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and Fiscal Analysis**

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# Senate

State of Minnesota

## **S.F. No. 20 - Children's Health Security Act**

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**Senate File No. 20** establishes the Children's Health Security program. **Senate File No. 20** also increases the tax on tobacco products.

**Section 1 (16A.725)** creates a Children's Health Security account in the State Treasury.

**Section 2 (256N.01)** states that this Act may be cited as the Children's Health Security Act.

**Section 3 (256N.02)** defines the following terms: "child" and "commissioner."

**Section 4 (256N.03)** requires the Commissioner of Human Services to establish the Children's Health Security program to begin implementation on July 1, 2006.

**Section 5 (256N.05)** describes eligibility for the program.

**Subdivision 1** states that if a child meets the eligibility requirements of the program, the child is eligible to enroll in the program.

**Subdivision 2** authorizes children who are eligible for MinnesotaCare or medical assistance to enroll on July 1, 2006, or upon federal approval. Effective July 1, 2008, eligibility is expanded to all children regardless of household income or assets.

**Subdivision 3** requires a child to be a permanent resident of Minnesota to be eligible. Permanent residency is defined.

**Subdivision 4** states that enrollment in the program is voluntary. Parents may retain private sector coverage or Medicare for a child. A parent may also enroll the child in the program

whereby the program would be secondary coverage to the private sector or Medicare coverage.

**Section 6 (256N.07)** states that services covered under the program include all services covered under medical assistance.

**Section 7 (256N.09)** specifies that under this program there are no enrollee premiums or cost-sharing requirements.

**Section 8 (256N.11)** describes the application procedure for the program.

**Subdivision 1** requires application forms to be made available in provider offices, local human services agencies, school districts, schools, community health offices, and other sites willing to participate in program outreach. These sites may accept applications and then forward them to the commissioner. Applicants may also apply directly to the commissioner.

**Subdivision 2** requires the commissioner to determine eligibility within 30 days of receiving the application. The date coverage begins is the date the application is approved unless presumptive eligibility applies.

**Subdivision 3** states that presumptive eligibility begins on the date a provider or other entity designated by the commissioner determines that a child meets the eligibility criteria. This period ends on the day in which determination is made as to the child's eligibility, except if an application is not submitted by the last day of the month following the month presumptive eligibility begins, the period of presumptive eligibility ends on the last day of the month.

**Section 9 (256N.13) paragraph (a)** authorizes the commissioner to contract with health maintenance organizations (HMOs), community integrated service networks (CISNs), and accountable provider networks to provide health care services to the program enrollees. Health plan companies under contract:

- (1) must authorize and arrange for the provision of all needed health services covered under the program with the exception of services provided under a medical assistance home and community-based waiver;
- (2) must accept the prospective, per capita payment from the commissioner;
- (3) may contract with health care and social service providers to provide services; and
- (4) must institute enrollee grievance procedures as required by the commissioner.

**Paragraph (b)** authorizes the commissioner to contract with a private sector entity to administer and manage the contracts with health plan companies authorized under paragraph (a).

**Paragraph (c)** requires the commissioner to contract with health care and social service providers, on a fee-for-service basis, to provide enrollees with services available under a medical assistance home and community-based waiver.

**Section 10 (256N.15)** requires the commissioner, in consultation with a health care actuary, to establish the method and amount of payments for services. The commissioner must contract annually with eligible entities to provide services to enrollees. This section also requires the commissioner to develop and implement a risk adjustment system for the program.

**Section 11 (256N.17)** provides consumer assistance requirements.

**Subdivision 1** requires the commissioner to assist applicants in choosing a health plan company.

**Subdivision 2** requires the commissioner to designate an ombudsperson to advocate for children enrolled in the program.

**Section 12 (256N.19)** requires each participating health plan company and provider to submit data for assessing enrollee satisfaction, quality of care, cost, and utilization of services. The commissioner is required to evaluate this data in order to make summary data available to consumers, require health plan companies to implement quality improvement plans, and compare the cost and quality of services provided to services provided to private sector enrollees.

**Sections 13 to 17** increase the tax on tobacco products, and requires the revenue from this increase be deposited in the Children's Health Security account.

