugs for chronic conditions.

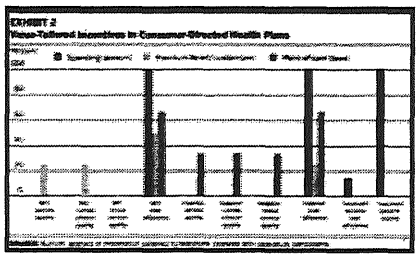

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EXHIBIT 2 Value-Tailored Incentives In Consumer-Directed Healtl Plans

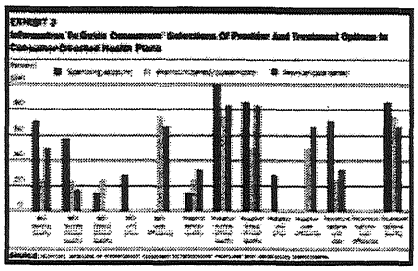
We also deemed spending accounts to offer enrollees incentives to select more cost-efficient physicians and treatments, because the individual bears the full cost of provider and treatment selections (up to the deductible). However, because nearly any hospital admission entails spending beyond the deductible, spending accounts do encourage selection of more cost-efficient hospitals (they only discourage admissions).

To test point-of-care tiered and premium-tiered plans, we examined the measures they used to rate providers for purposes of tiering. All used risk-adjusted information on cost-efficiency for this purpose, but only two used qualit measures.[15]

Decision support. If consumers lack access to information about the costs and quality of provider and treatmen options, the notion of a discriminating health care consumer is meaningless. Ideally, this information would incluc comprehensive cost-efficiency and broad quality measures and would be actively presented to consumers in particular health states. At a minimum, we looked for information on unit prices (for cost) and selected quality domains, available online, in print, or by telephone.

Only two spending-account plans provided any provider-specific cost information, and this was limited to unit pric a highly imprecise proxy measure of cost-efficiency (Exhibit 3). Three premium-tiered and two point-of-care tier plans made available qualitative ratings of physician or medical group costs (for example, an indication of being above or below a threshold using stars, arrows, or dollar signs). To rate cost performance, these five plans used measure of cost-efficiency—total cost per episode—rather than unit price.

EXHIBIT 3 Information To Guide Consumers' Selections Of



Provider And Treatment Options In Consumer-Directed Health Plans

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Health management support. We looked for four sentinel support mechanisms that provide direct, professional staffed support to consumers (rather than providers) to manage health and health care: nurse-staffed telephone l lines; health risk assessment linked to staffed risk-reduction programs, shared decision support/health coaching, case management.[16] Most of the plans undertook to engage consumers in managing their own health through th four mechanisms (Exhibit 4), although some differences among plan types emerged.

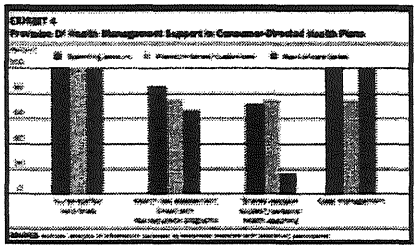

EXHIBIT 4 Provision Of Health Management Support In Consumer-Directed Health Plans

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Final Grades

To summarize the strengths and weaknesses of each type of consumer-directed plan model across the fourteen cases, we assigned final letter grades to the plan models based on the percentage that fulfilled each of our six evaluation criteria (Exhibit 5).

- Top
- Study Methods
- Effects Reported By Th
- The Grading System Fc
- Final Grades
- Discussion
- NOTES

View this table: EXHIBIT 5 Report Card On The Freshman Class Of Consumer-Directed Health Plans
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For value-sensitivity of cost sharing, we awarded one point each for physician or hospital cost-efficiency and for treatment option cost-efficiency. Similarly, we awarded one point each for sensitivity of cost sharing to the quality physician or hospital services and both narrowly defined and broadly defined clinical quality. We also allocated o point for cost sharing that reflected treatment quality (we gave a half credit on this measure for subsidizing preve care or maintenance drugs). The overall grade was then determined by the sum of points awarded over the maximum possible.

For decision support, we similarly aggregated binary scores for the availability of comparative cost information fo physicians, hospitals, and treatment options (half credit for unit cost; full credit for cost efficiency) to yield an over total. For quality information, we awarded one point each for reporting service quality measures, narrowly definec clinical quality measures, and broad quality measures for providers. Finally, we awarded each case a grade commensurate with the total number of staffed health management supports offered to enrollees, divided by four

In the overall scoring, no plan model ranked better than another across all criteria (Exhibit 5). The category in w grades were favorable overall was health management. Few plans provided consumers with incentives to select higher-quality care. With respect to incentives to economize, most plans require that consumers pay more for hig cost (less cost-efficient) options. Few plans, however, provide cost information that would enable consumers to compare various options, other than the option to avoid the health care system altogether.

Discussion

- Top
- Study Methods
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We studied the design and implementation of fourteen consumer-directed health plans to assess whether they were likely to reduce health care spending and improve the value of spending for health benefits. A natural limitation of the case-study approach is that the selected cases might not generalize to the universe of consumer-directed plans. In particular, we selected health plan models based in part on the length of time they had been in the market. This criterion favors the best plans (survivorship bias) but also might miss later design innovations. This market is rapidly evolving, particularly with the diffusion of HSAs, and is likely improving upon the first-generation plan models we examined.

Three critical weaknesses in plans. Efforts to refine consumer-directed plans should focus on rectifying three critical weaknesses in the freshman class.

First, if these plans are to succeed in promoting informed consumer choice, much more detailed information on c efficiency and quality needs to be made available to enrollees. To be fair, this lack of transparency is market-wid Other benefit models, however, do not claim to promote consumerism or to leverage consumer choice for value improvement. Off-the-shelf software that uses administrative data to compute risk-adjusted longitudinal cost-efficiency measures for episodes of care is widely available.[17] These measures, which reflect a combination of u prices and utilization patterns over an episode of acute illness or year of chronic illness, relieve plans' concerns about revealing negotiated unit prices. More importantly, they can protect consumers from the false economy of judging a provider's or treatment's cost-efficiency based on price, rather than on the likely impact on total spendir

The problem of inadequate denominator sizes to measure cost-efficiency and quality performance for individual physicians or hospital service lines could be partially addressed by giving health plans real-time access to the ful Medicare claims database from the Centers for Medicare and Medicaid Services (CMS), holding back data only t the extent necessary to protect the privacy of individual beneficiaries. Although there are obstacles—primarily political—to such a proposal, they are not insurmountable. Indeed, the Business Roundtable and a separate grou more than thirty large employers are actively supporting its inclusion in proposed legislation making its way throu Congress.[18] Moreover, in light of the CMS's own efforts to assess and reward physician quality and resource use substantial direct gains would accrue to the CMS by enabling the private sector to do the same via a common database. Meanwhile, the denominator can be enlarged via unit-price, neutralized, multiplan pooling of claims da which has already been achieved by six large Massachusetts health plans under the leadership of the state's Gr Insurance Commission.[19]

Second, it is difficult to rationalize the spread of spending-account models unless they incorporate easily underst cost-efficiency comparisons into the benefit design. For example, one plan we interviewed was developing for its spending-account model a drug benefit that put drugs in tiers by cost-effectiveness within a therapeutic class. In addition to applying it to physician and hospital selections, this concept could be refined to encompass cost-utility ratings defined collectively by insurance pool members rather than by the insurer and extended to other medical

surgical treatment choices for which sufficient outcome data exist.

Third, to be effective in controlling overall spending, consumer-directed plans will probably need stronger, more salient incentives that engage all enrollees, particularly those with high expected spending. Income-sensitive cos sharing or income-based contributions to spending accounts will be necessary to protect low-income consumers these more high-powered benefit designs. Positive incentives (payments to lower-income enrollees) might be be suited to induce participation in health management programs and selection of the most cost-efficient and high-quality provider and treatment options at high levels of spending.

Capturing the potential of consumer-directed plans to improve the affordability and quality of U.S. health care will require major refinements of the freshman class. Given the continued development of increasingly complex and valuable biomedical innovations, the future viability of employer health insurance pools requires equally sophistic benefit models in synergy with efforts to enable and motivate provider reengineering of clinical processes.

Editor's Notes

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NOTES

- Top
- Study Methods
- Effects Reported By Th
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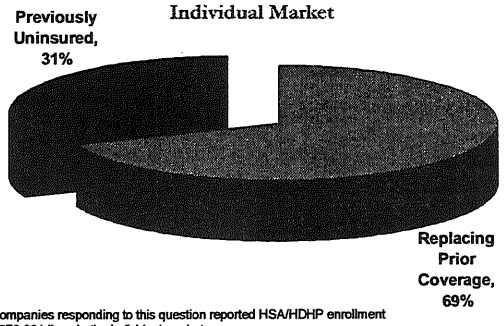
AHIP
Center for Policy and Research

Census of AHIP Members S] Savings Account (HSA) Plan

Health savings accounts (HSAs) allow people to save money tax-free to pay for their current and future health care needs. They are designed to give consumers financial incentive to manage their own health care expenses. An individual's HSA must be coupled with a high-deductible health plan (HDHP).

Figure 1. Percentage of HSA/HDHP Policies Purchased by Previously Uninsured*



*Companies responding to this question reported HSA/HDHP enrollment of 270,881 lives in the individual market.

Data as of January 2006

HSAs were first authorized in late 2003 as part of the Medicare Modernization Act, and regulations guiding their use were released in mid-2004. Since then, AHIP has conducted an ongoing census of its member companies to monitor and report on the HSA/HDHP health insurance market. For this census, AHIP received nearly complete membership participation.

Importantly, this census does not track participation in health reimbursement arrangement (HRA) products, which preceeded HSAs, share a number of features with HSAs and are offered by many large employers.

Market Overview

As of January 2006, almost 3.2 million people were covered by HSA/HDHP products. This is more than triple the HSA/HDHP enrollment of approximately 1 million that was reported by AHIP members in March 2005 (see Table 1).

Table 1. Enrollment	September 2004	March 2005	January 2006
Individual Market	346,000	556,000	855,000
Small-Group Market	79,000	147,000	505,000
Large-Group Market	13,000	162,000	670,000
Other Group[1]		88,000	248,000
Other[2]		77,000	878,000
Total	**438,000**	**1,031,000**	**3,155,000**

The January 2006 census included responses from 95 AHIP member companies. Fifty-three companies had enrollment in the individual market and eighty-six companies had enrollment in the

[1] For this census, AHIP members reported their membership in large and small group markets according to their internal reporting standards. The "other group" category contains enrollment data for companies that could not break down their group membership in data large and small group markets within the deadline for reporting.
[2] The "other" category was necessary to accommodate companies that were able to provide information on the number of people covered by HSA/HDHP policies, but were not able to provide a breakdown by market within the deadline for reporting.

group market.

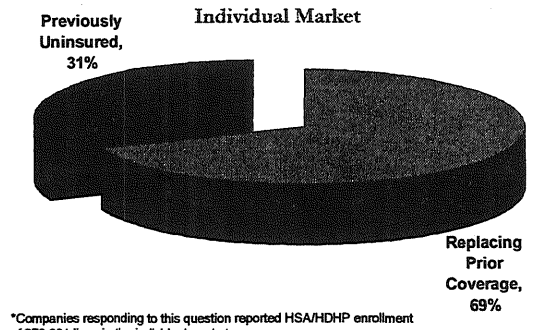
Individual Market

AHIP's member companies reported a total of 855,000 people covered by individually purchased HSA/HDHPs in January 2006. However, this tally for individual coverage almost certainly understates the total as 878,000 covered lives were not categorized by responding companies into either the group or individual market.

Of those companies reporting enrollment in individual HSA/HDHP plans, a subgroup3 reported that 31 percent of policies were purchased by individuals who previously did not have health insurance (see Figure 1).

The age distribution of people covered by HSA/HDHPs in the individual market appears to be evenly allocated among major age groups: 22 percent of covered people were younger than 20 years of age; 26 percent were between the ages of 20 and 39; 26 percent were between the ages of 40 and 49 years; and 26 percent were 50 years of age or older (see Figure 2).

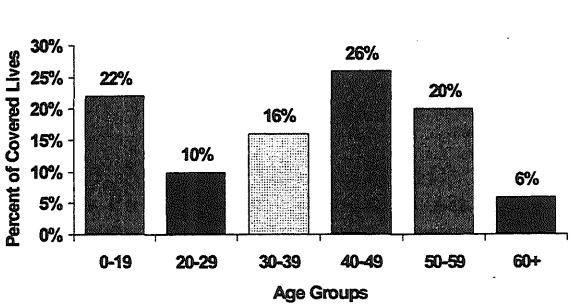
Figure 1. Percentage of HSA/HDHP Policies Purchased by Previously Uninsured*



*Companies responding to this question reported HSA/HDHP enrollment of 270,881 lives in the individual market.

Data as of January 2006

Figure 2. Age Distribution of People Covered by an HSA/HDHP Product



Data as of January 2006

Table 2 provides information on average deductible, out-of-pocket limit, and maximum lifetime benefit for the best-selling HSA/HDHP plans sold by companies in the individual market. Table 3 provides the average premium for the best-selling policies in the individual market, by age group.

Table 2. Description of HSA/HDHP Policies Individual Market – Best-Selling Product		
	Single	**Family**
Average Annual Deductible	$2,458	$4,916
Average Annual Out-Of-Pocket Limit	$3,586	$7,245
Average Lifetime Maximum Benefit*	$3.6 Million	$3.9 Million
*3 companies reported an unlimited Lifetime Maximum Benefit, not included in this calculation.		

Table 3. Individual Premiums by Age	Age 0-19	Age 20-29	Age 30-54	Age 55-64

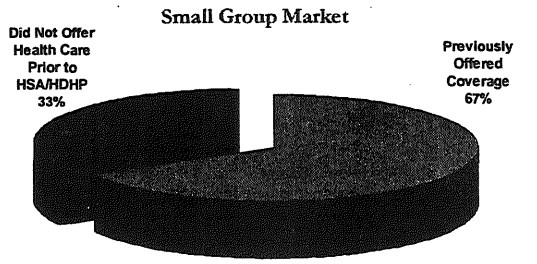
[3] Companies responding to this question reported HSA/HDHP enrollment of 270,881 lives in the individual market, with 83,973 previously uninsured.

Average Annual Premium, Single Policy	$1,340	$1,388	$2,220	$3,550
Average Annual Premium, Family Policy	$3,300	$3,190	$4,750	$6,494

Group Market

Approximately 1.4 million people were covered in the group market under HSA/HDHP plans as of January 2006. This includes 505,000 in the small-group market, and 670,000 in the large-group market. AHIP member companies reported covering an additional 248,000 people in the group market in January 2006 but did not report the breakdown between the small and large group markets. These responses were placed into a category called "other group." Finally, these totals for group coverage are understated because 878,000 covered lives in HSA/HDHP plans were not categorized by group or individual market (but were included in the overall totals).

Figure 3. Percentage of HSA/HDHP Policies Purchased by Companies That Previously Did Not Offer Coverage



* Companies responding to this question reported HSA/HDHP enrollment in 7,195 new small groups, covering 69,106 lives

Data as of January 2006

Small-Group Market

AHIP members offering HSA/HDHP products in the small-group market reported enrollment of 505,000 people as of January 2006. Of those companies that could provide information, 33 percent of small-group policies were purchased by employers that previously offered no health care coverage to their workforce (see Figure 3). These policies covered 69,000 employees and dependents.[4]

Average deductibles for the best-selling HSA/HDHPs in the small-group market were lower than those in the individual market, averaging $2,127 for single coverage and $4,279 for family coverage. The average lifetime maximum benefit for small-group policies was about $3.5 million (see Table 4).

Table 4. Description of HSA/HDHP Policies Small-Group Market – Best-Selling Product

	Single	Family
Average Annual Deductible	$2,127	$4,279
Average Annual Out-of-Pocket Limit	$3,316	$6,515
Average Lifetime Maximum Benefit	$3.3 Million	$3.7 Million
Average Annual Premium	$2,817	$7,075

Premiums averaged $2,817 for single coverage and $7,075 for family coverage. These premiums are

[4] Companies responding to this question reported HSA/HDHP enrollment in 7,195 new small groups, covering 69,106 lives.

considerably lower than premiums reported from surveys of all employer-based coverage. For example, the average premium was $10,880 in 2005 for employer-sponsored family policies, according to the Kaiser Family Foundation and the Hospital Research and Education Trust.[5]

Large-Group Policies

As of January 2006, large-group coverage had increased to at least 670,000 lives, up from 162,000 in March 2005. As noted previously, the January 2006 figure is understated by the fact that some responding AHIP member companies did not distinguish between the individual, small-group, or large-group market (representing 878,000 covered lives), and others did not distinguish between large and small firms within the group market (248,000 covered lives).

Table 5 provides the average annual deductible, out-of-pocket limit, and lifetime maximum benefit for the best-selling single and family HSA/HDHP policies in the large-group market.

Table 5. Description of HSA/HDHP Policies Large-Group Market – Best-Selling Product

	Single	Family
Average Annual Deductible	$1,763	$3,512
Average Annual Out-of-Pocket Limit	$3,303	$6,333
Average Lifetime Maximum Benefit	$2.9 Million	$3.4 Million
Average Annual Premium	$2,790	$6,707

Acknowledgements

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www.ahipResearch.org
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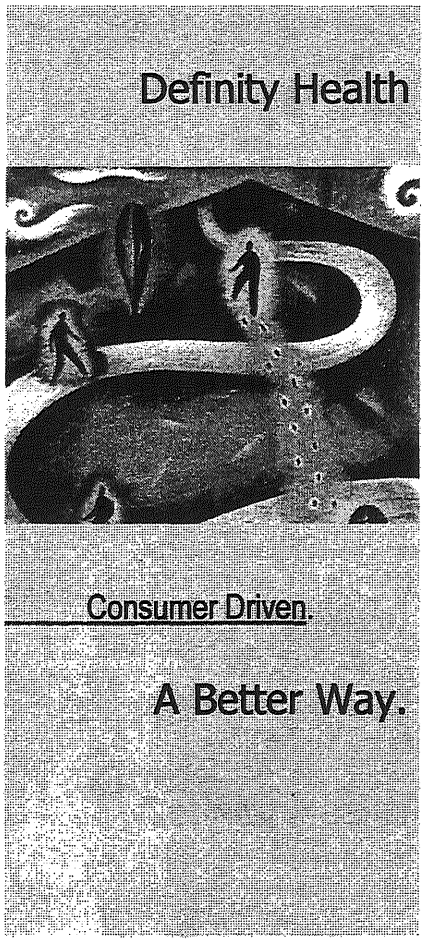
[5] Kaiser Family Foundation Employer Health Benefits 2005 Annual Survey. http://www.kff.org/insurance/chcm091405nr.cfm



Transforming Health Care: One Person at a Time

November 2005

Transforming Health Care

2005 Results from Definity Health

- Employers embrace consumer-directed health care
  - > (UHG book of business data)
- Consumer attitudes reflect deepening commitment, engagement
  - > And personalized outreach makes a difference
    - (2005 CDH member survey results)
- Utilization and cost trends are lower
  - > (Reden & Anders study of 2002 – 2004)
- Account balances grow over time
  - > (Reden & Anders study of 2002 – 2004)
- Consumers access preventive and health maintenance care more often
  - > (Definity Health study of chronically ill, Reden & Anders)

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Employers Embrace Consumer Strategies

- **4 - 5 million CDH members across the industry by 1/1/06**

- **Consumer familiarity will grow as plans become mainstream**
  - > Over 11,000 employers have implemented with UHG
  - > Approximately 1/3 of large clients (5000+ ees) will offer a CDH plan by 1/1/06

- **United Health Group CDH membership exceeds 1 million.**
  - > Roughly doubled year-end 2004 levels
  - > Expect approximately 1.5 million members by January 2006

- **2005 in-year growth shows small employers jumping in**
  - > Implementing HSAs primarily

- **Interest is increasing in full replacement**
  - > Large and small employers
  - > 45% of our large employer membership represents full replacement plans

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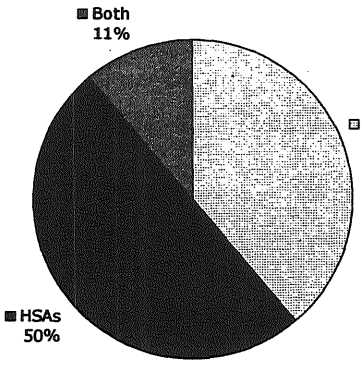
A UnitedHealth Group Company

Which Model? – CDH in 2006

- HRA and HSA serve different employer needs
  - > Desire for control on spending
  - > Portability
  - > Emphasis on individual accountability
- Large employer implementations for 2006:
  - > HRA 39%
  - > HSA 50%
  - > Both 11%
- 2006 membership growth projections slightly favor HSAs (55%)

2006 Large Employer Plan Implementations



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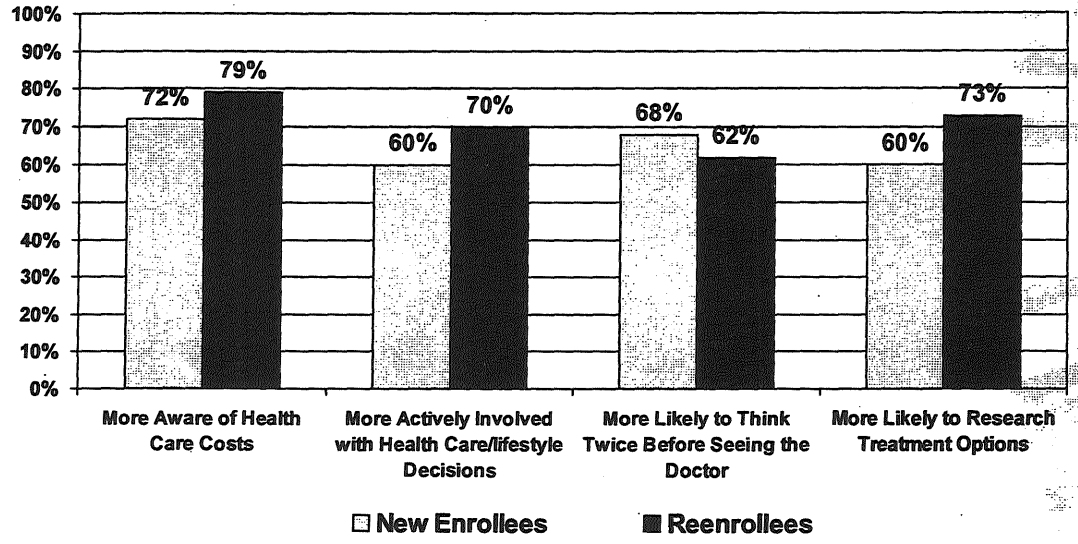
Consumer Attitudes Reflect Deepening Engagement

Those with more exposure to the plan and support services are more likely to report involvement in key health decisions:



60% of CDH enrollees access web tools, versus 45% in traditional plans.