**Section 18** requires the Commissioner of Human Services to develop an implementation plan for the program and present the plan to the Legislature. The commissioner is also required to evaluate the provision of services under the program to children with disabilities and present any recommendations for program changes necessary to ensure the quality and continuity of care to the Legislature.

**Section 19** requires the Commissioner of Human Services to seek all federal waivers and approvals necessary to implement the program.

**Section 20** requires the Commissioner of Human Services to adopt rules to implement the program.

**Section 21** provides for a blank appropriation from the Children's Health Security account to the Commissioner of Human Services to develop and implement the program.

KTC:rer



1        Subd. 2. [CHILD.] "Child" means an individual under age 19  
2 or an unmarried child who is a full-time student under the age  
3 of 25 years who is financially dependent upon a parent,  
4 grandparent, foster parent, relative caretaker, or legal  
5 guardian.

6        Subd. 3. [COMMISSIONER.] "Commissioner" means the  
7 commissioner of human services.

8        Sec. 4. [256N.03] [ESTABLISHMENT.]

9        The commissioner shall establish the children's health  
10 security program. The commissioner shall begin implementation  
11 of the program on July 1, 2006.

12        Sec. 5. [256N.05] [ELIGIBILITY.]

13        Subdivision 1. [GENERAL REQUIREMENTS.] Children meeting  
14 the eligibility requirements of this section are eligible for  
15 the children's health security program.

16        Subd. 2. [PHASE-IN OF ELIGIBLE GROUPS.] (a) Children who  
17 are eligible for MinnesotaCare or medical assistance are  
18 eligible to enroll effective July 1, 2006, or upon federal  
19 approval, whichever is later.

20        (b) Effective July 1, 2008, eligibility is expanded to  
21 include all children, regardless of household income or assets,  
22 who are not eligible for medical assistance or MinnesotaCare.

23        Subd. 3. [RESIDENCY.] (a) To be eligible for health  
24 coverage under the children's health security program, children  
25 must be permanent residents of Minnesota. For purposes of this  
26 requirement, a permanent Minnesota resident is a person who has  
27 demonstrated, through persuasive and objective evidence, that  
28 the person is domiciled in the state and intends to live in the  
29 state permanently.

30        (b) To be eligible as a permanent resident, an applicant,  
31 or the applicant's parent or guardian as applicable, must  
32 demonstrate the requisite intent to live in the state  
33 permanently by:

34        (1) showing that the applicant, or the applicant's parent  
35 or guardian as applicable, maintains a residence at a verified  
36 address, through the use of evidence of residence described in

1 paragraph (c); and

2 (2) signing an affidavit declaring that the applicant  
3 currently resides in the state and intends to reside in the  
4 state permanently, and the applicant did not come to the state  
5 for the primary purpose of obtaining medical coverage or  
6 treatment.

7 (c) An applicant, or a parent or guardian of an applicant,  
8 may verify a residence address by presenting a valid state  
9 driver's license, a state identification card, a voter  
10 registration card, a rent receipt, a statement by the landlord,  
11 apartment or emergency shelter manager, or homeowner verifying  
12 that the individual is residing at the address, or other form of  
13 verification approved by the commissioner.

14 (d) A child who is temporarily absent from the state does  
15 not lose eligibility for the children's health security  
16 program. "Temporarily absent from the state" means the person  
17 is out of the state for a temporary purpose and intends to  
18 return when the purpose of the absence has been accomplished. A  
19 person is not temporarily absent from the state if another state  
20 has determined that the person is a resident for any purpose.  
21 If temporarily absent from the state, the person must follow the  
22 requirements of the health plan in which the person is enrolled  
23 to receive services.

24 (e) A child who moved to Minnesota primarily to obtain  
25 medical treatment or health coverage for a preexisting condition  
26 is not a permanent resident.

27 Subd. 4. [ENROLLMENT VOLUNTARY.] Enrollment in the  
28 children's health security program is voluntary. Parents or  
29 guardians may retain private sector or Medicare coverage for a  
30 child as the sole source of coverage. Parents or guardians who  
31 have private sector or Medicare coverage for children may also  
32 enroll children in the children's health security program. If  
33 private sector or Medicare coverage is available, coverage under  
4 the children's health security program is secondary to the  
35 private sector or Medicare coverage.

36 Sec. 6. [256N.07] [COVERED SERVICES.]

1 Covered services under the children's health security  
2 program consist of all services reimbursed under chapter 256B.