Third-party survey of CDH members.

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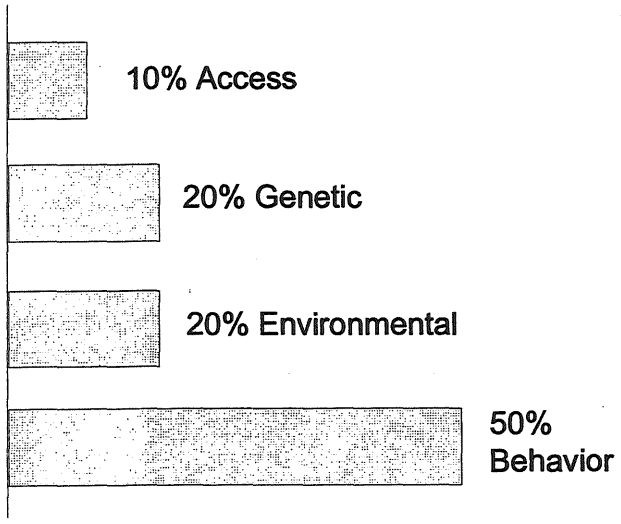
Impacting Consumer Behavior – The Leading Determinant of Health Status



Source: IFTF, Center for Disease Control and Prevention

Early Positive Indicators

Among consumers reading Definity's personalized messages:

- 2.4 times more likely to get a mammogram
- 100% increase in home delivery for pharmacy
- 31% increase in pill splitting

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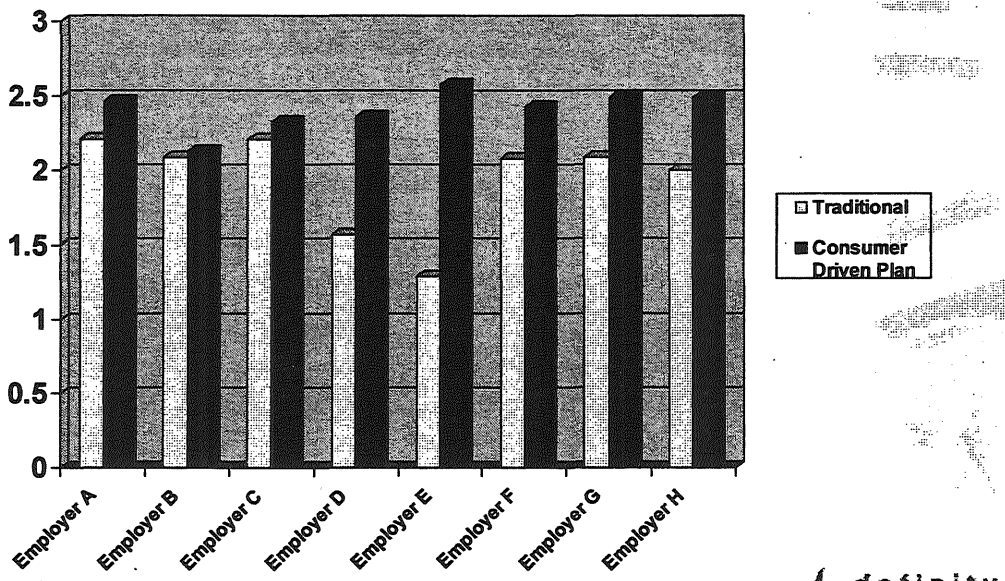
CDH Enrollees

Average Contract Size Comparison by Employer Group

Families enroll, not just the single employees, uniformly across groups studied.



Source: Definity and iPlan groups.

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Cost Effectiveness

Allowed cost trends are 30 - 50% lower than traditional plans

> Neutralizes impact of plan design

Longitudinal utilization trends are lower than those for traditional plans.

For individuals enrolled over a 2-year period:

> ER visits	35% of traditional plan trend
> OP surgery	28% of traditional plan trend
> Hospital days	32% of traditional plan trend
> Office visits	flat

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Consumers Are Accumulating Savings

The percentage of members carrying a balance into future years depends on the value contributed to their HRA.

Single HRA Contribution Level	Members with Balance
<$500	<50%
$501 - $700	43% - 73%
$701 - $900	55% - 83%
>$900	83% - 98%

The most common employer contribution level is $500 - $700 for single employees.

Source: iPlan data without Rx.

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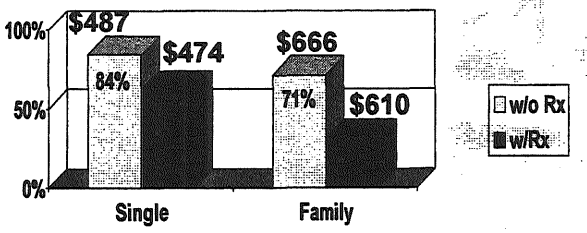
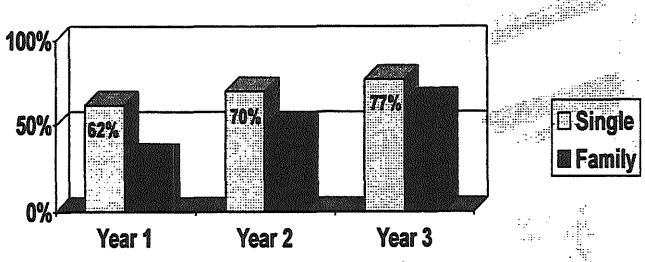
Year-End Account Balances

- Paying Rx from the HRA has an impact on account balance.
  - > (Balance amount represents average for contracts with balance.)



- More single employees carry over an account balance.
- Families with a year-end balance are growing quickly.
- Both increase over time.



Accounts with Balances at Year-End

- Terminating employees do not exhibit a "use it or lose it" approach to spending down account dollars.

Source: Definity.

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Account Spending

Account dollars are most often spent at entry points to care:
- Physician care
- Pharmacy

	Distribution of HRA Payments
Hospital Inpatient	1.2%
Hospital Outpatient	
• Emergency Room	4.7%
• OP Surgery	1.9%
• Other	7.1%
Subtotal	13.7%
Physician	
• Office Visits/Consults	17.6%
• Surgery	6.0%
• Radiology	5.9%
• Pathology	5.8%
• Physical Therapy	3.8%
• Other	9.4%
Subtotal	48.5%
Other	2.0%
Rx	34.6%
Total	**100.0%**

Source: Definity.

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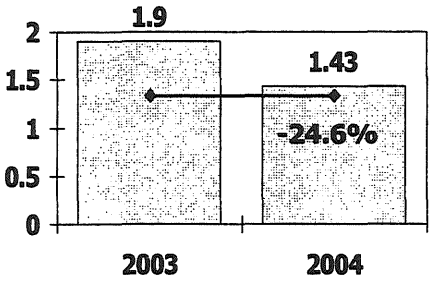
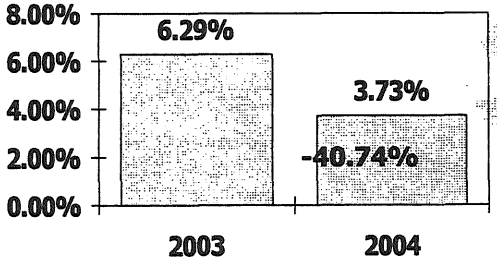
Maintaining Health for the Chronically Ill

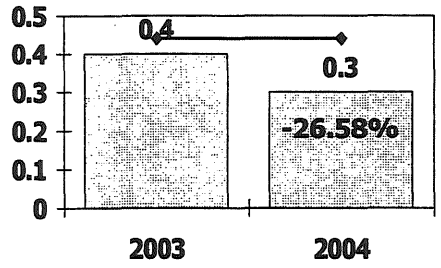
Visits Per 1,000 ER Asthma



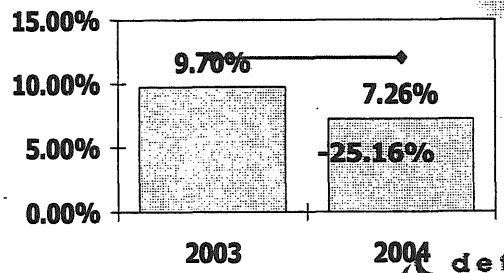
Pats Epis Asthma % Flare Up



Visits Per 1,000 ER Diabetes



Pats Epis Diabetes % Flare Up



Source:Definity Health Book of Business

definity health

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Health Reimbursement Accounts/ Health Savings Accounts: National Trends

Survey Results Report
April 2005

Human Resources & Investor Solutions

Executive Summary

In March and April of 2005, Mellon conducted a web-based survey of U.S. companies. Our goal: to assess trends in adopting consumer-driven plans, including Health Reimbursement Accounts (HRAs) and Health Savings Accounts (HSAs).

A total of 361 employers responded. Our findings: U.S. employers appear very interested in consumer-driven healthcare, including HSAs. Key results include the following:

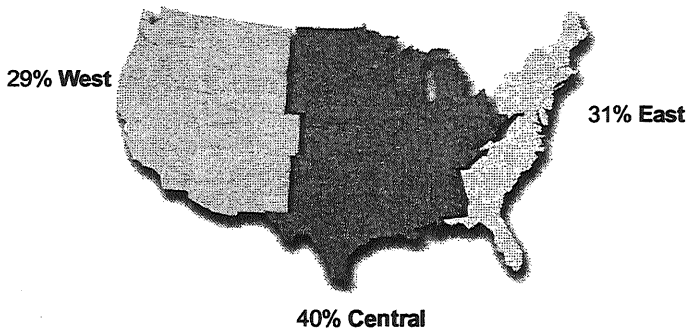
- Of the employers who had not implemented an HRA by 2005, 53% are likely to skip over HRA-style plans and move directly to HSAs.
- Median current enrollment in HRA-style plans is 17% of employees, with hopes of achieving a median target of 25% enrollment sometime in the future.
- About two-thirds of companies are considering implementing, or planning to implement, an HSA (or have already implemented).
- About one-third of companies plan to implement an HSA in 2006 as an option; a handful (2%) plan to offer HSAs as a total replacement.
- The percentage of employees enrolled in HSAs is still low (5% at the median). Goals for HSA enrollment are 15% at the median for 2006.
- Two-thirds (66%) expect to make an employer contribution to the HSAs.
- HSAs appear to be nearly equally attractive to both large and small employers.
- Understanding of HSAs/HRAs: 67% believe their HR staff understand HRAs very or relatively well, and 65% say the same for HSAs.
- Most (66%) believe that consumer-driven health plans can be designed and communicated to help promote more informed consumerism and decision-making behaviors.

This report provides additional highlights of our findings and background on the survey.

Participant Demographic

The 361 companies that provided data for this survey represent a broad cross section of company size, industry and geographic location. The median eligible employee population represented is 2,218, with the largest company having 160,000 employees, while the smallest had 12 employees. Manufacturing companies represented the largest industry sector, accounting for 22% of the participant base.

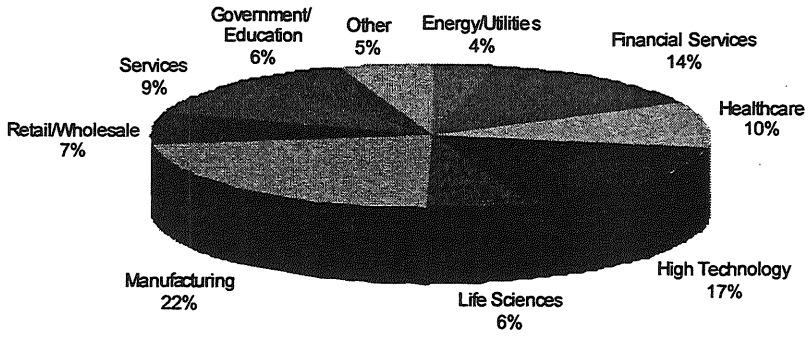
Geographic Distribution



Company Size

	Participant Employee Population
Median	2,218
Average	9,249
Largest	160,000
Smallest	12

Company Industry



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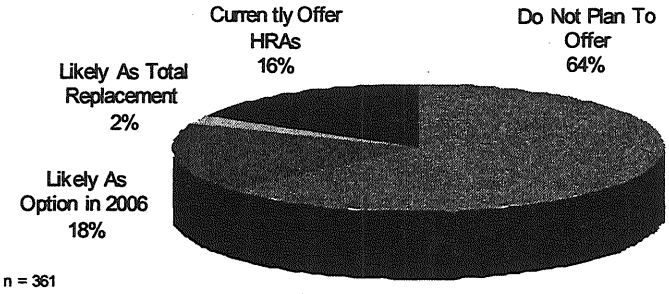
Survey Results

We asked participants about the two leading consumer-driven health plan approaches: Health Reimbursement Accounts (HRAs) and Health Savings Accounts (HSAs). We also asked about issues in health care communications.

Health Reimbursement Accounts (HRAs)

Do you currently offer HRAs?



n = 361

What percentage of the eligible employee population is enrolled in HRAs, and what is the target participation level?

	% of Eligible Ees Enrolled in HRA	Target % Enrolled
Median	17%	25%
Average	28%	36%

What is the number of plan options?

	Number of Plan Options
Median	1
Average	1.2

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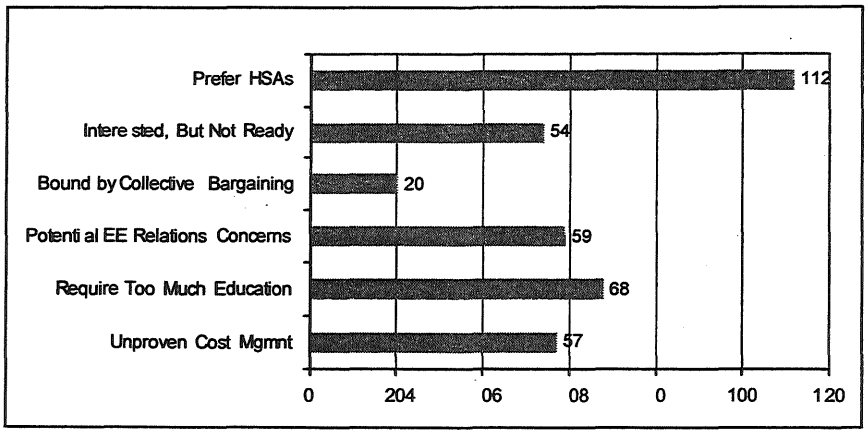
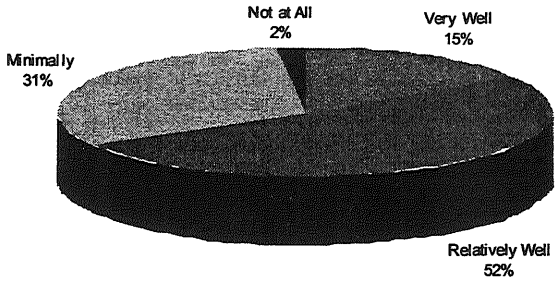
It appears that employers who waited to implement an HRA are now strongly considering moving to HSAs. In fact, the survey results indicate that 53% of employers are likely to skip over HRA-style plans and move directly to HSAs.

Why are HRAs not of current interest?



Note: Participants allowed to select more than one choice.

Overall, how well do your Benefits and HR decision-makers currently understand HRAs?



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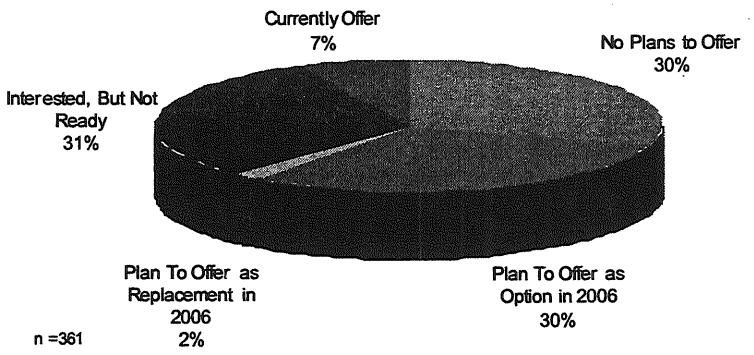
Health Savings Accounts (HSAs)

Currently, about 7% of participants offer an HSA-style plan. However, 30% indicated that they plan to offer HSAs as an option, and another 2% will offer HSAs as a total replacement for their health plans in 2006. HSAs have been somewhat more attractive to companies with fewer than 10,000 employees; however, there is little difference based on company size in the percent of companies planning to implement HSAs.

Which one of the following statements is true for your organization regarding offering a high deductible health plan with an HSA?



Which one of the following statements is true for your organization regarding offering a high deductible health plan with an HSA?

	Under 10,000 Eligible Ees	Over 10,000 Eligible Ees
Not In Next Few Years	28%	34%
Likely As Option in 2006	32%	28%
Likely as Replacement in 2006	1%	3%
Interested, But Not Ready	32%	30%
Currently Offer	8%	5%

What percentage of eligible employees are currently enrolled in an HSA?

	Percent of Eligible Employees Enrolled
Median	5%
Average	16%
High	100%
Low	1%

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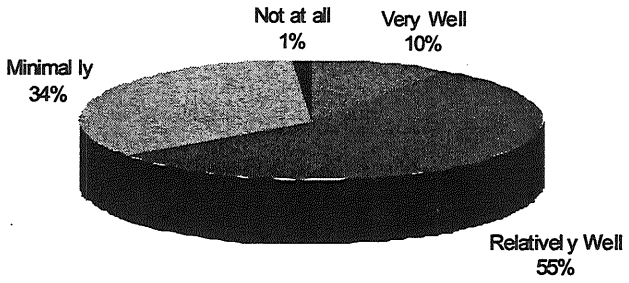
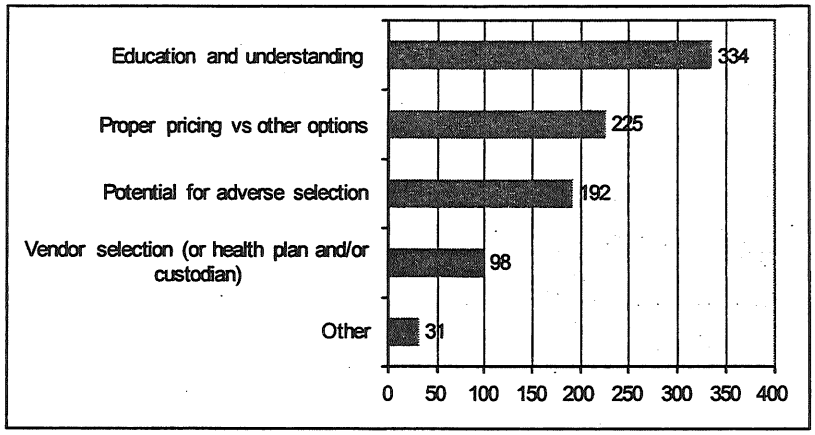
Target HSA Participation Rates

	All Companies	Under 10,000 Eligible Ees	Over 10,000 Eligible Ees
Median	15%	20%	10%
Average	24%	26%	15%

Overall; how well do your Benefits and HR decision-make rs currently understand HSAs?



What do you consider to be the key challenges in implementing HSAs?

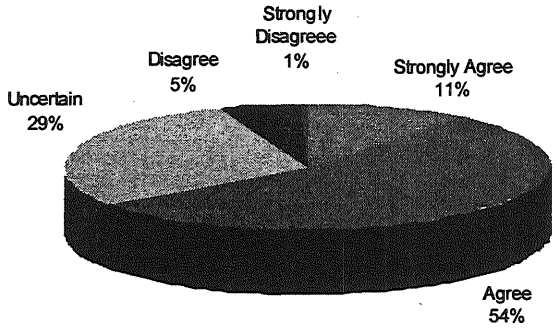


Note: Participants allowed to select more than one option.

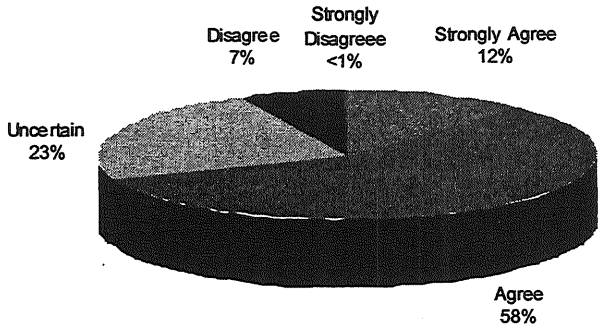
HRA/HSA Effectiveness

The majority of participants believe HRAs and HSAs can be effective in driving health care consumerism; however, many are still uncertain about their effectiveness. Companies are divided as to whether HRAs and HSAs are primarily about cost-shifting.

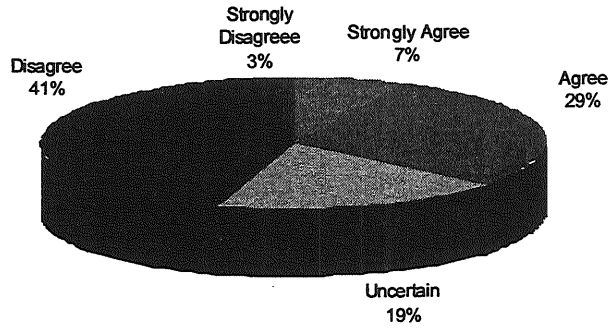
I believe HRAs can be designed and communicated to help promote more informed health care consumerism and decision-making by employees.



I believe HDHP/HSA offerings can be designed and communicated to help promote more informed health care consumerism and decision-making by employees.

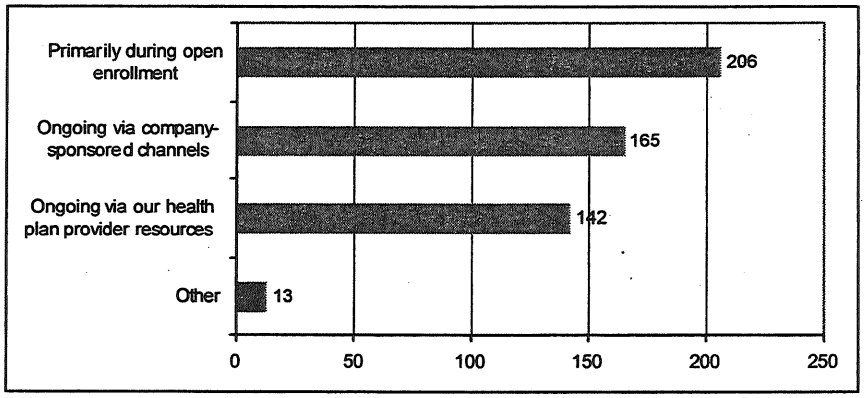


I believe HRA and HSA offerings are primarily focused on masking cost-shifting to employees.



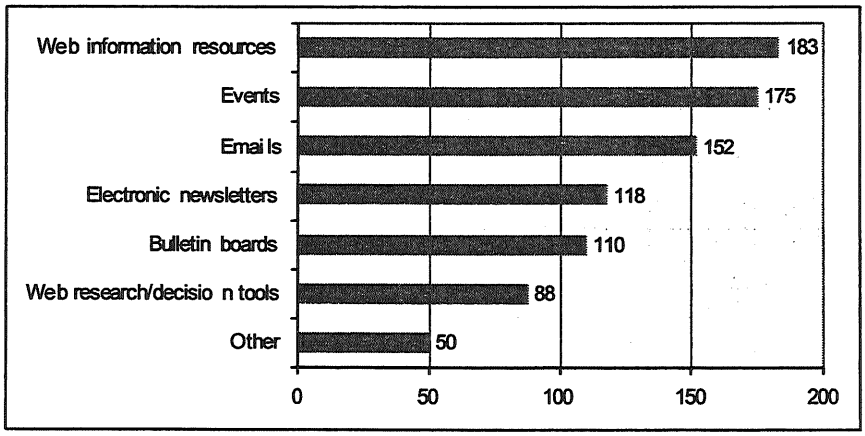
Communication

How do you conduct health care communications?



Note: Participants allowed to select more than one.

Outside of open enrollment, how do you communicate health care during the year?



Note: Participants allowed to select more than one.

Respondents

Employers responding to the survey included (not all participants provided their company name):

- Aastrom Biosciences
- ABIOMED
- Adaptec
- ADC Telecommunicatio ns
- Advanta
- Affiliated Computer Systems
- Agilent Technologies
- AIPSO
- Air Products and Chemicals
- Alexza MDC
- Allen County Government
- Allianz Life
- Allvac
- Alticor
- AMD
- American Airlines
- American Community Mutual
- American Fidelity
- American Greetings
- American Mathematical Society
- Ameron International
- Amylin Pharmaceuticals
- Anadys Pharmaceuticals
- Apogee Enterprises
- Apple Computer
- Arch Coal Inc.
- Archstone-Smit h
- Arizona State Retirement System
- Arnold & Porter LLP
- ArrayComm
- Aspen Medical Group
- Atys US Inc.
- Automatic Data Processing
- Avaya
- Ball State University
- Banknorth N.A.
- Barnes & Noble College Booksellers
- Barnes & Noble
- Basler Electric
- Bayer Corporation
- Becton Dickenson
- Bechtel Bettis
- Best Buy
- Bethesda Health Group
- BioMarin Pharmaceutical
- Blessing Corporate Services
- Blue Coat Systems
- Boeing
- Boston Scientific
- Bowne Business Solutions
- Bremer Financial Services
- Bridgestone Americas
- Brown Brothers Harriman
- Brown Printing Company
- Buckeye Partners
- Burke
- Business Objects Americas
- Caliper Life Sciences
- CapGemini
- Caraustar
- Carlson
- Castle & Cooke
- Cerus Corporation
- CH Robinson Worldwide
- Charlevoix Area Hospital
- Chemung Canal Trust
- Chicago Mercantile Exchange
- Citizens Bank
- City of Dallas
- City of San Leandro
- Claremont University Consortium
- Clear Channel
- ClubCorp
- CMS
- Coachmen Industries
- Coinstar
- Commerzbank AG
- Con Edison
- Consolidated Edison
- Cook Communications Ministries
- Coors Brewing Company
- Corixa
- Compro Companies
- Country Insurance & Financial Services
- Cranston Print Works Company
- Crown Castle International
- CTI
- CuraGen Corporation
- Curtiss-Wright Corporation
- CVS Pharmacy
- Cytec Industries
- Denver Public Schools
- Devro
- Dey
- Digi International
- Dimco-Gray
- Dinsmore & Shohl
- Donaldson Company
- Dorel Juvenile Group; Inc.
- Dow Corning Corporation
- Dow Jones & Company
- Drexel university
- Duke University
- Duke University & Health System
- Dura Automotive Systems Inc.
- EarthLink
- eBay
- Ecolab
- EDS
- eFunds Corporation
- Electro Rent
- Epler Company
- Equitable Resources
- Ervin Industries
- Evangelical Community Hospital
- ExpressJet Airlines
- Fairchild Semiconductor
- Fairview Health Services
- FANUC Robotics
- FedEx Supply Chain Services
- Ferrellgas
- FHLBI
- First Charter Bank
- First National Bank
- First State Bank of Adams County
- Flint Ink Corporation

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- Follett Corporation
- Ford
- Fort Wayne Foundry
- Francis Howell School District
- G&K Services
- GAF Materials Corporation
- Garden City Hospital
- GATX
- Genencor International
- General Cable
- Georgia-Pacifi c
- Gilead Sciences
- Global Crossing Limited
- GPCVB
- Grand Canyon University
- Greyhound Lines
- Guardian Life Insurance
- Guilford Pharmaceuticals
- Hallmark Health
- Hamilton County, Ohio
- Hamot Health Foundation
- Hannaford
- Harmonic
- Hartford Hospital
- Hayes Lemmerz International
- Hazelden Foundation
- HealthEast Care System
- Heinz
- Hella
- High Industries
- Horsburgh & Scott
- Hudson Health Plan
- IBM
- Illinois Tool Works
- Integris Health
- International Assets Holding Corporation
- Intertape Polymer Group
- Investors Bank & Trust Company
- ITT Industries; Inc.
- IUE-CWA Pension Fund
- JCPenney
- Jefferson Health System
- Joint Commission
- Katy Industries
- Kayser-Roth Corporation
- Kellwood Company
- Kelly Services
- Kendal at Ithaca
- Kettering University
- Key Automotive Group
- Kraft Foods
- KWS Seeds/Betaseed
- Kyphon
- Lawson Software
- La-Z-Boy
- Lear
- Leith Ventures
- Leprino Foods Company
- Level 3 Communications
- Leviton Manufacturing
- Lifetouch
- Liguori Publications
- Little Caesar Enterprises
- Loews Corporation
- Loyola University
- LSI Logic Corporation
- Macromedia
- MaineGeneral Health
- Maritrans
- Marshall Medical Center
- Matthews International Corporation
- Memorial Hospital at Gulfport
- Mentor Graphics
- Merrill
- Metropolitan St. Louis Sewer District
- Michaels Stores
- Midas International
- Midwest Research Institute
- Milacron
- Mindspeed Technologies
- Moog
- Neoforma
- New York Stock Exchange
- Newcor
- Newport Corporation
- Nokia
- Northwest Airlines
- Novell
- Novozymes North America
- Nuance Communications
- Nuvelo
- NVIDIA Corporation
- NYSNA Pension & Benefits
- Oakwood Healthcare
- Oglebay Norton Company
- Ohio Police and Fire Pension Fund
- OpenWorks
- Orange and Rockland Utilities
- Otsuka America; Inc.
- Packeteer
- palmOne
- Partners HealthCare System
- Pathmark Stores
- Pentair
- Penwest Pharmaceuticals
- Pepco Holdings
- PepsiAmericas
- PETsMART
- Pfizer
- Pilgrim's Pride
- Plastipak Packaging
- Platinum Underwriters Reinsurance
- Portal Software
- PPG Industries
- Premera Blue Cross
- Principal Financial Group
- ProQuest Company
- QLogic
- Quantum Corporation
- Questar Corporation
- Quidel
- Qwest Communicatins International
- Rayonier
- Reckitt Benckiser
- Reed Smith LLP
- Rent-A-Center
- RGA Reinsurance Company
- Rice University
- Roquette America
- Rosemount Inc.
- S&T Bank
- SAIC

- Saint Mary's Hospital
- SBC Communications
- Schnabel Engineering
- Schneider Electric
- Seagate Technology
- Sealaska Corporation
- Sealed Air
- Secure Computing
- Select Comfort
- Sepracor
- Service Corporation International
- Sirva
- Skadden, Arps, Slate, Meagher & Flom LLP
- Skyworks Solutions
- SMUD
- Solectron Corporation
- Southern Methodist University
- Spartech Corporation
- Spinnaker Coating
- St John Health
- Standard Register
- Standex International
- State of Montana
- Stein Mart
- STMicroelectro nics
- StorageTek
- STRS Ohio
- Stryker
- Suburban Hospital
- Sun Chemical Corporation
- SunTrust
- Supervalu
- Symantec Corporation
- Target
- TDIndustries
- Terayon
- The Auto Club Group
- The Dow Chemical Company
- The Estate of James Campbell
- The Hilliard Corporation
- The Interpublic Group
- The Lubrizol Corporation
- The May Department Stores
- The Schwan Food Company
- The Shaw Group
- The Washington Hospital
- Thornburg Companies
- Tidewater
- Tiffany & Co.
- Time Warner Telecom
- Tractor Supply Company
- Trimble Navigation Limited
- Trinity Health
- TriQuint Semiconductor
- TSA
- TSMC North America
- Tufts-NEMC
- TYBRIN Corporation
- Union Bank of California
- Union Pacific
- Unisys
- Universal Forest Products
- Universal Hospital Services
- Universal Premium Acceptance Corporation
- University of Colorado Hospital
- University of Iowa
- University of Minnesota
- University of Puget Sound
- Upper Chesapeake Health
- US Bank
- Valmont Industries
- Vanderbilt University
- Varain Semiconductor Equipment Associates
- Ventiv Health
- Veritas Software
- Virgin Atlantic Airways
- Visteon
- VISX
- Waste Management
- Wellmark Blue Cross Blue Shield
- Westfield Group
- Widener University
- William Beaumont Hospital
- Wireless Facilities
- Wisconsin Energy
- Wm. Wrigley Jr. Company
- Worldspan
- Xcel Energy
- Xerxes Corporation
- XOMA
- XYZ Company
- YMCA Retirement Fund
- Zoran

About Mellon

Mellon's Human Resources & Investor Solutions is the worldwide human resources and shareholder services business of Mellon Financial Corporation, a global financial services company. In addition to providing leading-edge plan design and communication support for consumer-driven health plans, Mellon also offers the Mellon HSA Solution℠–an integrated approach to HSA custodial services, investments, and customer service.

Headquartered in Pittsburgh, Mellon Financial Corporation is one of the world's leading providers of financial services for institutions, corporations and high net worth individuals, providing institutional asset management, mutual funds, private wealth management, asset servicing, human resources and investor solutions, and treasury services.

Mellon Financial Corporation has approximately $3.6 trillion in assets under management, administration or custody, including more than $675 billion under management. Its asset companies include The Dreyfus Corporation and U.K.-based Newton Investment Management Limited. News and other information about Mellon are available at www.mellon.com.

For More Information

For more information on this survey—or for special data cuts or analyses—please contact:

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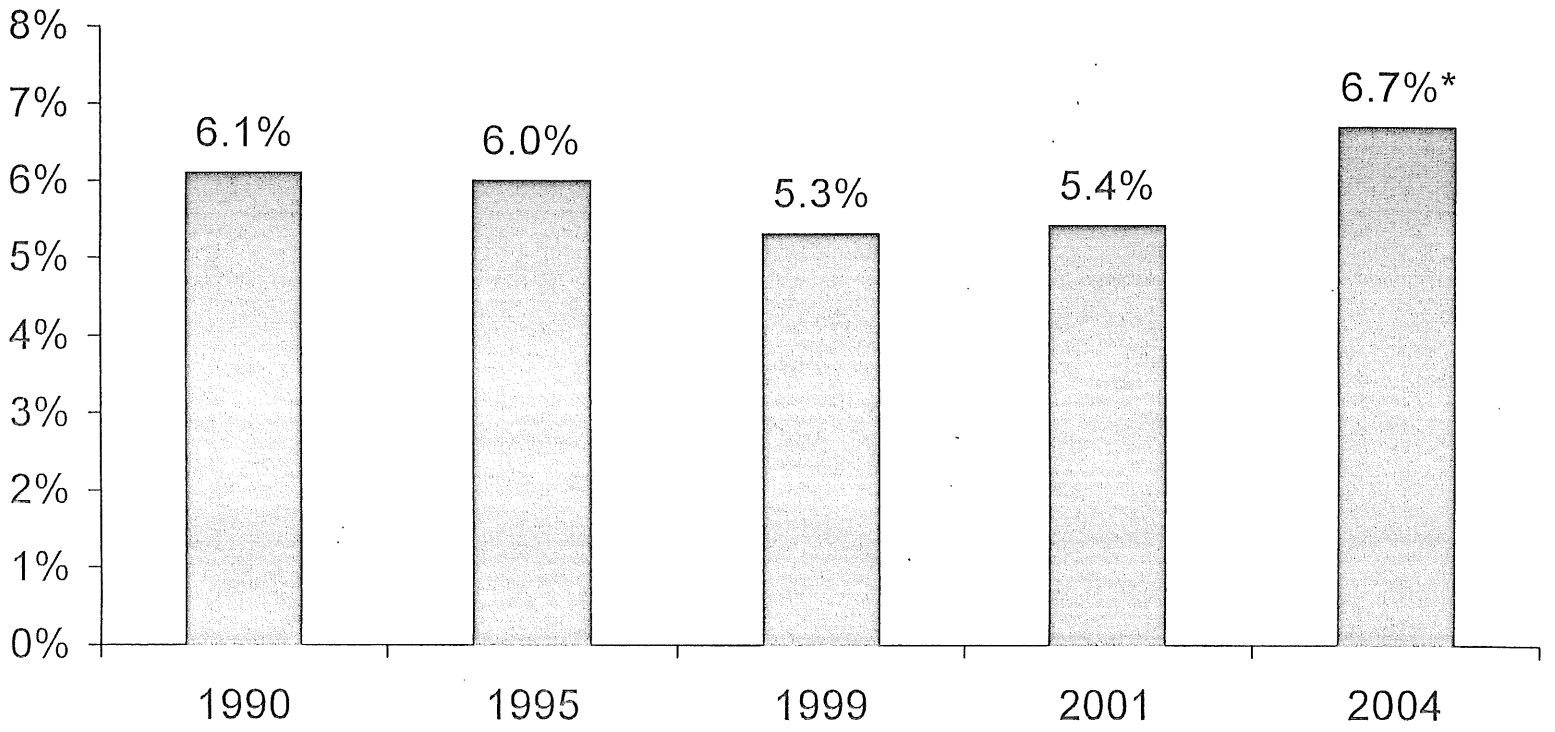
Joint Committee Session

Information compiled by
Hennepin County Medical Center
in support of testimony by
Dr. Michael Belzer, Medical Director
Hennepin County Medical Center
February 16, 2006

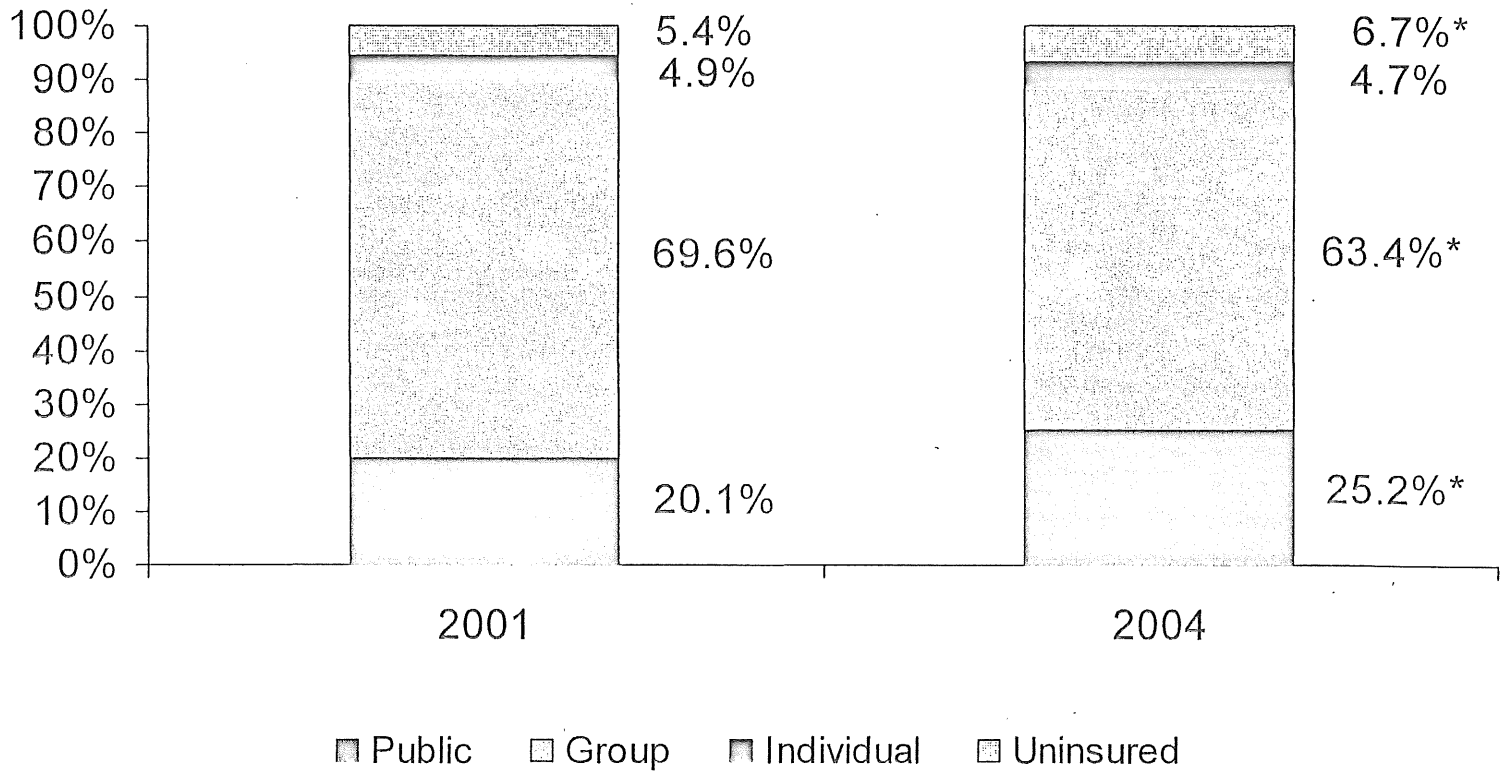
Uninsurance Rate Trends in Minnesota



MINNESOTA MDH DEPARTMENT OF HEALTH

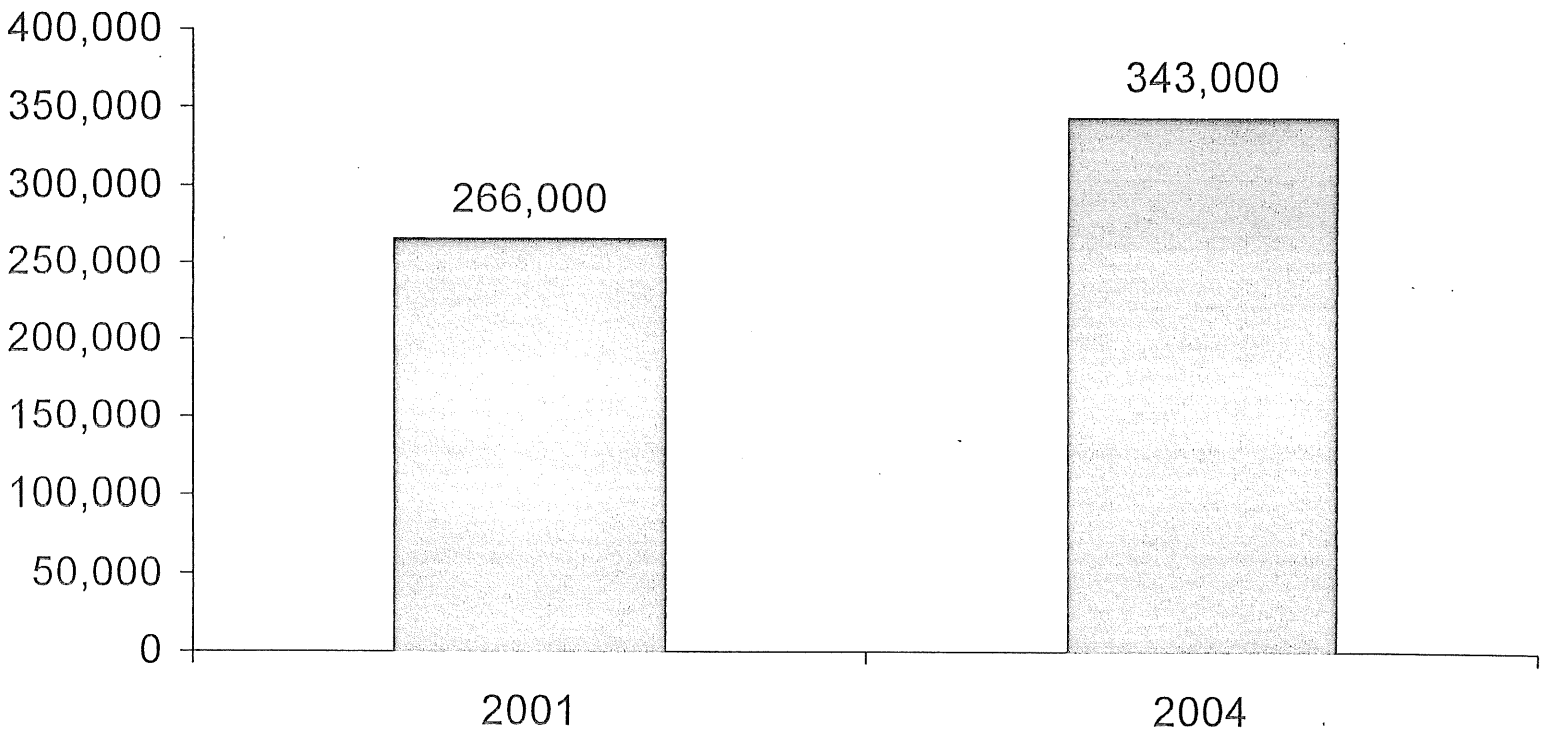
*Indicates statistically significant difference (95% level) from prior survey year.
Source: Minnesota Health Access Surveys 1990, 1995, 1999, 2001, 2004. Uninsurance measured as point in time estimate (people uninsured at the time of the survey). 2004 estimate is preliminary.

Sources of Insurance Coverage in Minnesota, 2001 and 2004



Source: Minnesota Health Access Surveys, 2001 and 2004 (preliminary). Estimates that rely solely on household survey data differ slightly from annual estimates that include both survey and administrative data.