3 Sec. 7. [256N.09] [NO ENROLLEE PREMIUMS OR COST SHARING.]

4 In order to ensure broad access to coverage, the children's  
5 health security program has no enrollee premium or cost-sharing  
6 requirements.

7 Sec. 8. [256N.11] [APPLICATION PROCEDURES.]

8 Subdivision 1. [APPLICATION PROCEDURE.] Applications for  
9 the program must be made available to provider offices, local  
10 human services agencies, school districts, schools, community  
11 health offices, and other sites willing to cooperate in program  
12 outreach. These sites may accept applications and forward  
13 applications to the commissioner. Applicants may also apply  
14 directly to the commissioner.

15 Subd. 2. [ELIGIBILITY DETERMINATION.] The commissioner  
16 shall determine an applicant's eligibility for the program  
17 within 30 days of the date the application is received by the  
18 Department of Human Services. The effective date of coverage is  
19 the day upon which eligibility is approved, except in cases of  
20 persons applying under presumptive eligibility.

21 Subd. 3. [PRESUMPTIVE ELIGIBILITY.] Coverage under the  
22 program is available during a presumptive eligibility period.  
23 The presumptive eligibility period begins on the date a health  
24 care provider or other entity designated by the commissioner  
25 determines, based on preliminary information, that the person  
26 meets the criteria in section 256N.05. The presumptive  
27 eligibility period ends on the day on which a determination is  
28 made as to the person's eligibility, except that if an  
29 application is not submitted by the last day of the month  
30 following the month during which the determination based on  
31 preliminary information is made, the presumptive eligibility  
32 period ends on the last day of the month.

33 Sec. 9. [256N.13] [SERVICE DELIVERY.]

34 (a) The commissioner may contract with health maintenance  
35 organizations licensed under chapter 62D, community integrated  
36 service networks licensed under chapter 62N, and accountable

1 provider networks licensed under chapter 62T to provide health  
2 care services to program enrollees. Health plan companies under  
3 contract are responsible for coordinating health care services  
4 provided to eligible individuals. Health plan companies under  
5 contract:

6 (1) shall authorize and arrange for the provision of all  
7 needed health services reimbursed under chapter 256B, with the  
8 exception of services available only under a medical assistance  
9 home and community-based waiver, in order to ensure appropriate  
10 health care is delivered to enrollees;

11 (2) shall accept the prospective, per capita payment from  
12 the commissioner in return for the provision of comprehensive  
13 and coordinated health care services for enrollees;

14 (3) may contract with health care and social service  
15 providers to provide services to enrollees; and

16 (4) shall institute enrollee grievance procedures according  
17 to the method established by the commissioner, utilizing  
18 applicable requirements of chapter 62D. Disputes not resolved  
19 through this process may be appealed to the commissioner using  
20 the procedures in section 256.045.

21 (b) The commissioner may contract with a private sector  
22 entity to administer and manage contracts with health plan  
23 companies under paragraph (a).

24 (c) The commissioner shall contract with health care and  
25 social service providers, on a fee-for-service basis, to provide  
26 program enrollees with services available only under a medical  
27 assistance home and community-based waiver. The commissioner  
28 shall determine eligibility for home and community-based waiver  
29 services using the criteria and procedures in chapter 256B.  
30 Disputes related to services provided on a fee-for-service basis  
31 may be appealed to the commissioner using the procedures in  
32 section 256.045.

33 Sec. 10. [256N.15] [PAYMENT RATES.]

34 The commissioner, in consultation with a health care  
35 actuary, shall establish the method and amount of payments for  
36 services. The commissioner shall annually contract with

1 eligible entities to provide services to program enrollees. The  
2 commissioner, in consultation with the risk adjustment  
3 association established under section 62Q.03, subdivision 6,  
4 shall develop and implement a risk adjustment system for the  
5 program.

6 Sec. 11. [256N.17] [CONSUMER ASSISTANCE.]

7 Subdivision 1. [ASSISTANCE TO APPLICANTS.] The  
8 commissioner shall assist applicants in choosing a health plan  
9 company by:

10 (1) establishing a Web site to provide information about  
11 health plan companies and to allow on-line enrollment;

12 (2) make information on health plan companies available at  
13 the sites specified in section 256N.11, subdivision 1;

14 (3) make applications and information on health plan  
15 companies available in Spanish, Hmong, Laotian, Russian, Somali,  
16 Vietnamese, and Cambodian, and provide language interpreter  
17 services as necessary to assist applicants in choosing a health  
18 plan company; and

19 (4) make benefit educators available to assist applicants  
20 in choosing a health plan company.