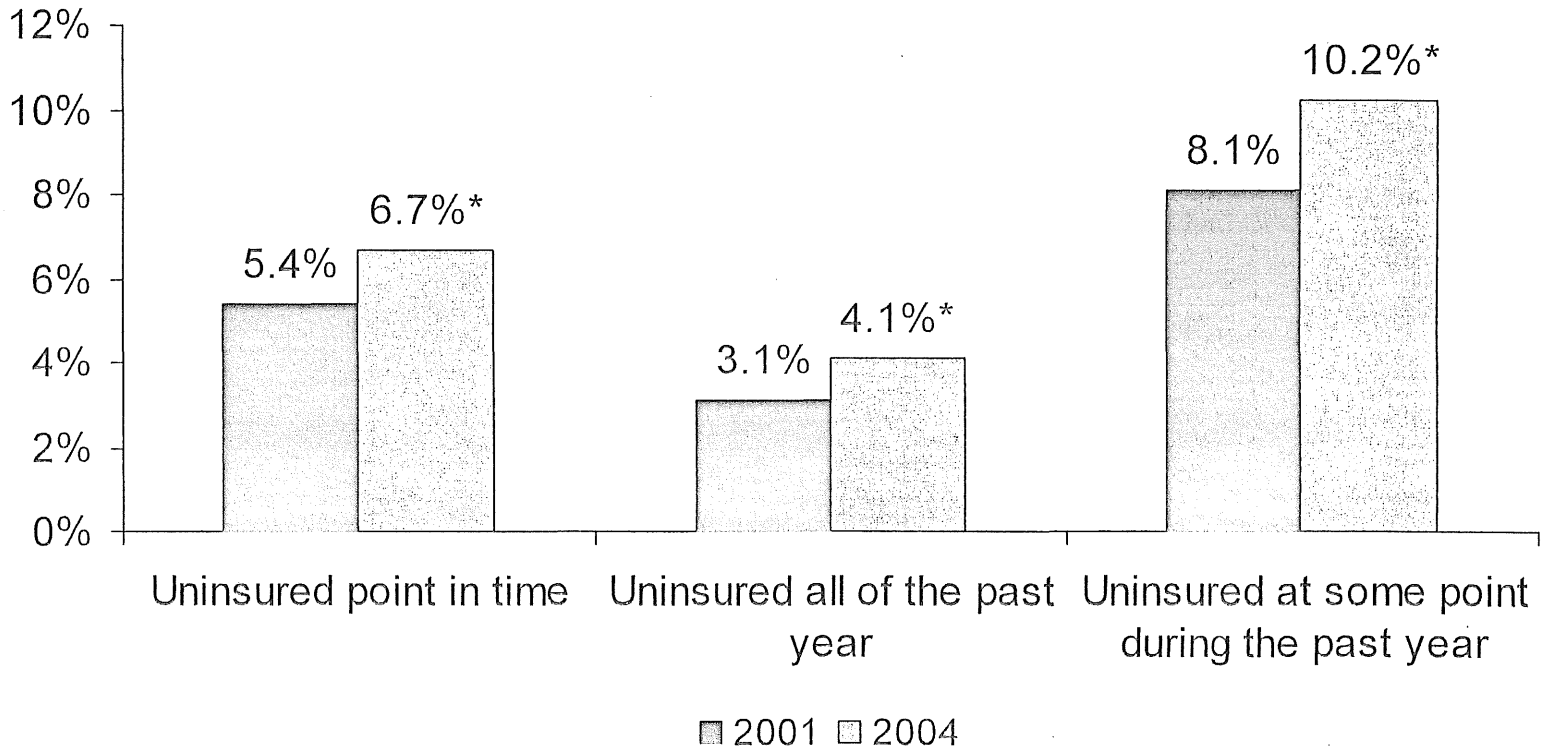
Number of Uninsured Minnesotans, 2001 and 2004



Source: Minnesota Health Access Surveys, 2001 and 2004 (preliminary). Uninsurance measured as a point in time estimate.

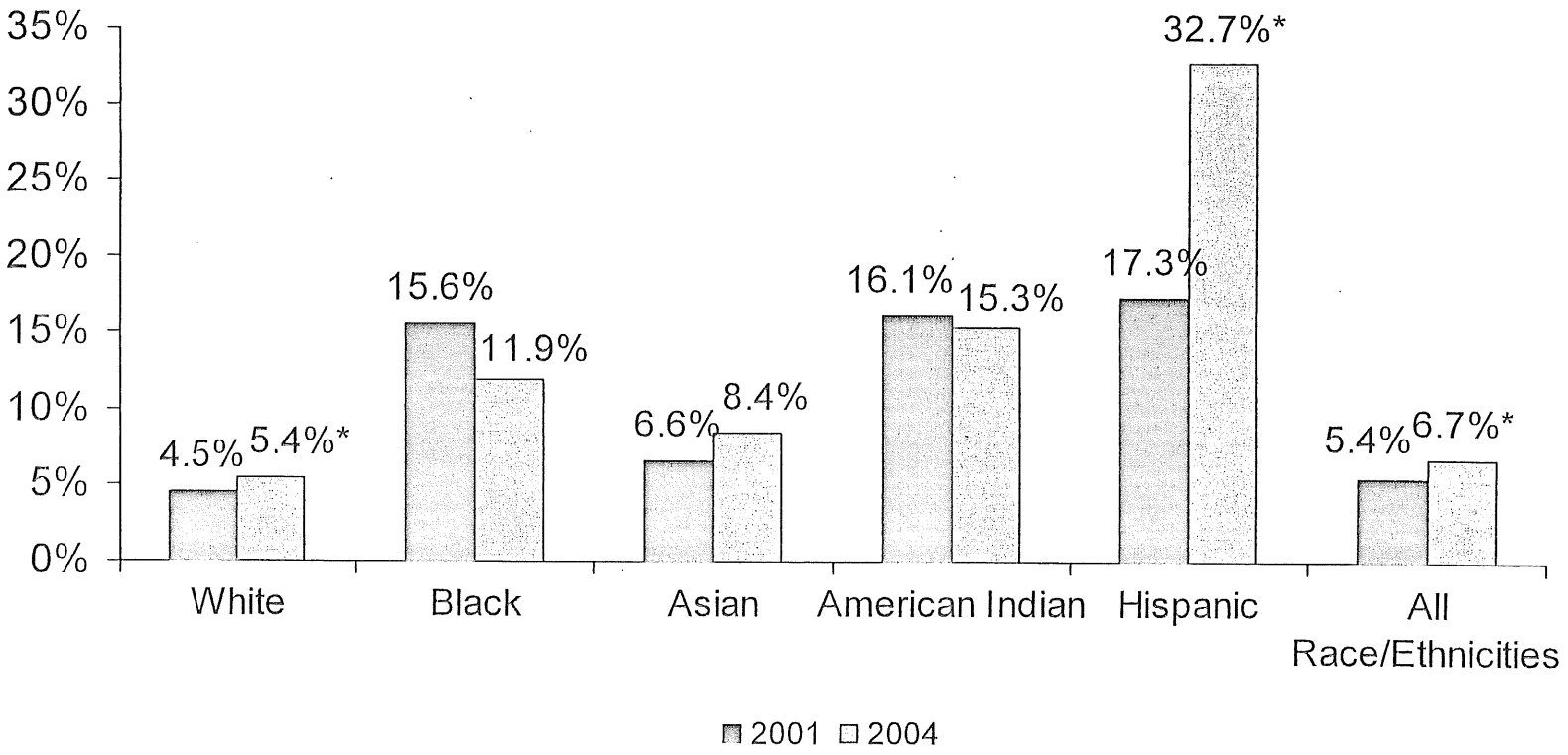
MINNESOTA MDH DEPARTMENT OF HEALTH

Measures of Uninsurance in Minnesota, 2001 vs 2004



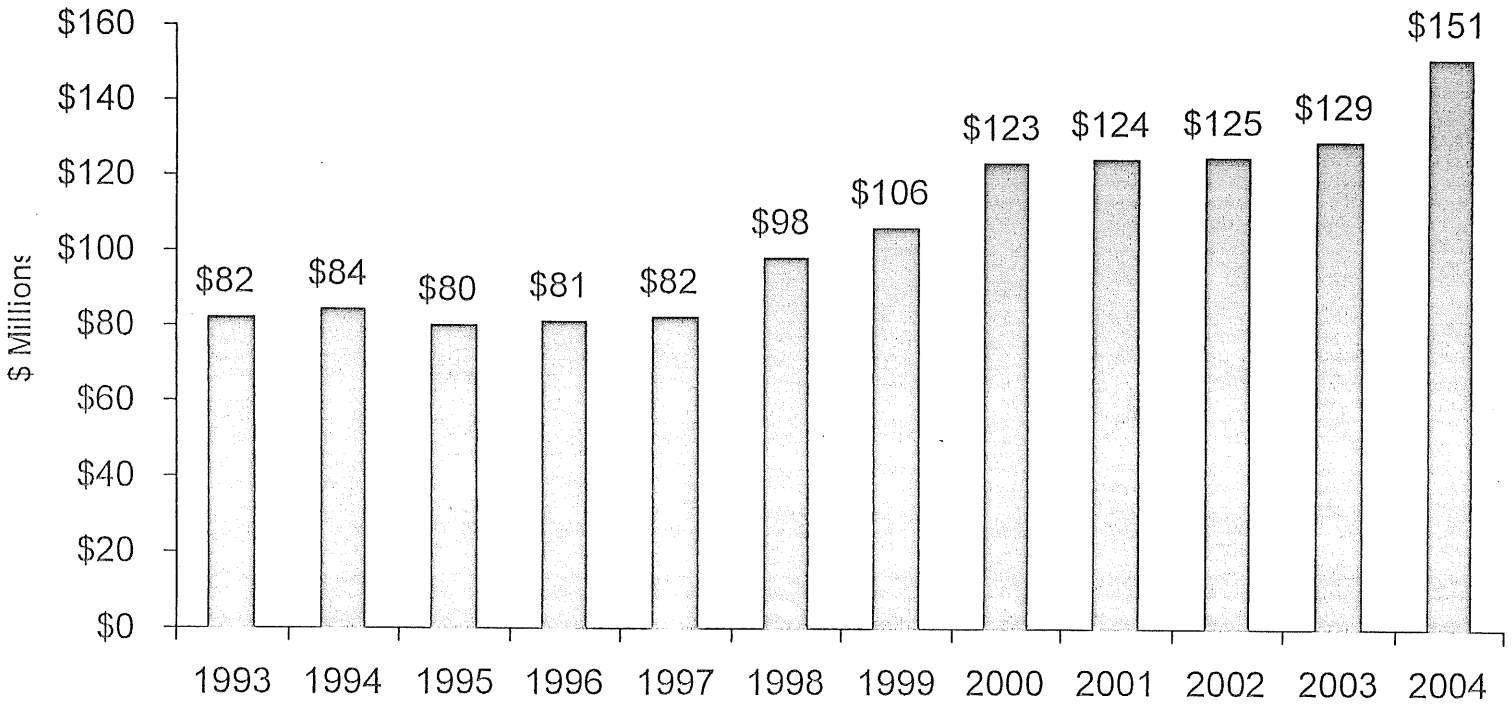
*Indicates statistically significant difference (95% level) from 2001.
Source: Minnesota Health Access Surveys, 2001 and 2004 (preliminary)

Minnesota Uninsurance Rates by Race/Ethnicity, 2001 and 2004



* Indicates statistically significant difference (95% level) from 2001.
Source: Minnesota Health Access Surveys, 2001 and 2004 (preliminary)

Uncompensated Care Costs in Minnesota Hospitals, 1993 to 2004



MINNESOTA MDH DEPARTMENT of HEALTH

*Uncompensated care figures are adjusted by a cost to charge ratio.
Source: MDH, Health Care Cost Information System.

Largest Providers of Uncompensated Care, 2004

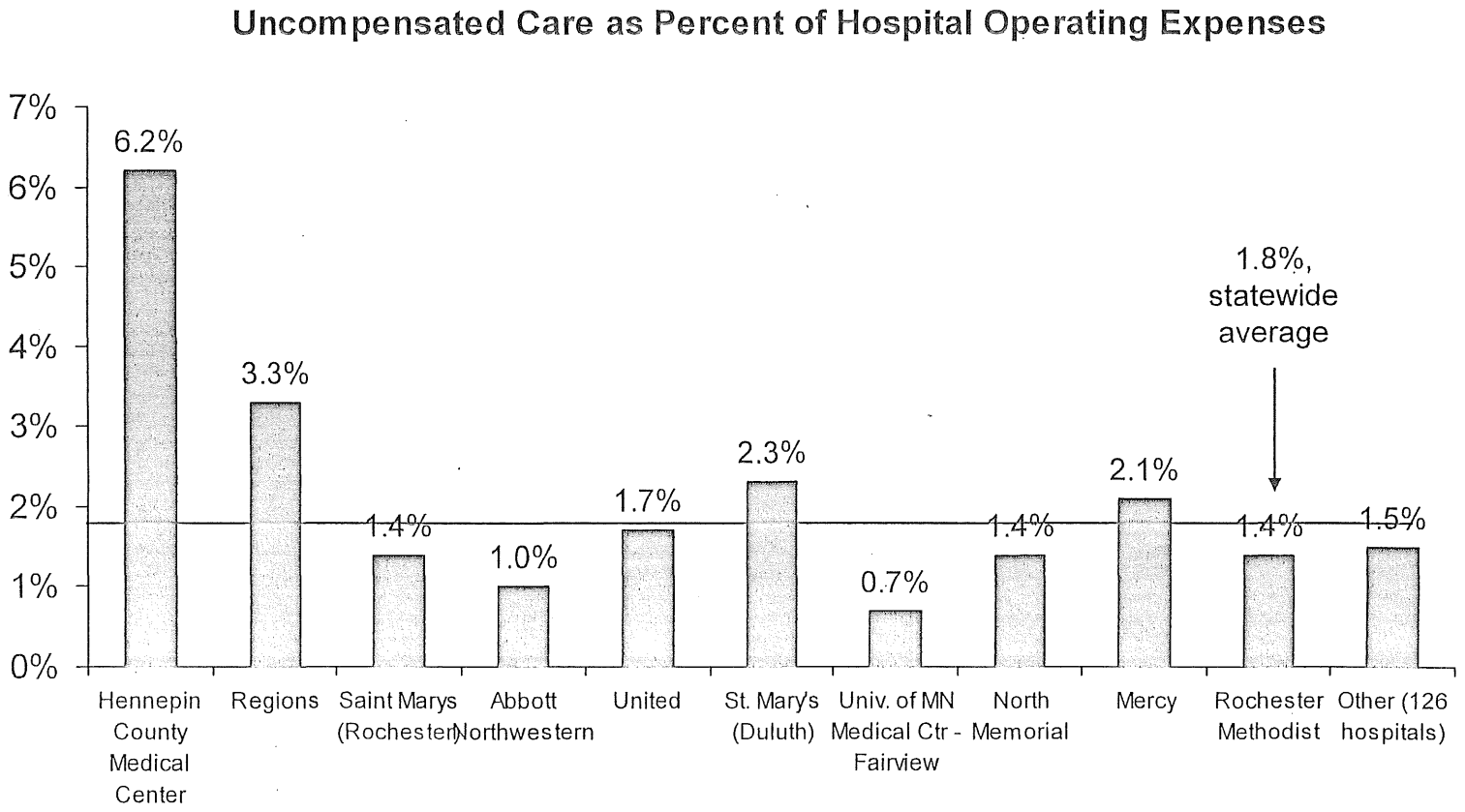
	2004 Uncompensated Care ($ millions)	UC as % of Operating Expenses
Hennepin County Medical Center	$26.3	6.2%
Regions Hospital	$11.8	3.3%
Saint Marys Hospital (Rochester)	$7.1	1.4%
Abbott Northwestern Hospital	$5.9	1.0%
United Hospital	$5.6	1.7%
St. Mary's Medical Center (Duluth)	$5.2	2.3%
University of Minnesota Medical Center – Fairview	$5.2	0.7%
North Memorial Medical Center	$4.8	1.4%
Mercy Hospital	$4.6	2.1%
Rochester Methodist Hospital	$3.9	1.4%
Other hospitals (126 hospitals)	$70.7	1.5%
Statewide total	$151.3	1.8%

*Uncompensated care figures are adjusted by a cost to charge ratio.

Source: MDH, Health Care Cost Information System.

MINNESOTA MDH DEPARTMENT of HEALTH

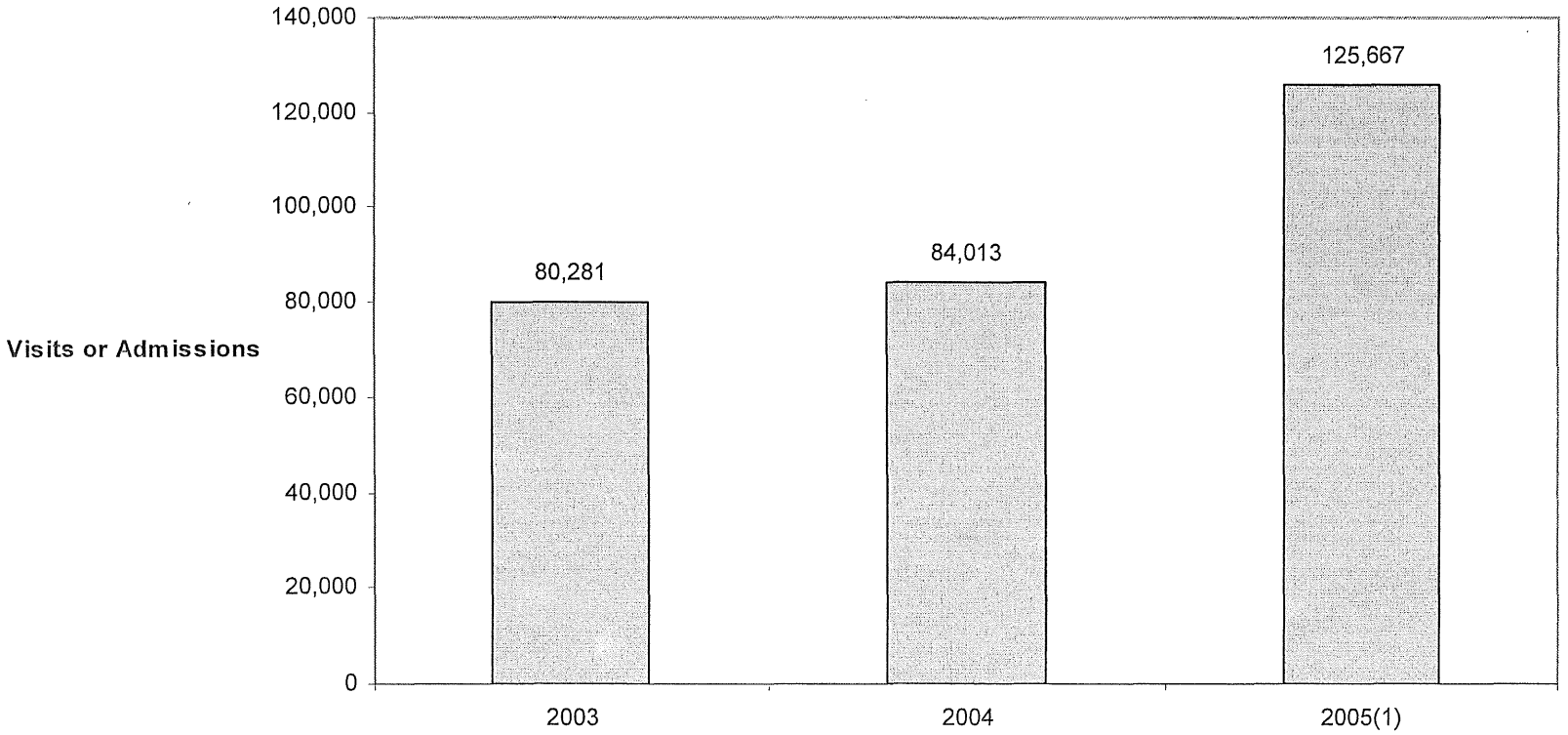
Minnesota's Largest Providers of Hospital Uncompensated Care, 2004



*Uncompensated care figures are adjusted by a cost to charge ratio.

Source: MDH, Health Care Cost Information System.

Hennepin County Medical Center: Occasions of Service to Uninsured

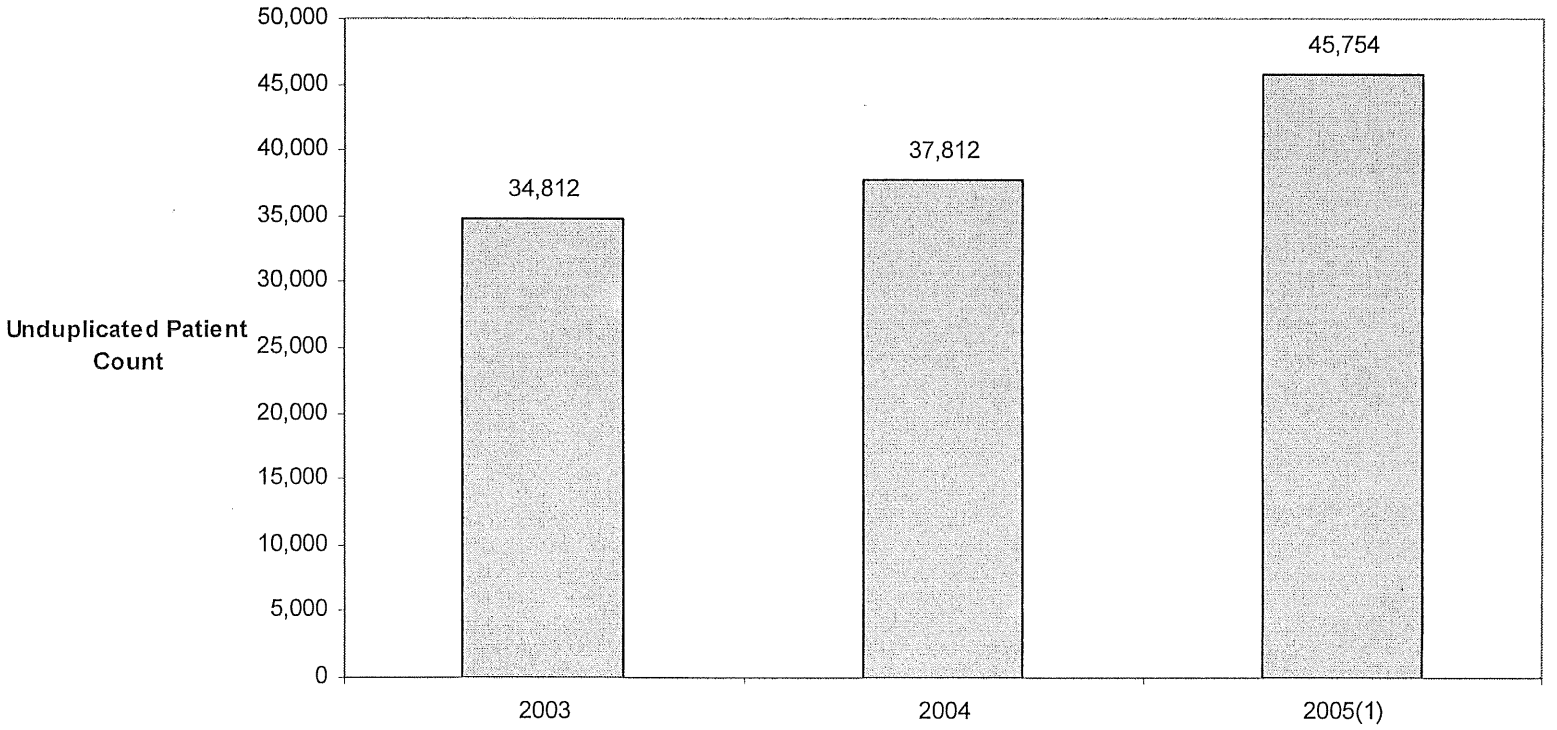


(1) Preliminary estimate

Source: HCMC Finance Department, February 2006

HCMC
Level I Trauma Center

Hennepin County Medical Center: Uninsured Patients Served



(1) Preliminary estimate

Source: HCMC Finance Department, February 2006

HCMC
Level I Trauma Center

Hennepin County Medical Center

HCMC Level I Trauma Center

FACT SHEET

2/16/06

HCMC: A Minnesota Public Healthcare Asset

1. Hennepin County medical Center (HCMC) was first established in 1887 and continues today as a nationally recognized public safety-net hospital, a designated State of Minnesota "Essential Community Provider" (ECP) and a prominent teaching hospital serving an increasingly diverse and growing patient population.

2. Award winning clinical services with over 50 specialized programs including a nationally recognized Level I Trauma and Heart Center, a regional Burn Center, 24-hour Emergency Medical Services, and a broad range of medical education initiatives and training programs.

3. HCMC and their physician group, Hennepin Faculty Associates (HFA), contribute either directly (approx. 75-80) or indirection (20-25 via University of Minnesota Medical School) to the annual graduation of approximately 100 new physicians – a majority of which to maintain a Minnesota practice.

4. In CY2005 HCMC and HFA provided quality medical care to 136,650 unique patients of which approximately twenty percent relied upon interpreters to ensure accurate medical communication.

5. HCMC interpreters were called upon over 110,600 times in CY2005 requiring HCMC staff of 47 full-time equivalent interpreters addressing 58 different languages – predominately Spanish, followed by Somali, Hmong and 55 others.

6. In CY2002 HCMC provided necessary medical care to 34,812 different uninsured patients 80,281 times. In CY2003 HCMC provided necessary medical care to 37,812 different uninsured patients 84,013 times. In CY2004 HCMC provided necessary medical care to 45,754 different uninsured patients 125,667 times. This reflects an increase of 11,000 additional uninsured individuals (34,812 in 2002 increasing to 45,754 in 2004 or a 31.4% jump) and a concurrent increase in uninsured visits from 80,281 uninsured visits in CY2002 to 125,667 in CY2004 – a 56.5% jump,

7. In spite of aggressive, and successful, HCMC procedures to qualify the uninsured for Minnesota public program enrollment – or other health insurance – the cost of uncompensated care at HCMC has risen 52% between 1999 and 2005, i.e., $20.9M to an estimated $31.7M for CY2005.

8. Three of every four (78%) HCMC inpatient visits in CY2005 were enrolled in a public insurance program, uninsured, or "self-insured". Whereas, two of every three outpatient registrations in CY2005 (64%) were enrolled in a public health insurance program, uninsured, or "self-insured".

9. HCMC established the Minnesota Regional Poison Control Center (MRPCC) in 1977. This regional asset addresses not only elements of emergency preparedness, professional and general public education, and awareness, but averages close to 90,000 calls annually from the general public and healthcare professionals regarding the ingestion of toxic materials.

10. HCMC's Emergency and Urgent Care Department's volume totaled close to 100,000 visits in CY2005, i.e. 98,838 encounters. HCMC's inpatient Trauma Care cases totaled 3,305 in CY2005 vis 3,272 in CY2004. In CY2005, trauma inpatients under 18 totaled 13.44%; the over 65's totaled just over 11% or 369 cases – little change from CY2004.

11. Total outpatient visits reached 463,791 in 2005.

12. HCMC's Acute Psychiatric Services (a.k.a. Crisis Intervention Center) volume increased from 12,733 mental health visits in CY2004 to 13,212 visits in CY2005. This around-the-clock HCMC/HFA safety-net service provides the most prominent psychiatric care for the general public in the greater metropolitan area and throughout the State of Minnesota. Thousands of visits are experienced from 40 different Minnesota counties.

13. Commencing with the Federal Balanced Budget Act of 1997 and, when coupled with the State of Minnesota's reimbursement rate and eligibility reductions in public programs like MA, GAMC, and MinnesotaCare (SFYs 2003 and 2005), a conservatively estimated $70M in [heretofore scheduled] income has in fact been withdrawn from HCMC over the last seven years – excluding inflation updates as well. Such reductions or cutbacks – be they federal or state – significantly constrain HCMC's ability to adequately capitalize the hospital and it's clinic system – much less meet the rising demand for medical care by uninsured residents.

FACT SHEET

HCMC services reflecting public safety net role

Alternative Therapies

Burn Center

Chaplaincy Program

Chemical Dependency Services

Commitment to International Patients

Cultural Diversity Training for Employees and Volunteers

Dentistry

High Risk Perinatology

Hyperbaric Medicine

International Screening

Major Medical/Health Education Programs

Native American Advocacy

On-Site Economic Assistance Program

Regional Poison Control

Sexual Assault Resource Services

Trauma and Critical Care

Hennepin County Medical Center

HCMC Level I Trauma Center

FACT SHEET

Preparing Minnesota hospitals for bioterrorism and other emerging threats

- As a **Regional Hospital Resource Center**, HCMC leads coordination of hospital response to emergency events within the metro area and the state.

- As a **Global Migration and Quarantine Facility for the CDC,** HCMC is prepared to treat the first cases of any unknown infectious disease that arrive in the Twin Cities. The U.S. Centers for Disease Control has identified a **Global Migration and Quarantine Facility** in most major metropolitan areas.

- HCMC coordinated the development of the **Metropolitan Hospital Compact**, which brought 28 area hospitals together to commit to cooperate with each other and coordinate response efforts. The compact, one of the **first of its kind in the U.S.**, was signed by all hospitals in 2002.

- In an emergency, HCMC Emergency Medical Services and the Medical Resource Control Center at HCMC monitor and report hospital bed availability and coordinate transportation of patients coming to our hospitals from disaster sites in other parts of the country and for patients going from Minnesota to other parts of the country.

- Together with local public safety and public and private health agencies, developed the **Metropolitan Medical Response System** (MMRS) in the Twin Cities. A function of the U.S. Department of Health and Human Services, MMRS provides funding to hospitals and law enforcement agencies to purchase equipment, build decontamination facilities, increase supplies of key pharmaceuticals, and otherwise prepare to respond to any incident where a large number of casualties must be treated.

- Provides **training in hazardous materials handling** to police, firefighters, and paramedics from across the state, as well as professional education to physicians, nurses, and other health care providers in the recognition and treatment of illnesses and injuries related to weapons of mass destruction.

2/16/2006

Hennepin County Medical Center

HCMC Level I Trauma Center

FACT SHEET

Our centers of emphasis and excellence

Cardiology/CV Surgery

Critical Care Medicine/Pulmonary

Diabetes

Emergency Services

Gastroenterology/Digestive Disorders

Infectious Diseases

Maternal/Child Health

Neurosciences

Oncology

Orthopaedics

Primary Care/Adult and Children

Psychiatry

Renal Diseases/Transplantation

Physical Rehabilitation

Sleep Disorders

Trauma

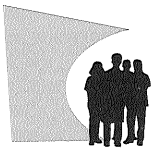
Hennepin County Medical Center

HCMC Level I Trauma Center

FACT SHEET

A national reputation for quality care, physician excellence, and customer satisfaction

- Named one of **America's Best Hospitals** by *U.S. News & World Report* in 2005, 2004, 2003, 2002, 2001, 2000, 1999, and 1998.
- Thirty-eight Hennepin Faculty Associates (HFA) physicians named 2006 "Top Docs" by their peers in MSP/St. Paul magazine.
- A national benchmark study shows that patients admitted to HCMC adult intensive care units have **mortality rates and overall hospital lengths of stay that are much lower than those predicted**. Patients in HCMC intensive care units have a 40 - 50% better chance of survival than the national standards predict.
- Kidney Transplant program ranked third in the nation by the University HealthSystem Consortium (UHC) study of **"best performers"** in kidney transplants.
- Recipient of the **Partners for Change Award** from the Hospitals for a Healthy Environment (H2E) program, by the US Environmental Protection Agency, the American Hospital Association, the American Nurses Association and Health Care Without Harm designed to improve the environmental performance of the health care field.
- Awarded a **2003 Medica Choice Care Quality Improvement award** in diabetes, prenatal, and child and teen check up.
- Named one of the **10 best hospitals in the country in which to have a baby** in 2002 by *FitPregnancy* magazine.
- Awarded a 2002 Safety Net Workforce Award from the National Association of Public Hospitals (NAPH) in recognition of efforts to attract and retain employees.
- Recognized by the National Association of Counties with a **2002 Achievement Award** for the Family Safety Resource Center, a hospital-based resource center where families receive car seats, bike helmets, and education and resources about a variety of safety issues.



Minnesota Association of
COMMUNITY HEALTH CENTERS

Joint Hearing

Senate Health & Family Security Committee

House Health Care Cost Containment Division

February 16, 2006

Safety Net for the Uninsured

Testimony of
MINNESOTA ASSOCIATION OF COMMUNITY HEALTH CENTERS
Rhonda Degelau, Executive Director

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Good afternoon, Madame Chair (Mister Chair), and members of the Committees. My name is Rhonda Degelau. I am the Executive Director of the Minnesota Association of Community Health Centers. With me is Sherlyn Dahl, Executive Director of the Family HealthCare Center in Fargo, North Dakota. I will be brief in my comments, reserving most of our time for Ms. Dahl.

The Association represents 18 member clinics that serve disproportionately high numbers of low-income, uninsured patients throughout Minnesota.

On average, 39% of our patients are uninsured, 37% are covered by Minnesota Health Care programs, 19% are commercially insured, and 5% are covered by Medicare.

In this folder, you will find data on the growth in the numbers of uninsured seeking care at these clinics. Over the past 4 years, the number of uninsured served by our clinics has increased by 33%. That increase has averaged about 8% per year. However, in the year 2004 alone, we saw a significant jump of 12%. That same year, we also saw a decrease in the numbers of patients covered by Minnesota Health Care programs and by commercial insurance.

The cost to our clinics of serving the uninsured has doubled over the past 4 years. We currently provide $18.4 million in care for the uninsured. While our clinics do receive federal grants to offset the cost of care for the uninsured, those grants cover only a portion of those expenses. In 2004, our clinics received $9.6 million in federal grants to offset the $18.4 million in

actual cost. Those grants have been flat-funded for the past several years and have not kept pace with the need.

The sharp increases in the numbers of uninsured and the costs of care over the past several years signal a dangerous trend. We are very concerned about the financial stability of the community health center system.

I thank you for your attention and, unless the Committee has questions for me, I would like to turn this over to Sherlyn Dahl, who can describe for you first-hand the realities of operating a community health center in this environment.

TESTIMONY TO MINNESOTA LEGISLATIVE COMMITTEES

Senate Health & Family Security Committee and House Health Care Cost Containment Division
February 16, 2006

Committee members:
Thank you for the opportunity to speak to you today. You've requested information on the status of the safety net. I am here to share with you how fragile that system. My name is Sherlyn Dahl and I am the Executive Director of the Family HealthCare Center, a Community Health Center with sites in Fargo, ND and Moorhead, MN. Last week our Board of Directors approved a consolidation plan that will transition our medical services to our Fargo location, closing the medical clinic in Moorhead. We will transition our medical providers to the Fargo location and hopefully the patients currently being served in Moorhead will cross the river to Fargo. We also have a dental clinic in Moorhead which is not affected by this decision and will continue to provide dental services there.

There is no single factor that can be isolated as the primary cause for this action but rather a combination of forces that over time produced a cumulative effect. FHC has been struggling financially for the past few years. Those of us working in health centers are used to the daily challenges of serving a high-risk, vulnerable population with minimal resources. However, there comes a time when creativity and determination are not enough. We need money to make this work.

Background on FHC
FHC is a primary care home for nearly 12,000 patients with 40,000 visits a year. Over eighty percent (80%) of our patients are low income; 30 - 35% have **no** health insurance. Nearly fifty percent (50%) are a racial or ethnic minority. FHC serves a young population, 33% are under the age of 19, and over 50% are between the ages of 20 and 45.

Medical services have been provided at two clinic locations, one in Fargo, the other in Moorhead. Lab and x-ray are available. We also offer an on-site pharmacy through a collaborative relationship with NDSU College of Pharmacy. FHC also provides dental services at both the Fargo and Moorhead locations. We are one of the very few in the surrounding area that accepts Medical Assistance. It is not unusual to have patients travel over 100 miles to access dental services. FHC also administers Homeless Health Services, and has a small outreach site for Native American programs.

Last year FHC served over 4,500 Minnesota residents at all of our locations. Our medical clinic in Moorhead had 2,500 patients with 7,000 visits last year.

The demand for services at Family HealthCare Center is great. We average 250 new patients every month. Each day the number of requests for appointments ranges from 150 to 350. FHC's capacity (determined by the number of providers and exam rooms available) averages 65 - 90 patients per day.

The number of uninsured and underinsured accessing our sliding fee scale (SFS) is growing. Applications and approval for participation on the sliding fee scale has increased from an average of 125 per month two year ago, to 157 per month currently, an increase of 25%.

About Our Patients

Patients of FHC generally have multiple and complex health issues. Serving high risk populations including American Indians, Hispanic/Latino, and refugees' means there is a higher prevalence of chronic disease, such as diabetes, asthma, and heart disease. Depression and other mental health issues are common. In addition, psycho-social issues stemming from poverty, violence and abuse, and discrimination are common.

FHC has incorporated chronic disease management into every day practice. Evidence based protocols, recall and follow-up systems, and nursing case management are critical to improving health outcomes. We can demonstrate success in improving the health of our patients. The average Hgb A1c of FHC's 420 diabetics is 7.4. Our patients are screened for depression. Nearly 600 patients are followed in a depression registry. Eighty percent (80%) are on antidepressants; nearly 50% demonstrate improvements in their mental health status with proper follow-up and treatment.

FHC also has a strong prevention focus. Not only are prevention activities incorporated in our care delivery model but additional efforts take place to reach out to high risk populations. Outreach, patient education, and screening activities are brought to the community to reach Native Americans and homeless people. Immunizations are a high priority and over 90% of FHC's children are adequately immunized.

In 2005, FHC provided prenatal care to 340 women, nearly 70% of which are a racial or ethnic minority. Seventy five percent (75%) started their prenatal visit in the first trimester. Only 12 of the 150 births last year were low-birth weight infants.

Having patient education, diabetic educators, nursing case management, interpreters, and our refugee health nurse have proven to be highly successful in reducing health disparities. Community Health Centers embrace these strategies because we know they work. Our outcomes with high risk populations are frequently better than can be found in private practice, yet they are not adequately supported financially. So health centers carry the financial burden. There must be changes in health care reimbursement system to support strategies that produce results.

Financial Situation

The total budget for FHC is just over $5 million. Twenty three percent (23%) of funding is the federal grant. Although nationally CHC's have received increases in the President's budget over the last several years, a significant portion of that funding is going to new starts and new access points. Federal increases to FHC over the last two years were approximately 2%. However, the increase in sliding fee scale (SFS) participation has increased 9%. In 2005, FHC wrote off nearly $700,000 in SFS adjustments alone. The federal grant not keeping pace with the growth in uninsured contributes to the financial vulnerability of existing health centers.

The largest source of funding for FHC comes from medical assistance, 41% of total revenue. Anything affecting Medicaid has a significant impact on our health center. Here in Minnesota, the change initiated three years ago in the process for receiving PMAP settlement payments created an additional financial challenge. Although recently there are indications progress is

being made in addressing the problems that occurred in the payment process, waiting three years for the fix has taken its toll. This certainly is not the only factor that contributed to our financial struggles, but health centers that are entitled to FQHC reimbursement, were caught in the middle of a data nightmare between the DHS and the health plans.

Medicaid issues also exist on the ND side. Although a completely different problem, ND has no method for reviewing, rebasing, or adjusting the PPS rate. The PPS rate established five years ago is no longer covering our health centers cost. With 80% of our patients on medical assistance or uninsured, and only 20% of patients on commercial insurance, there is no stable payer.

So health centers turn to state funding to assist us in reducing health disparities and serving vulnerable populations but, those funds have been decreasing over the past few years. We turn to the local community and foundation grants and as budget concerns are rising across the non-profit sector, grants are becoming highly competitive.

Health Center Mission

Those of us involved with health centers are passionate and dedicated to our mission of serving those the health care system has left behind. We constantly juggle the ever increasing burden of growing need with too few resources. The recent Presidents budget recommending cuts to Medicaid and other health and human service funding is frightening. Reducing Medicaid costs through reducing eligibility or services is avoiding the real issue – a health care system in crisis. It will only add to the already growing number of those without insurance and ultimately we will all pay.

There are no simple, easy, or obvious solutions to this problem. However, health centers have proven their ability to deliver high quality care and improve health outcomes to a high-risk population and do it in a cost-effective manner. The health center safety net must be supported to continue providing those services that not only improve the health of our patients but also improves the health of our communities. Financial support must be there from all levels federal, state, and local. We owe it to our patients and we owe it to ourselves to tackle this challenge by working together, thinking creatively, recognizing those models that work, and committing resources. Health centers can't do it alone, we need help so hopefully we can prevent the further loss of access points

WORKING TOGETHER FOR AFFORDABLE HEALTH CARE

Minnesota Association of
COMMUNITY HEALTH CENTERS

The Minnesota Association of Community Health Centers (MNACHC) is a non-profit association Federally Qualified Health Centers (FQHCs) and other providers that offer comprehens preventive and primary health care services to all individuals, regardless of their ability to pay. member clinics provide medical, dental and mental health care to patients in urban, rural a tribal areas throughout the state. The majority of patients served by these clinics are low-incom and uninsured.

HOW DO COMMUNITY HEALTH CENTERS BENEFIT MINNESOTA?

FQHCs help prevent illness and disease by supplying preventive and primary care for low-income individuals and families who might otherwise delay seeking medical attention. Not only do FQHCs reduce expensive emergency room visits, but FQHCs cost-effectively save both lives and dollars for Minnesota.

HOW ARE FQHCs FUNDED?

FQHCs are unique among health care providers in the fact that nearly 40 percent of their patients are uninsured. Uninsured and low-income patients contribute, as they are able, to their cost of care. Less than one-third of FQHC revenue can be attributed to federal funding sources.

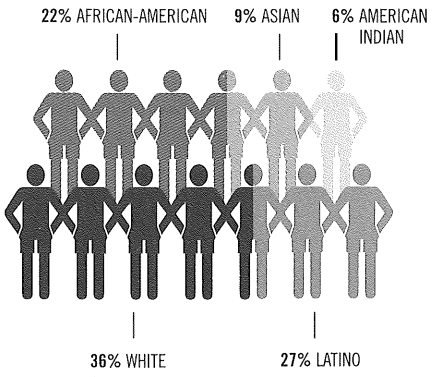
WHY SUPPORT FQHCs?

The number of uninsured in Minnesota is on the rise. FQHCs provide a safety net for these individuals with sliding-scale fees, culturally competent care, translation and transportation services, and geographically convenient locations.

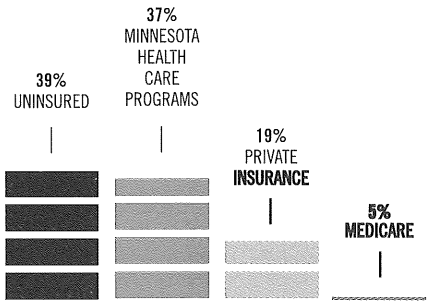
MINNESOTA'S COMMUNITY HEALTH CENTER PATIENT POPULATION

SERVING A RACIALLY DIVERSE POPULATION

COMMUNITY HEALTH CLINIC PATIENTS IN MINNESOTA



PATIENT INSURANCE STATUS AT MINNESOTA'S FQHCs



Visit www.mnachc.org for comprehensive data analysis.

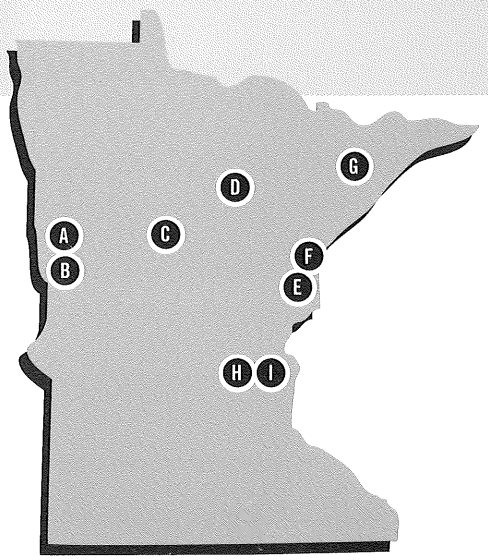
TREATING UNINSURED, LOW-INCOME PATIENTS

- Minnesota's community health clinic patients are **FIVE TIMES MORE LIKELY TO BE BELOW 100% OF POVERTY** than the state's general population. (2003 Federal guidelines set poverty at annual income up to $18,400 for a family of four.)

- Compared to the state population, community health clinic patients are **EIGHT TIMES MORE LIKELY TO BE UNINSURED.** With a high percentage of uninsured patients, community health centers rely heavily on state, federal and private funds to remain in operation.

CLINICS OF THE MINNESOTA ASSOCIATION OF COMMUNITY HEALTH CENTERS

18 member organizations serving
129,000 patients annually at 54 sites.



A Migrant Health Services, Inc.
- Grafton
- Moorhead
- Seasonal locations

B Family Health Care Center
- Moorhead

C Leech Lake Tribal Health Services
- Ball Club
- Bemidji
- Cass Lake
- Inger

D Scenic Rivers Health Services
- Big Falls
- Bigfork
- Cook
- Floodwood
- Northome

E Fond du Lac Tribal Health Services
- Cloquet

F Lake Superior Health Center
- Duluth

G Sawtooth Mountain Clinic, Inc.
- Grand Marais

H MINNEAPOLIS
- Cedar Riverside People's Center
- Community University Health Care Center (CUHCC)
- Fremont Community Health Services, Inc.
- Hennepin County Health Care for the Homeless
- Indian Health Board of Minneapolis
- Native American Community Clinic
- NorthPoint Health and Wellness Center
- Southside Community Health Services, Inc.

I ST. PAUL
- Open Cities Health Center
- United Family Practice
- West Side Community Health Services, Inc.