21 Subd. 2. [OMBUDSPERSON.] The commissioner shall designate  
22 an ombudsperson to advocate for children enrolled in the  
23 children's health security program. The ombudsperson shall  
24 assist enrollees in understanding and making use of complaint  
25 and appeal procedures and ensure that necessary medical services  
26 are provided to enrollees. At the time of enrollment, the  
27 commissioner shall inform enrollees about: the ombudsperson  
28 program; the right to a resolution of the enrollee's complaint  
29 by the health plan company if the enrollee experiences a problem  
30 with the health plan company or its providers; and appeal rights  
31 under section 256.045.

32 Sec. 12. [256N.19] [MONITORING AND EVALUATION OF QUALITY  
33 AND COSTS.]

34 The commissioner, as a condition of contract, shall require  
35 each participating health plan company and participating  
36 provider to submit, in the form and manner specified by the

1 commissioner, data required for assessing enrollee satisfaction,  
 2 quality of care, cost, and utilization of services. The  
 3 commissioner shall evaluate this data, in order to:

4 (1) make summary information on the quality of care across  
 5 health plan companies, medical clinics, and providers available  
 6 to consumers;

7 (2) require health plan companies and providers, as a  
 8 condition of contract, to implement quality improvement plans;  
 9 and

10 (3) compare the cost and quality of services under the  
 11 program to the cost and quality of services provided to private  
 12 sector enrollees.

13 Sec. 13. Minnesota Statutes 2004, section 297F.05,  
 14 subdivision 1, is amended to read:

15 Subdivision 1. [RATES; CIGARETTES.] A tax is imposed upon  
 16 the sale of cigarettes in this state, upon having cigarettes in  
 17 possession in this state with intent to sell, upon any person  
 18 engaged in business as a distributor, and upon the use or  
 19 storage by consumers, at the following rates:

20 (1) on cigarettes weighing not more than three pounds per  
 21 thousand, ~~24~~ 74 mills on each such cigarette; and

22 (2) on cigarettes weighing more than three pounds per  
 23 thousand, ~~48~~ 148 mills on each such cigarette.

24 [EFFECTIVE DATE.] This section is effective January 1, 2006.

25 Sec. 14. Minnesota Statutes 2004, section 297F.05,  
 26 subdivision 3, is amended to read:

27 Subd. 3. [RATES; TOBACCO PRODUCTS.] A tax is imposed upon  
 28 all tobacco products in this state and upon any person engaged  
 29 in business as a distributor, at the rate of ~~35~~ 108 percent of  
 30 the wholesale sales price of the tobacco products. The tax is  
 31 imposed at the time the distributor:

32 (1) brings, or causes to be brought, into this state from  
 33 outside the state tobacco products for sale;

4 (2) makes, manufactures, or fabricates tobacco products in  
 35 this state for sale in this state; or

36 (3) ships or transports tobacco products to retailers in

1 this state, to be sold by those retailers.

2 [EFFECTIVE DATE.] This section is effective January 1, 2006.

3 Sec. 15. Minnesota Statutes 2004, section 297F.05,  
4 subdivision 4, is amended to read:

5 Subd. 4. [USE TAX; TOBACCO PRODUCTS.] A tax is imposed  
6 upon the use or storage by consumers of tobacco products in this  
7 state, and upon such consumers, at the rate of 35 108 percent of  
8 the cost to the consumer of the tobacco products.

9 [EFFECTIVE DATE.] This section is effective January 1, 2006.

10 Sec. 16. Minnesota Statutes 2004, section 297F.10, is  
11 amended to read:

12 297F.10 [DEPOSIT OF PROCEEDS.]