Minnesota Association of
COMMUNITY HEALTH CENTERS

1113 E. Franklin Avenue, Suite 211 | Minneapolis, MN 55404 .| Tel: 612.253.4715 | Fax: 612.872.7849 | info@mnachc.org | www.mnachc.org

MNACHC SERVICES

A VOICE FOR COMMUNITY HEALTH CENTERS

MNACHC provides state and federal public policy analysis, educational programs and advocacy for member clinics. We advocate for policies that will maintain and increase access to community health care services for low-income and uninsured persons.

LEVERAGING FUNDS

At the state and federal levels, MNACHC fosters public and private partnerships to support health center infrastructure and opportunities for growth.

DATA CLEARINGHOUSE

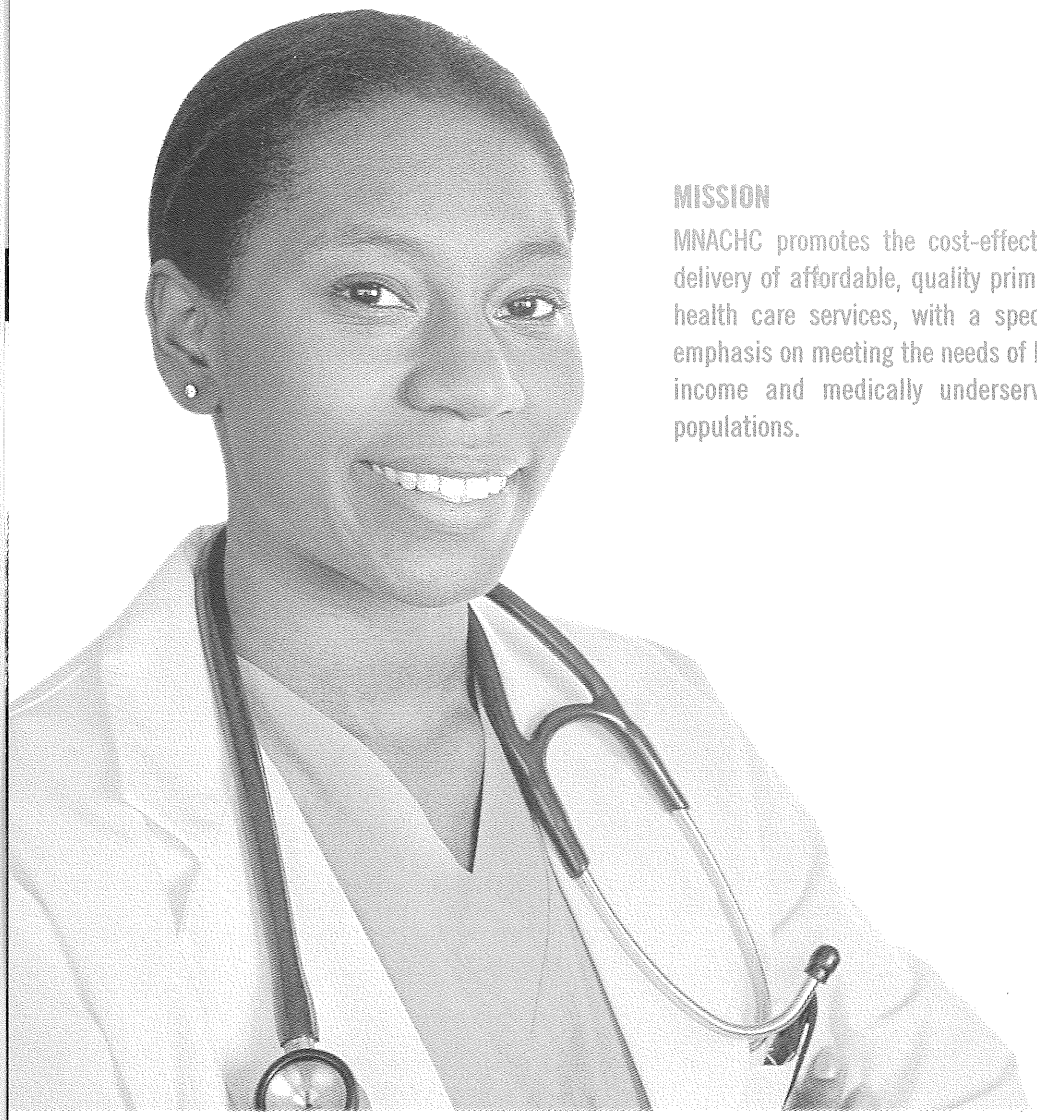
MNACHC compiles data on patient demographics, clinic revenue and market trends. Our Web site—www.mnachc.org—provides timely data and analysis for member clinics, government officials and the public at large.

COMMUNITY DEVELOPMENT

MNACHC identifies Minnesota communities that could benefit from FQHC presence and then assists these communities through the FQHC designation process. We also work to support the expansion of existing FQHCs throughout Minnesota.

TRAINING AND TECHNICAL ASSISTANCE

MNACHC equips community health centers with the administrative, financial and clinical tools necessary to sustain high-quality operations.



MISSION

MNACHC promotes the cost-effective delivery of affordable, quality primary health care services, with a special emphasis on meeting the needs of low income and medically underserved populations.

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MNACHC
Issue Brief

Issue Brief #06-02, February 2006

Community Health Centers - Part of Minnesota's Health Care Safety Net

CHCs and the Uninsured

Minnesota's Community Health Centers (CHCs) are located throughout the state in federally designated Medically Underserved Areas. The communities they serve may be urban, rural, tribal, or migrant and are home to disproportionately high numbers of low-income, uninsured residents. Minnesota's CHCs serve 129,000 patients per year, of which 48,400 are uninsured. The typical patient mix at a typical CHC consists of:

— **39% Uninsured**
— **37% Covered by MN Health Care Programs**
— **19% Commercially Insured**
— **5% Covered by Medicare**

Increasing Numbers of Uninsured

2004 was a significant year for CHCs in Minnesota since the number of uninsured increased 12 percent over the previous year. Moreover, 2004 marked the fifth consecutive year that the number of uninsured patients using CHCs increased.

- During the 1999-2004 time period, the average annual change in the number of uninsured grew by 8 percent per year.
- During that same time period, the average annual change in the number of uninsured children grew by 3.8 percent per year.

At the same time, patients covered by private insurance and public programs such as Medicaid, MinnesotaCare, GAMC and Medicare decreased in 2004 relative to 2003.

Cost of Serving the Uninsured

The cost of serving the uninsured has sky-rocketed in recent years. From 2002-2004, the cost of serving the uninsured increased 24 percent — from $14.8 million to $18.4 million. This represents, on average, 29 percent of a typical CHC's operating budget.

CHCs receive annual federal grants to subsidize uninsured care. In 2004, they received $9.6 million. Those grants have been flat-funded for several years and have not kept pace with the need.

Member Clinics

Cedar Riverside People's Center Minneapolis

Community University Health Care Center, Minneapolis

Family Health Care Center Moorhead

Fond du Lac Tribal Health Services, Cloquet

Fremont Community Health Services, Minneapolis

...in County Health Care for the ...ss, Minneapolis

...ndian Health Board of Minneapolis

Leech Lake Tribal Health Services Cass Lake

Lake Superior Community Health Center, Duluth

Migrant Health Services, Inc. Moorhead

Native American Community Clinic Minneapolis

NorthPoint Health & Wellness Minneapolis

Open Cities Health Center Saint Paul

Sawtooth Mountain Clinic Grand Marais

Scenic Rivers Health Services Cook

Southside Community Health Services, Minneapolis

United Family Practice Saint Paul

West Side Community Health Services, ...int Paul

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Minnesota Association of Community Mental Health Programs, Inc.
Improving quality through education, public policy advocacy, and member services
1821 University Avenue West, Suite 350-S, St. Paul, Minnesota (651) 642-1903; FAX (651) 645-1399

February 16, 2006

Community Mental Health Safety-Net Services

Ron Brand, Executive Director

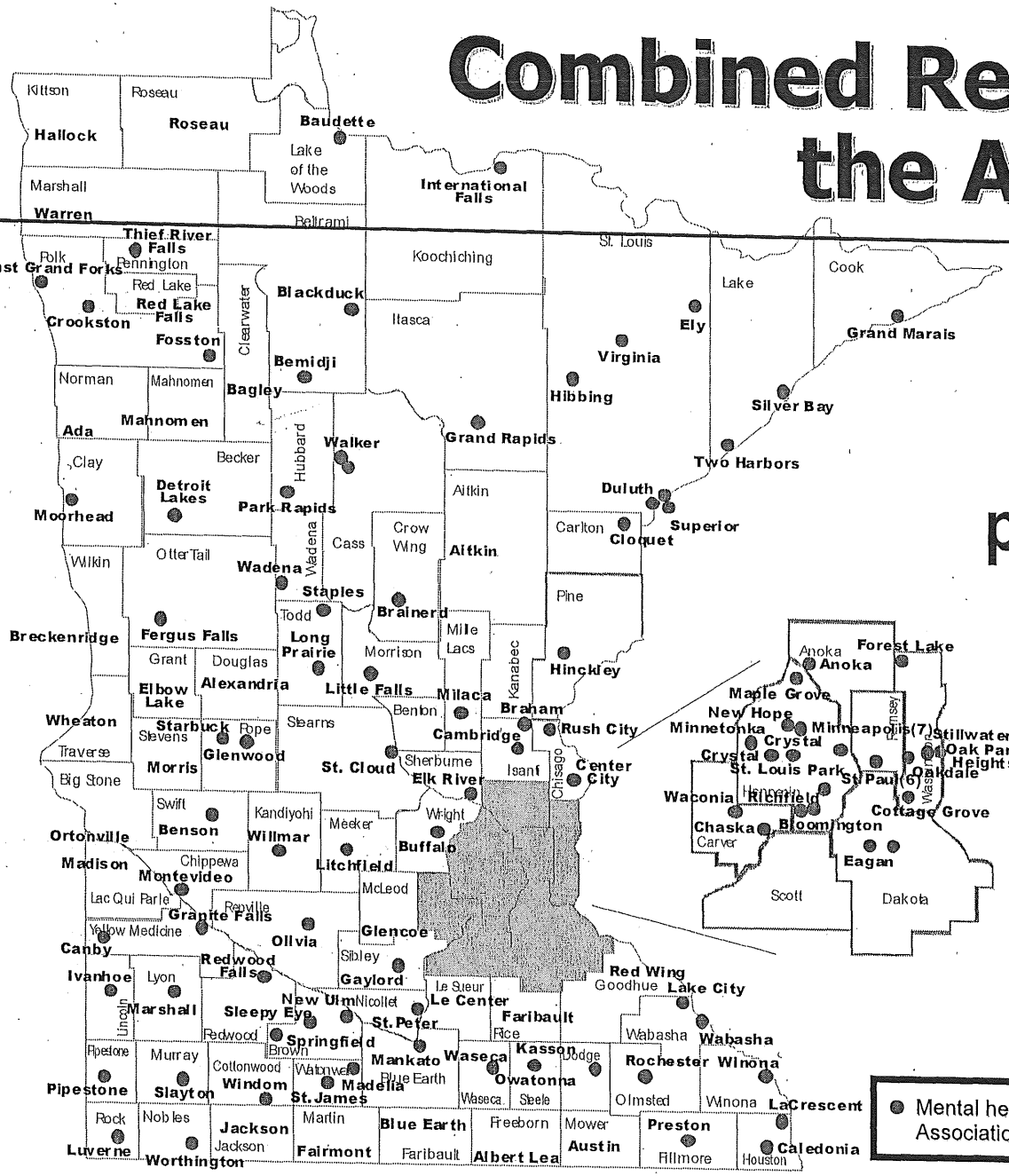
Uncompensated care for community mental health centers/ providers

- Uninsured (MH clients are high percent)
- Under-insured (benefit limits, limited array of services)
- Non-collectable cost-sharing (deductibles, co-pays, sliding fees)
- Desired & necessary services that are not reimbursed
- Services where rates do not cover cost of care (eg. travel costs)
- Tangible benefits (bus card, medication samples, housing deposit)

Other issues affecting community mental health safety-net

- High "no show" rates (often over 20%, despite efforts to improve)
- Cost of training/supervising new Board-eligible professionals
- Cost of clinical supervision of non-licensed MH practitioners
- Complex clients that require "care coordination", collateral contacts
- High proportion of MA and Medicare clients (w/ low reimb. rates)
- Admin./operational (billing, HIPAA, buildings, records, etc.)

Combined Resources of the Association



& its public & private partners

- Mental health clinics and services affiliated with Minnesota Association of Community Mental Health Programs

Backgroun nformation

- The providers, (nonprofit, multi-site, community boards, budgets= $1.5M-15M), staff-model, continuum of services, etc.)
- Services: psychiatry, therapy, MH rehab. services, array of others
- Service locations (see map with dots)
- Revenue/payer mix information on revenue mix (PMAP, private insurance, out-of-pocket, MA-FFS, counties, foundations, United Way)
- Budget and financial (profit-loss, reserves, budget size, expenses)
- Client characteristics (adults and kids: depression, severe anxiety, psychosis, bipolar, ADHD, often co-occuring problems—CD, chronic health)
- Sources and amount of uncompensated care: 14.6% of expenses-'99 MDH Study
- Major challenges (ex. off-setting psychiatry losses, therapy, and uncomp. care drags down opportunities to improve and innovate);

Some interests going forward:

Telehealth (to improve access; reduce disparities)

E.H.R. (electronic health records)

Admin. simplification (make it easier to do the right thing)

Payment for intensive non-residential/outpatient services

Earlier intervention—prior to disability and disaster

Blending acute medical care-social supports-and therapy in coordinated care

Recognition in payment model for critical access providers and key role

Minnesota Association of Community Mental Health Programs, Inc.
Safety-Net Provider Presentation

	Average % Revenue by Source	
Revenue Payer Mix Information	**2002**	**2004**
County grants or contracts	21.5	28
MA/GAMC Fee for Services	28.9	28.6
Medicare	3.1	3.8
Private -out of pocket	8.7	6.1
Private 3rd party insurance	26.5	18.7
PMAP/MnCare: healthplan	12.1	9.5
Other private contracts	8.9	9.7

Staff turn over rate (% per year)	**2002**	**2003**
Senior Management	9.17	8.58
Administrative Services	15.18	14.72
Licensed Mental Health Professionals	17.65	14.29
Unlicensed Direct care practitioners	24.65	25.28

Defensive Interval	**2002**	**2004**
(Cash reserves for operation, in days)		
Average	54 days	68 days
Median	53 days	39 days

Financial

7 Centers with less than 1.5% margin (3 lost 3-9% in 2004)

MN Dept. of Health Report, Jan. 2000

Figure 2: Estimated Aggregate Minnesota Uncompensated Care (in millions) and as a Percent of Total Expenditures

	Charge-Based (1996 values in brackets)	Cost Based (1996 values in brackets)
Clinics		
Uncompensated Care	**$ 76.9** ($ 71.8)	-
Uncompensated Care as a Percent of Expenses	2.2 %	
Hospitals		
Uncompensated Care	**$ 134.5** ($ 130.5)	**$ 81.7** ($ 81.2)
Uncompensated Care as a Percent of Expenses	2.7 %	1.7 %
Community Clinics (NHCN)		
Uncompensated Care	**$ 3.1** ($ 4.1)	**$ 3.0** ($ 3.6)
Uncompensated Care as a Percent of Expenses	11.1 %	10.7 %
Clinics in the MN Primary Care Association		
Uncompensated Care	($ 3.9)	-
Uncompensated Care as a Percent of Expenses	(17.2 %)	
MN Assocation of Community Mental Health Programs		
Uncompensated Care	**$ 5.7** ($5.0)	-
Uncompensated Care as a Percent of Expenses	14.6%	
Other Provider Groups**	currently undetermined	
Total Minnesota Uncompensated Care (above provider groups)	$ 224.1 ($ 215.3)	$ 171.2 ($ 165.5)
	2.6%	2.0%

Source: MDH, Health Care Cost Information System with adjustments, January 1999; Provider Financial and Statistical Report, January 2000; Neighborhood Health Care Network/Community Clinic Reporting System, January 1999; Minnesota Primary Care Association, January 2000; Minnesota Mental Health Association, January 2000.

* Uncompensated Care is defined as the sum of charity care and bad debt

** Included in this table are only those provider groups that have data collection systems in place which allow for accurate identification of uncompensated care per MDH definitions

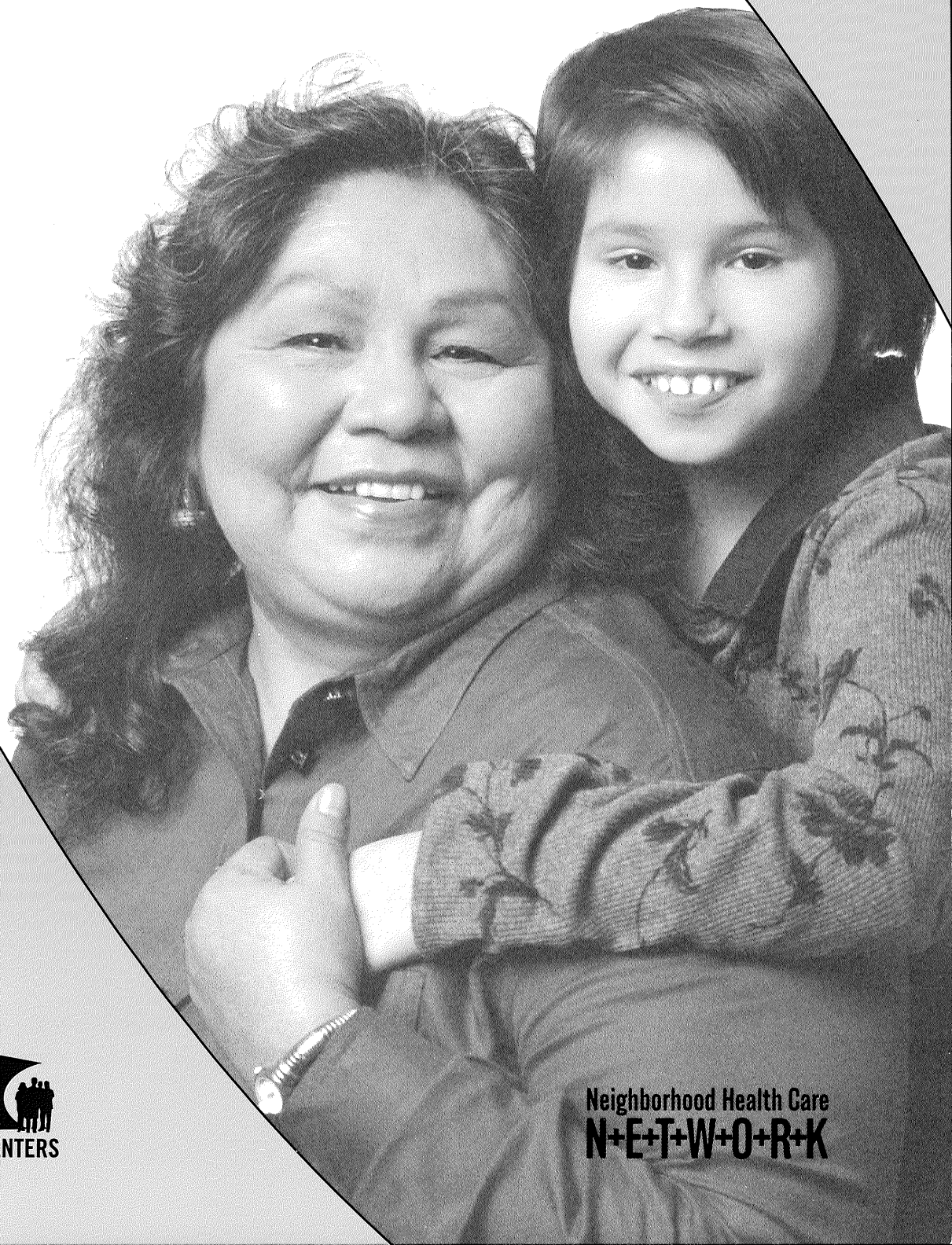
Note: A share of the growth reported by the MN Primary Care Association and the MN Association of Community Mental Health Programs is due to increased compliance with reporting.

Demographics of the Uncompensated Care Population

The Legislature also requested the Department develop information "...on the types of care provided, the settings in which the care is provided, and if known, the most common reasons why the care is uncompensated." (Minn. Laws, 1999, Chapter 245, Article 1, Sec. 3, Subd. 2). In response, the Department of Health has worked with providers in the community to develop information to better describe the demographics of the population receiving uncompensated care at Minnesota's hospitals and community clinics. Preliminary information of some providers with a large uncompensated care burden is contained in the Appendices of this report.

Community Partners in Prevention℠

Community-based efforts to reduce health disparities in Minnesota



Minnesota Association of
COMMUNITY HEALTH CENTERS

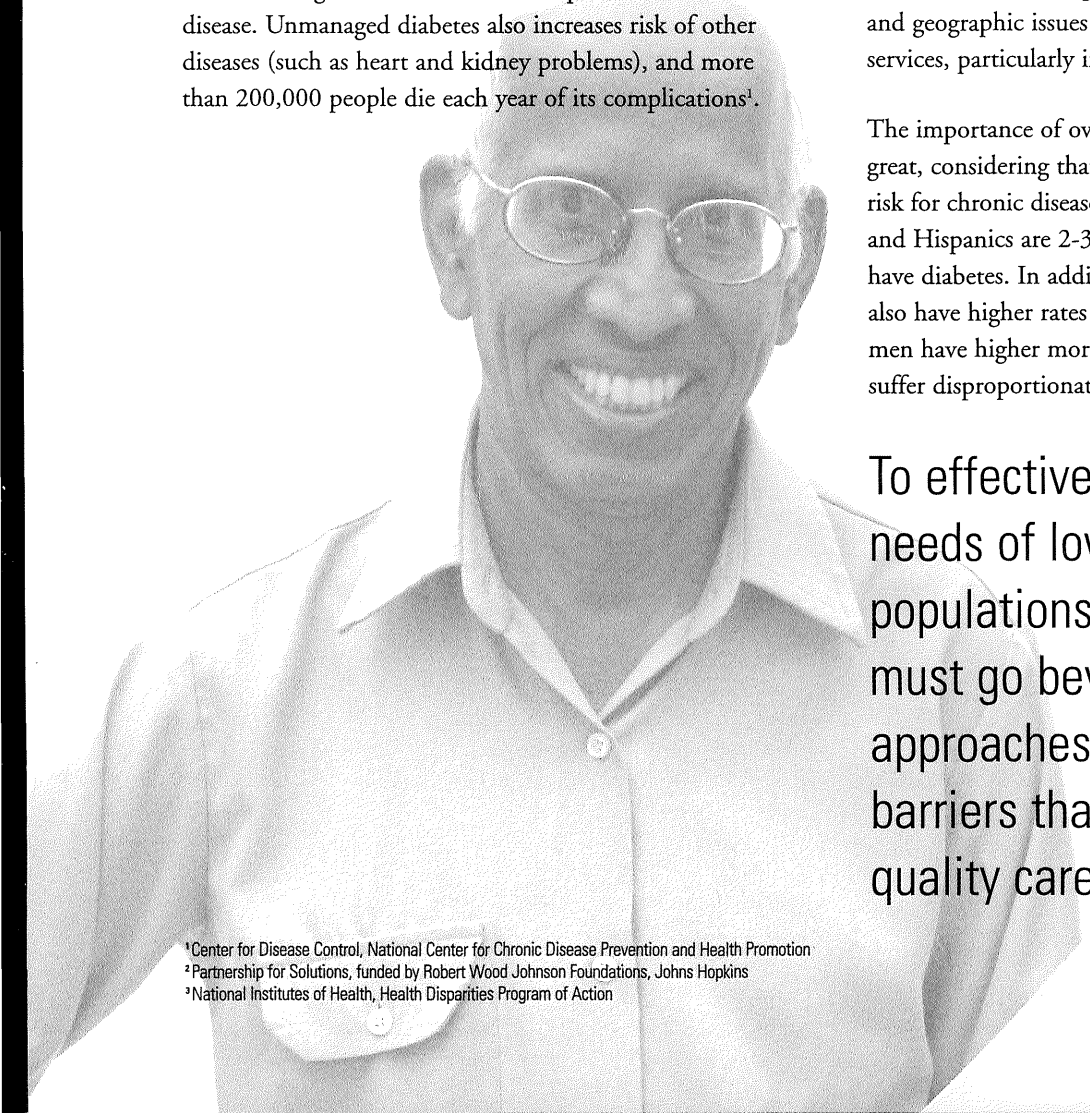
Neighborhood Health Care
N+E+T+W+O+R+K

Prevention Makes Sense *– and Saves Dollars*

As the saying goes, an ounce of prevention is worth a pound of cure. Such is the case for several major perilous (but preventable) health conditions. Prevention efforts can help identify potential health problems early on, to manage symptoms, alleviate complications and minimize risks.

About 10 percent of Americans have a chronic health condition, such as diabetes, heart disease, cancer, depression, etc. Yet these chronic diseases account for about 60 percent of the nation's health care spending[1]. It is estimated that $500 billion is spent annually in direct and indirect costs, such as health claims, absenteeism and low productivity[2].

Consider the cost of diabetes alone. In 2002, the average medical expenditure for a person with diabetes was $13,243, or 2.4 times great than the cost for a person without the disease. Unmanaged diabetes also increases risk of other diseases (such as heart and kidney problems), and more than 200,000 people die each year of its complications[1].



But prevention, early detection and chronic disease management of diabetes – and other chronic conditions – can stem the tide. According to the CDC, every dollar invested in diabetes self-management training can cut health costs by $8.76. In addition, intensive blood pressure control efforts can reduce risk of heart attack and stroke, cutting costs by $900 over an individual's lifetime and extending life expectancy by 6 months.

However, to effectively address health needs of low-income populations, prevention efforts must go beyond traditional approaches to also tackle barriers that deter access to quality care. These deterrents may include economic issues (such as lack of transportation or lack of funds for doctor visits or medications), cultural issues (such as language or beliefs that inhibit understanding of the importance of preventive care), and geographic issues (such as isolation or distance from services, particularly in rural areas).

The importance of overcoming these obstacles is particularly great, considering that underserved groups are often at higher risk for chronic disease. American Indians, African Americans, and Hispanics are 2-3 times more likely than Caucasians to have diabetes. In addition, African Americans and Hispanics also have higher rates of hypertension, while Asian American men have higher mortality due to strokes. Minorities also suffer disproportionately from cancer[3].

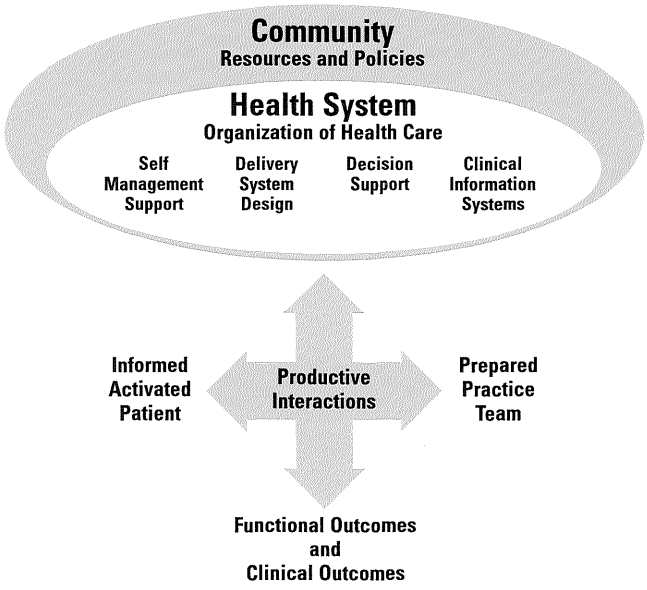
To effectively address health needs of low-income populations, prevention efforts must go beyond traditional approaches to also tackle barriers that deter access to quality care.

[1] Center for Disease Control, National Center for Chronic Disease Prevention and Health Promotion
[2] Partnership for Solutions, funded by Robert Wood Johnson Foundations, Johns Hopkins
[3] National Institutes of Health, Health Disparities Program of Action

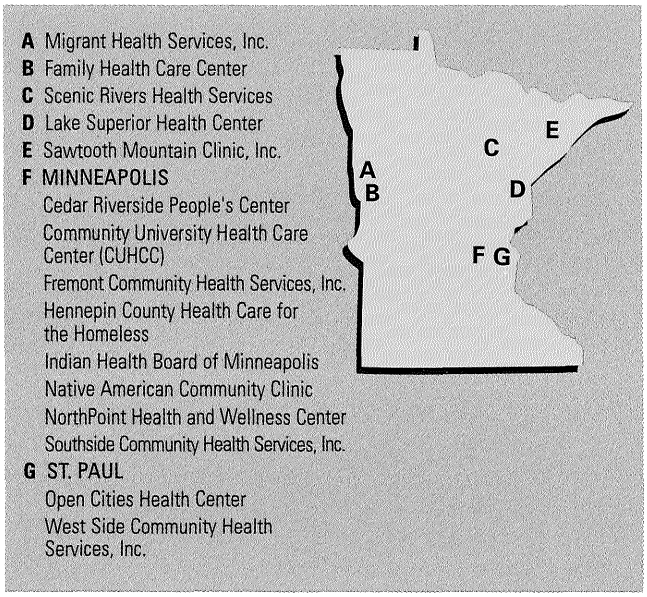
Prevention Makes a Difference *– and Saves Lives*

To address the growing problem of health disparities, the Bureau of Primary Health Care (in collaboration with the Center for Disease Control and public and private agencies) launched an innovative program called "Health Disparities Collaboratives" (HDC).

This nationally coordinated effort is designed to change health care practices, track high-risk patients and manage chronic disease through training, tools and technical assistance. HDC first adhere to an intensive 12-month Learning Model, and then follow a Care Model emphasizing delivery system redesign, ongoing reporting and data management, and community partnerships to create productive interactions between patients and health practitioners. These outreach efforts help to increase access to quality care and support ongoing patient self-management.



Federally Qualified Health Centers (FQHC) can apply to participate in HDC on a local level. In Minnesota, HDC serve ethnically diverse patients throughout the state (see map). Compared to the state's population, these patients are eight times more likely to be uninsured and five times more likely to live in below the poverty level (i.e., less than $18,400 annual income for a family of four).



The Minnesota-based HDC focus on prevention and management of diabetes, cardiovascular disease and clinical depression. These programs rely on partnerships with a variety of community organizations to most effectively reach those in need.

Overall, programs are making great strides with increasing access to care, managing chronic illness via various risk reduction activities and improving health outcomes. For example, a 2004 study of a community-based diabetes management program found improvement on several performance measures, such as increased rates of diabetic exams and improved blood sugar levels, over a 1-year period[4]. There is potential for economic impact as well, as efforts help to avert costly emergency health situations and unnecessary visits to the emergency room. Another indication of effectiveness is that mainstream health care organizations in Minnesota are incorporating components of the Care Model as well.

But the need remains as strong as ever. With dramatic increases in health costs and decreases in insurance coverage and government funding, there is little doubt that underserved populations are growing – as are their health care risks and needs. For optimal impact, there must be more provider buy-in, more trained health workers, more community awareness and more funding to support local efforts. Only then can we effectively reduce barriers to access and diminish health care disparities in Minnesota and across the country.

[4] "Improving Diabetes Care in Midwest Community Health Centers with the Health Disparities Collaborative," Diabetes Care, Volume 27, Number 1, January 2004

Prevention in Action

In community health centers around Minnesota, creative efforts are underway to reach those in need. One of the most significant approaches involves dispatching bi-lingual and multi-cultural community health workers to identify, educate and serve high-risk patients -- not merely at the clinic site but also at schools, churches, local businesses and neighborhood events.

Here are a few examples of these cost-effective, community-based approaches – and their impact:

- **Blow Dry and Blood Pressure Check:** As part of their community outreach program, workers from Fremont Community Clinic in Minneapolis provide equipment and teach local barbers and stylists how to administer blood pressure checks at a local salon to identify those with uncontrolled hypertension. A woman customer at the salon is identified with dangerously high blood pressure, prompting immediate medical and educational intervention.
- **Diabetes Interpreted:** At clinics and health fairs in the Twin Cities, community health workers conduct brief screenings – in various languages – to identify those at risk for diabetes and to encourage them to see a provider. Workers also help identified individuals work on nutrition and exercise goals, make lifestyle changes, develop self-management skills and monitor their progress.
- **Culturally Sensitive Screening:** In St. Paul, community health workers use targeted outreach and culturally sensitive education to help Hmong women overcome barriers to early prenatal care and preventive gynecological exams.
- **Attacking Heart Problems:** At Sawtooth Mountain Clinic in Grand Marais, a physician builds rapport with a man who is resistant to seeking care for a cardiovascular condition. As a result, his undiagnosed diabetes is discovered, and through subsequent visits and diet modification the man brings his blood glucose level under control, loses 25 pounds, and reduces his cholesterol level.
- **From Social Isolation to Social Integration:** At CUHCC in Minneapolis, mental health workers assist clients with mental illness to integrate them into the community. Workers educate public housing staff about the disease, as well as make regular visits to high-risk individuals to build trust and encourage participation in social activities.
- **Lifestyle Learning:** At Migrant Health Services, Inc. in Moorhead, health workers provide direct services to Hispanic migrant farm workers and their families. Through their efforts, they diagnose a 65-year-old man with diabetes, hypertension, obesity and cardiovascular disease, and help him make several lifestyle changes – regular blood sugar monitoring, clinic appointments and exercise – resulting in improved physical health and overall wellbeing.

What communities and organizations can do to become Community Partners in Prevention℠

Here are a few ideas for putting prevention into action in your community:

What health care providers (hospitals, clinics and community health centers) can do:

- Provide cultural competency training for health workers
- Increase availability and funding of interpreter services
- Reduce barriers to health care access by targeting outreach and education efforts

What insurers and health payers (health plans, insurance companies, government) can do:

- Establish standards for ongoing data collection
- Use data to develop effective prevention and disease management programs
- Increase access to affordable health insurance coverage for the uninsured/underinsured

What colleges and universities can do:

- Train culturally competent health care providers
- Increase diversity of the health care workforce

What policymakers and government agencies can do:

- Ensure health security for all, regardless of socioeconomic status
- Develop infrastructure for tracking racial and ethnic disparities in health care
- Research state variations in minority health policy and outcomes

What media can do:

- Increase public awareness of best practices in health care and disease management
- Call attention to barriers that inhibit access to quality care and create health disparities
- Sponsor community-based programs and health events

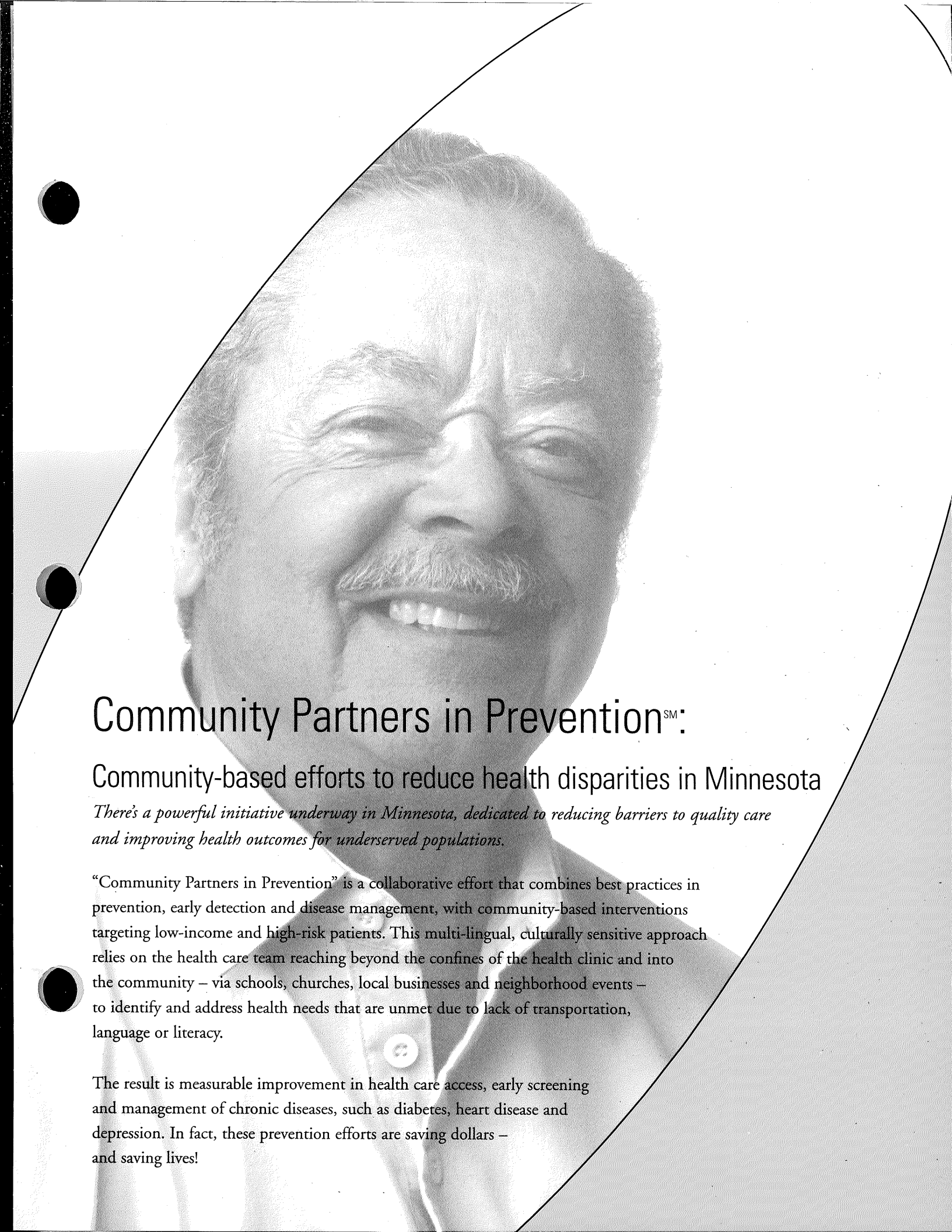
What communities (schools, neighborhoods, local businesses, private foundations) can do:

- Support efforts to extend health care beyond the clinic and into the community
- Partner with health care agencies to identify and address unmet needs in your community

What individuals can do:

- Donate time, money or in-kind services in support of community-based programs
- Schedule regular health care visits, and maintain a healthy lifestyle

Reference: Health Affairs (Special Issue on Racial and Ethnic Disparities), Vol 24, Issue 2, April 2005



Community Partners in Prevention℠:

Community-based efforts to reduce health disparities in Minnesota

There's a powerful initiative underway in Minnesota, dedicated to reducing barriers to quality care and improving health outcomes for underserved populations.

"Community Partners in Prevention" is a collaborative effort that combines best practices in prevention, early detection and disease management, with community-based interventions targeting low-income and high-risk patients. This multi-lingual, culturally sensitive approach relies on the health care team reaching beyond the confines of the health clinic and into the community – via schools, churches, local businesses and neighborhood events – to identify and address health needs that are unmet due to lack of transportation, language or literacy.

The result is measurable improvement in health care access, early screening and management of chronic diseases, such as diabetes, heart disease and depression. In fact, these prevention efforts are saving dollars – and saving lives!

Community Partners in Prevention[SM] is a collaborative effort of Minnesota Association of Community Health Centers and Neighborhood Health Care Network, as well as member clinics and community partners throughout Minnesota.

Minnesota Association of Community Health Centers promotes the cost-effective delivery of affordable, quality primary health care services to meet the needs of low income and medically underserved populations.

Neighborhood Health Care Network (NHCN) provides support services to 45 metro-area health clinics serving 100,000 low-income patients

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Minnesota Association of
COMMUNITY HEALTH CENTERS

Neighborhood Health Care
N+E+T+W+O+R+K

UCare MINNESOTA The production of this brochure was made possible by a grant from UCare Minnesota.

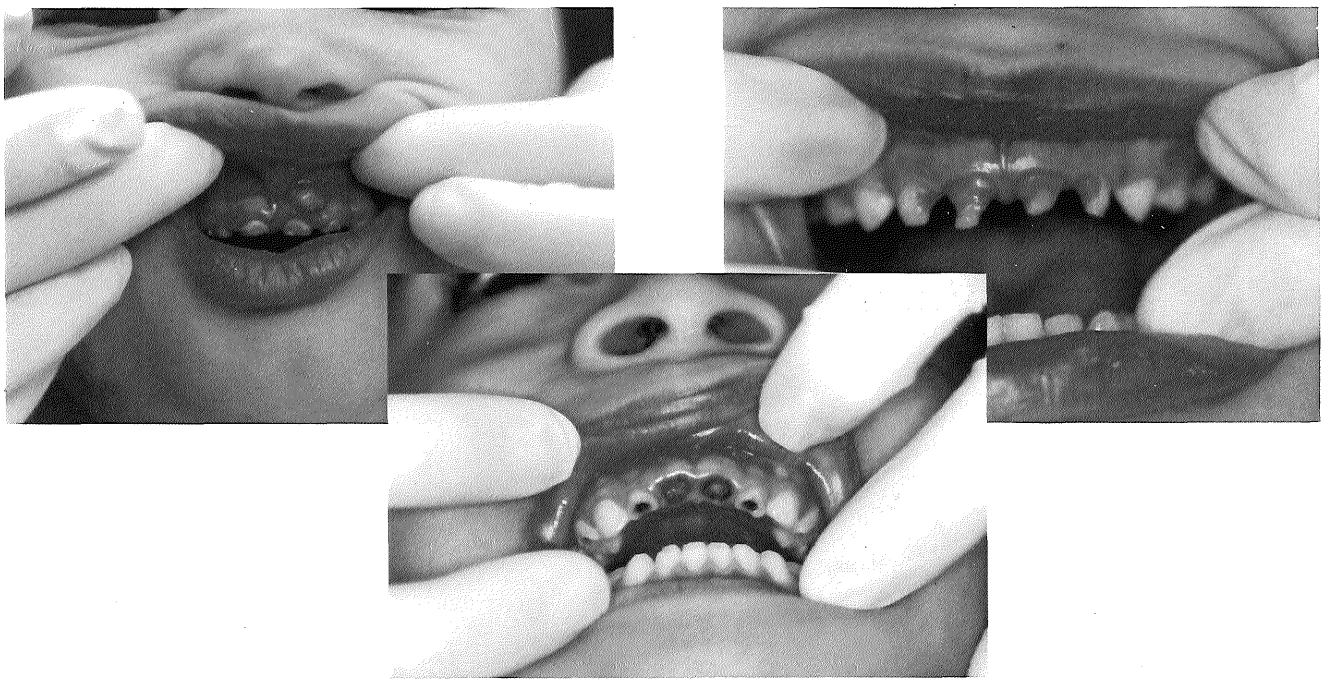
Sharon Oswald

Greater Twin Cities UNITED WAY

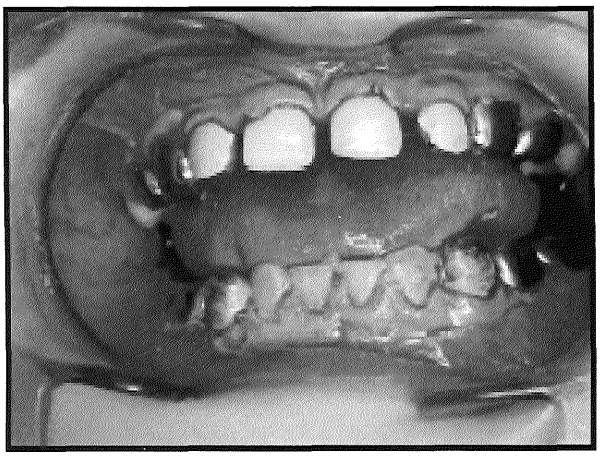
United Way Bright Smiles

According to *Oral Health In America: A Report of the Surgeon General*, dental decay is the most common chronic disease of childhood; five times more common than asthma and seven times more common than hay fever. In fact, over 51 million school hours are lost each year due to dental illness.

Incidences of early childhood tooth decay found through West Side Community Health Services outreach efforts in 2005.



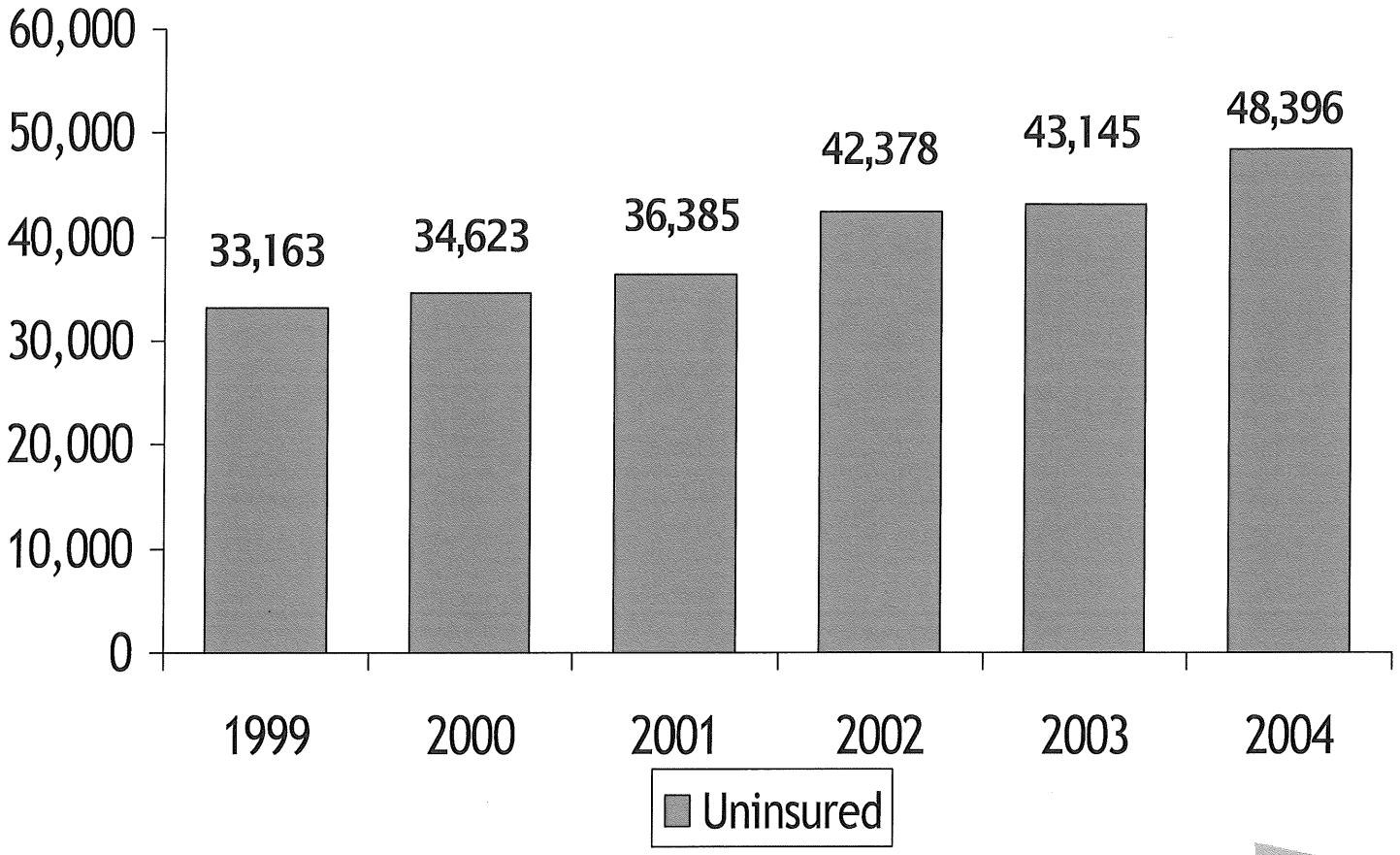
Treatment requires extensive and costly dental care, and is often provided under general anesthesia.



Minnesota Association of Community Health Centers

- The number of uninsured patients using MNACHC clinics increased for the 5th consecutive year.
- Since 2001, the number of uninsured at MNACHC clinics increased 33%.

Chart 1 - MNACHC Uninsured Patients, 1999-2004

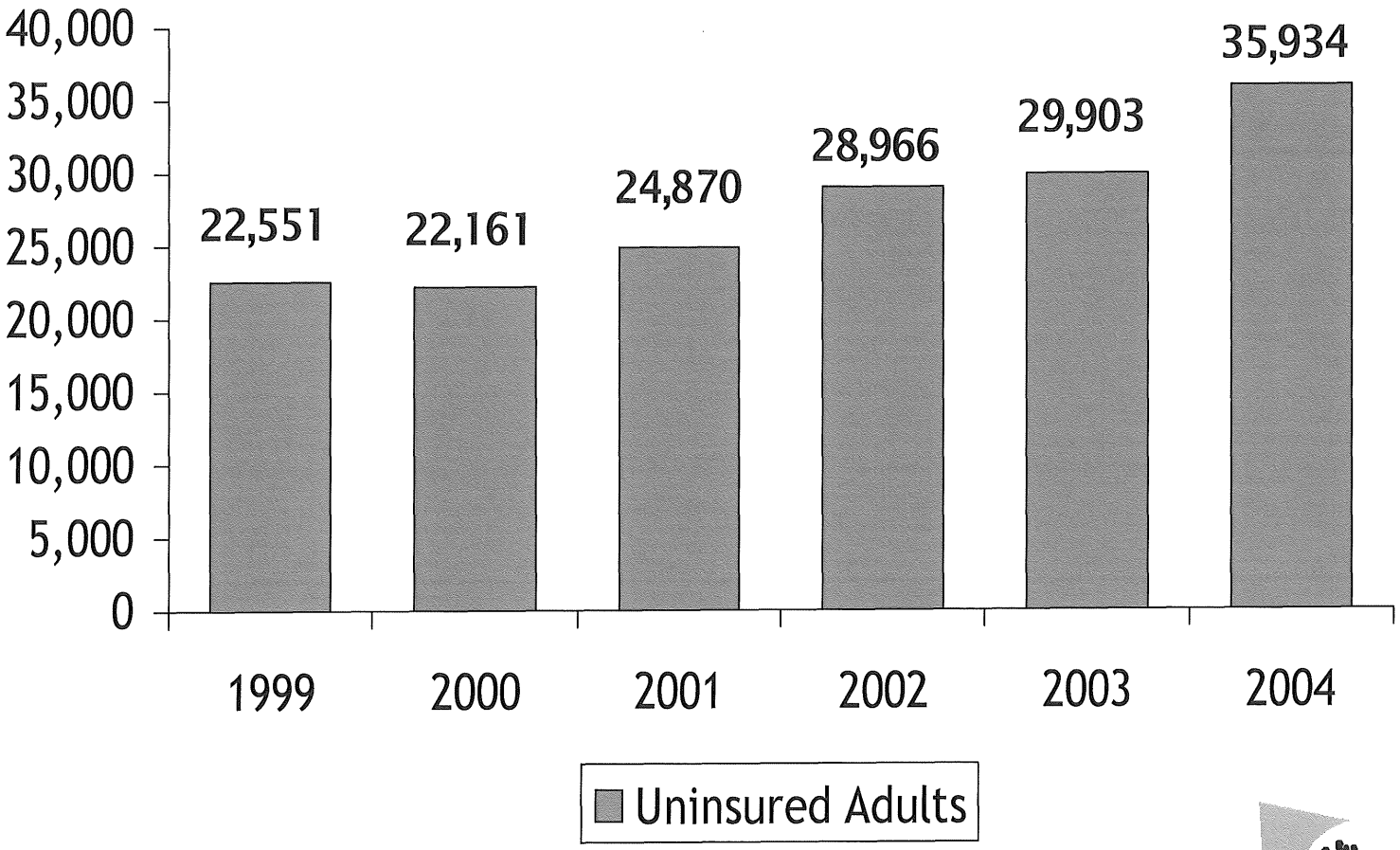


Minnesota Association of COMMUNITY HEALTH CENTERS

Minnesota Association of Community Health Centers

- The number of uninsured adults using a MNACHC clinic increased by 20.2% from 2003 to 2004.

Chart 2A - MNACHC Uninsured Adults, 1999-2004

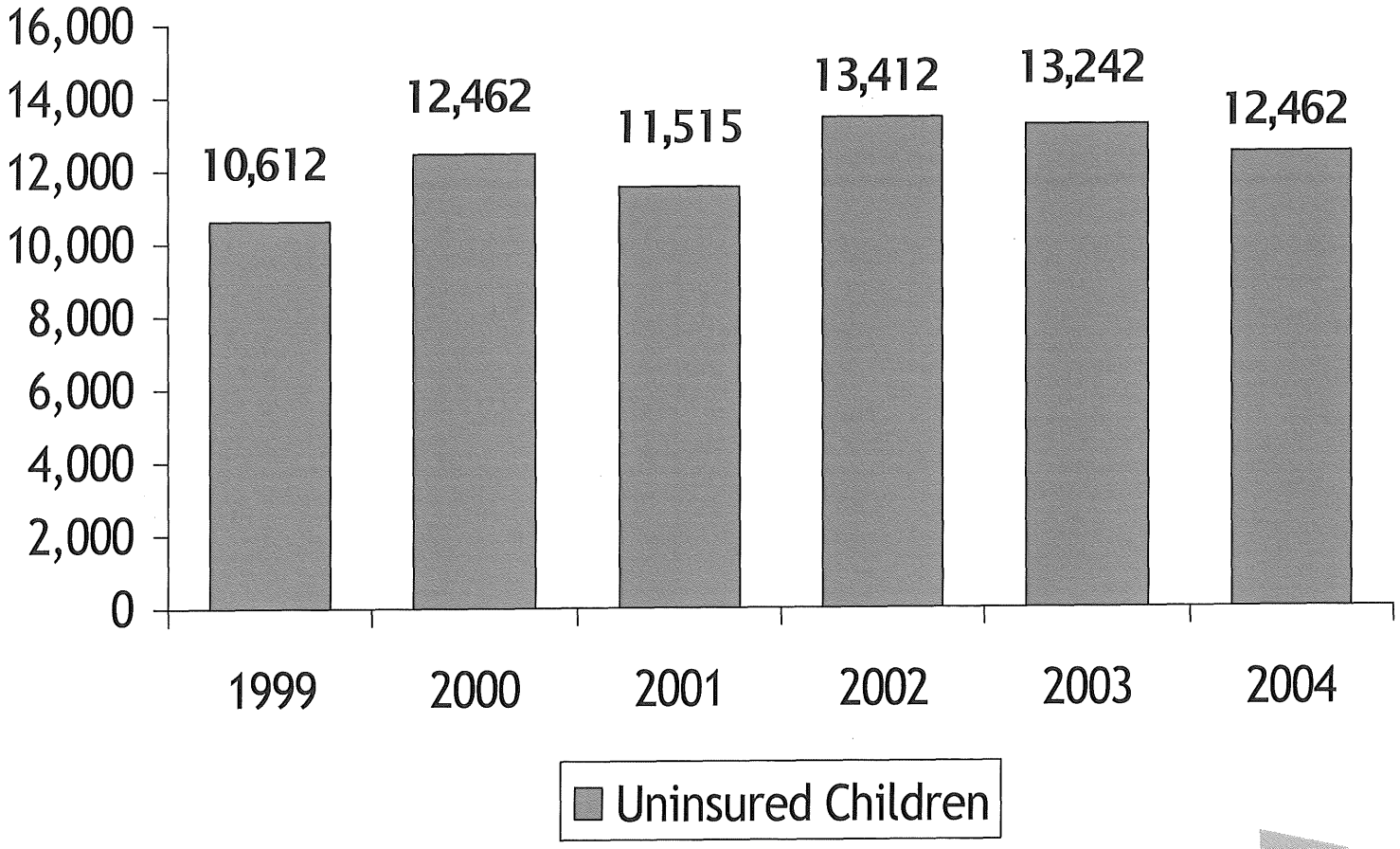


Minnesota Association of COMMUNITY HEALTH CENTERS

Minnesota Association of Community Health Centers

- The number of uninsured children using a MNACHC clinic declined by 5.9% from 2003 to 2004.
- This is the second consecutive year that the number of uninsured children declined.

Chart 2B - MNACHC Uninsured Children, 1999-2004

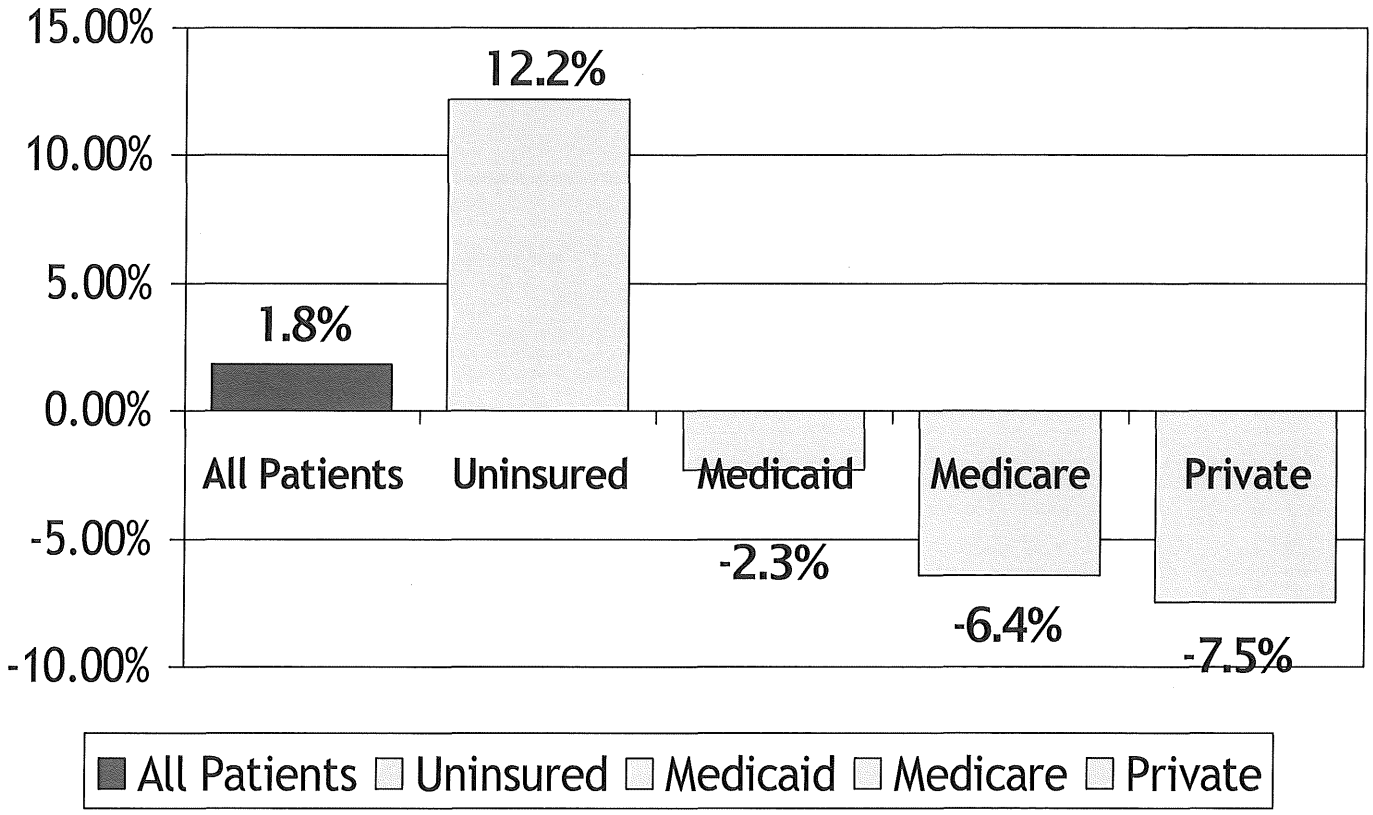


Minnesota Association of COMMUNITY HEALTH CENTERS

Minnesota Association of Community Health Centers

- While overall patient volume increased by 1.8% in 2004 much of the growth is a result of the 12% increase in the number of UNINSURED patients using Minnesota's FQHCs.

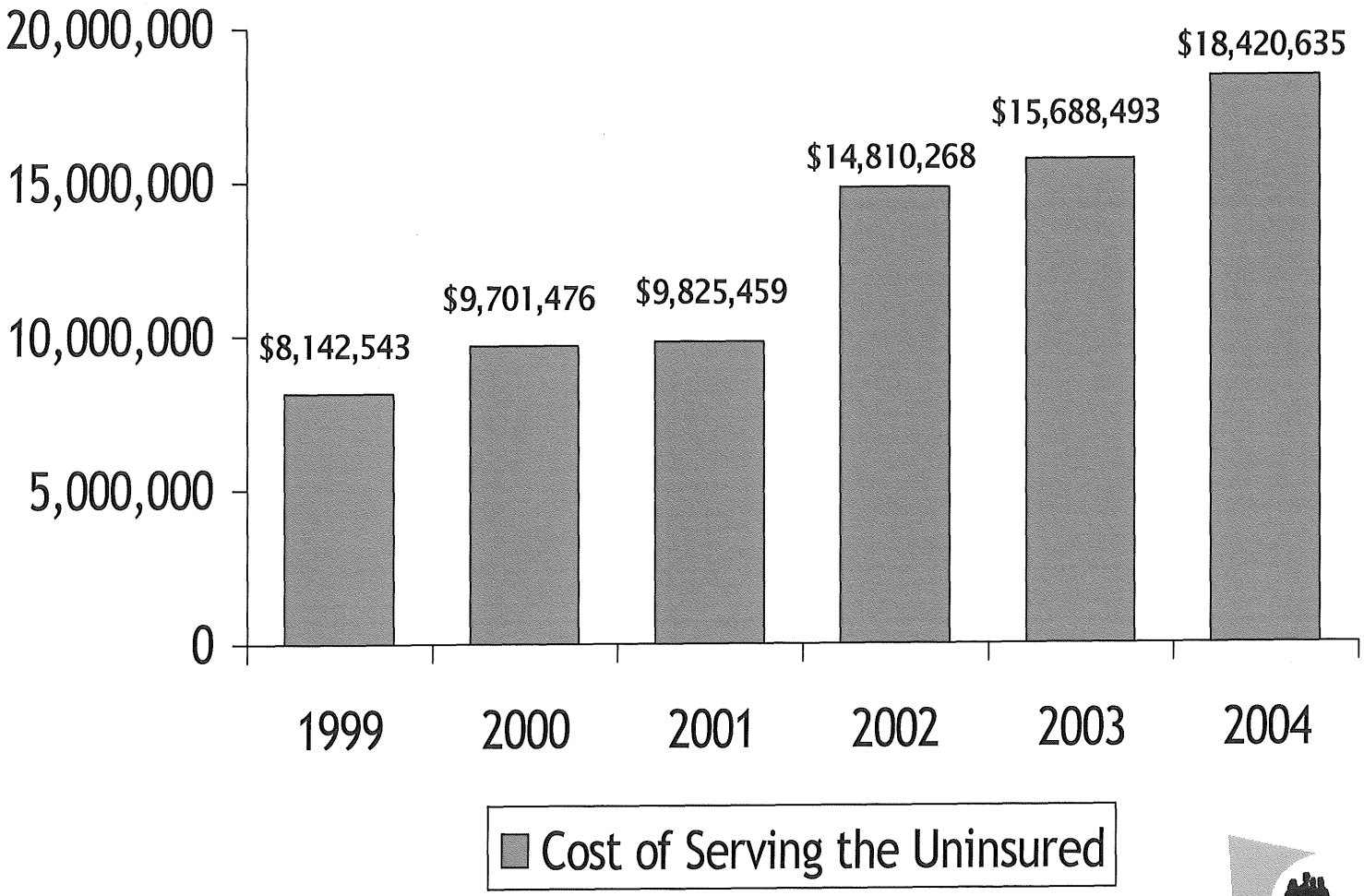
Chart 3 - MNACHC Percent Change in Patients, 2004 vs. 2003, By Insurance Status



Minnesota Association of COMMUNITY HEALTH CENTERS

Minnesota Association of Community Health Centers

Chart 4 - Cost of Serving the Uninsured, 1999-2004

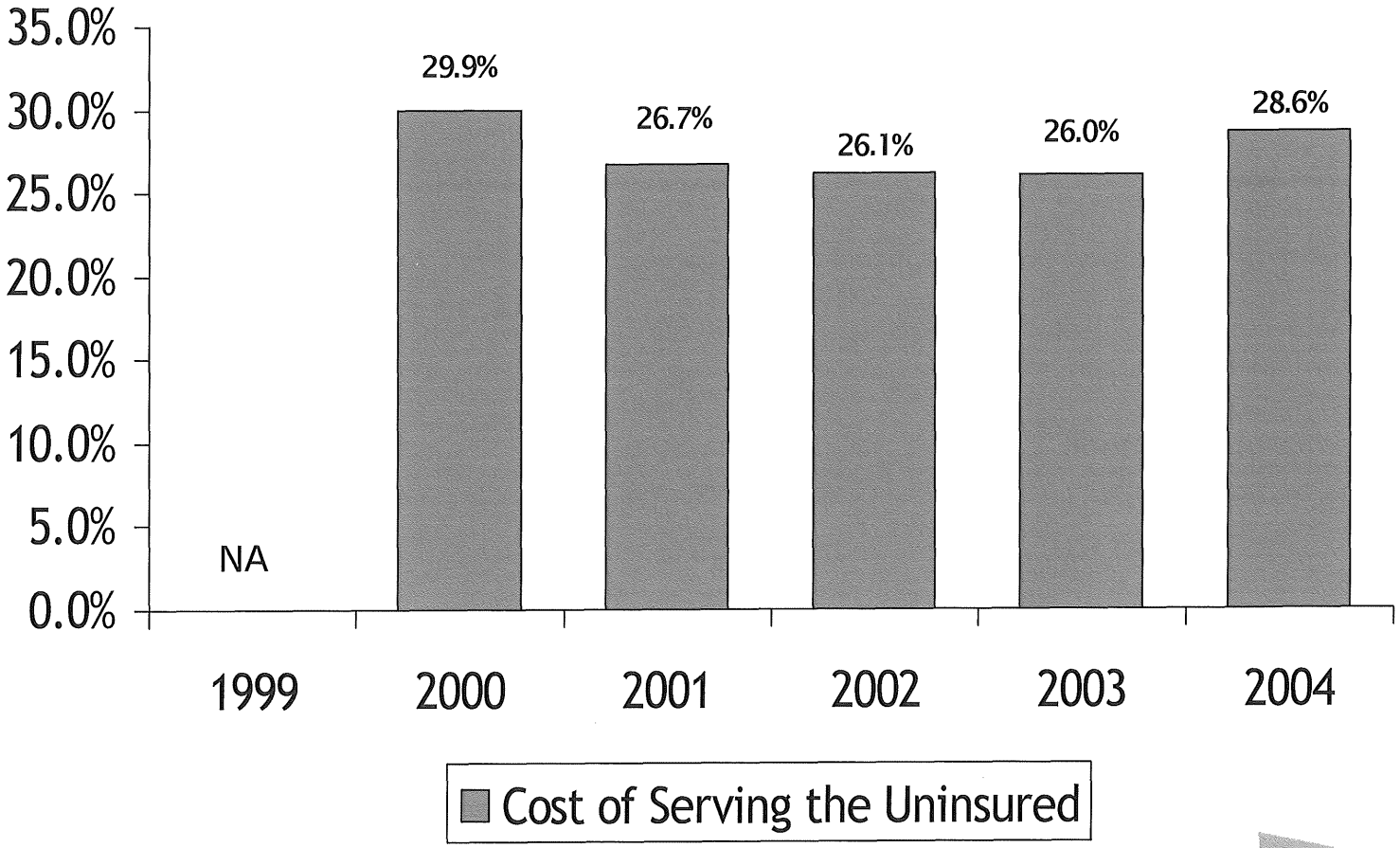


- The cost of serving the uninsured rose 24% from 2002 to 2004.

Minnesota Association of
COMMUNITY HEALTH CENTERS

Minnesota Association of Community Health Centers

Chart 5 - Cost of Serving the Uninsured, As a Percent of Total CHC Costs, 1999-2004



- After briefly declining from 2000-2002, CHCs are devoting an increasing share of their budget to care for the uninsured.

Minnesota Association of COMMUNITY HEALTH CENTERS