13 Subdivision 1. [TAX AND USE TAX ON CIGARETTES.] Revenue  
14 received from cigarette taxes, as well as related penalties,  
15 interest, license fees, and miscellaneous sources of revenue  
16 shall be deposited by the commissioner in the state treasury and  
17 credited as follows:

18 (1) the revenue produced by 3.25 mills of the tax on  
19 cigarettes weighing not more than three pounds a thousand and  
20 6.5 mills of the tax on cigarettes weighing more than three  
21 pounds a thousand must be credited to the Academic Health Center  
22 special revenue fund hereby created and is annually appropriated  
23 to the Board of Regents at the University of Minnesota for  
24 Academic Health Center funding at the University of Minnesota;  
25 and

26 (2) the revenue produced by 1.25 mills of the tax on  
27 cigarettes weighing not more than three pounds a thousand and  
28 2.5 mills of the tax on cigarettes weighing more than three  
29 pounds a thousand must be credited to the medical education and  
30 research costs account hereby created in the special revenue  
31 fund and is annually appropriated to the commissioner of health  
32 for distribution under section 62J.692, subdivision 4; and

33 (3) the balance of the revenues derived from taxes,  
34 penalties, and interest (under this chapter) and from license  
35 fees and miscellaneous sources of revenue shall be credited to  
36 the general fund, except that the portion of tax revenue

1 resulting from the increase in the tax on cigarettes weighing  
2 not more than three pounds per thousand from 24 to 74 mills and  
3 the increase in the tax on cigarettes weighing more than three  
4 pounds per thousand from 48 to 148 mills shall be deposited in  
5 the children's health security account.

6 Subd. 2. [TAX AND USE TAX ON TOBACCO PRODUCTS.] Revenue  
7 received from taxes on tobacco products, as well as related  
8 penalties, interest, and license fees shall be deposited by the  
9 commissioner in the state treasury and credited to the general  
10 fund, except that the portion of tax revenue resulting from the  
11 increase in the tax on the wholesale sales price of tobacco  
12 products from 35 to 108 percent shall be deposited in the  
13 children's health security account.

14 [EFFECTIVE DATE.] This section is effective January 1, 2006.

15 Sec. 17. [FLOOR STOCKS TAX.]

16 Subdivision 1. [CIGARETTES.] (a) A floor stocks tax is  
17 imposed on every person engaged in business in this state as a  
18 distributor, retailer, subjobber, vendor, manufacturer, or  
19 manufacturer's representative of cigarettes, on the stamped  
20 cigarettes and unaffixed stamps in the person's possession or  
21 under the person's control at 12:01 a.m. on January 1, 2006.  
22 The tax is imposed at the following rates, subject to the  
23 discounts in Minnesota Statutes, section 297F.08, subdivision 7:

24 (1) on cigarettes weighing not more than three pounds per  
25 thousand, 50 mills on each cigarette; and

26 (2) on cigarettes weighing more than three pounds per  
27 thousand, 100 mills on each cigarette.

28 (b) Each distributor, by January 8, 2006, shall file a  
29 report with the commissioner of revenue, in the form the  
30 commissioner prescribes, showing the stamped cigarettes and  
31 unaffixed stamps on hand at 12:01 a.m. on January 1, 2006, and  
32 the amount of tax due on the cigarettes and unaffixed stamps.  
33 The tax imposed by this section is due and payable by February  
34 1, 2006, and after that date bears interest as provided in  
35 Minnesota Statutes, section 270.75. Each retailer, subjobber,  
36 vendor, manufacturer, or manufacturer's representative shall

1 file a return with the commissioner, in the form the  
2 commissioner prescribes, showing the cigarettes on hand at 12:01  
3 a.m. on January 1, 2006, and pay the tax due on the cigarettes  
4 by February 1, 2006. Tax not paid by the due date bears  
5 interest as provided in Minnesota Statutes, section 270.75.

6 Subd. 2. [TOBACCO PRODUCTS.] A floor stocks tax is imposed  
7 on every person engaged in business in this state as a  
8 distributor of tobacco products, at the rate of 73 percent of  
9 the wholesale sales price of each tobacco product in the  
10 person's possession or under the person's control at 12:01 a.m.  
11 on January 1, 2006, and the amount of tax due on them. The tax  
12 imposed by this section, less the discount provided in Minnesota  
13 Statutes, section 297F.09, subdivision 2, is due and payable by  
14 February 1, 2006, and thereafter bears interest as provided in  
15 Minnesota Statutes, section 270.75.

16 Subd. 3. [AUDIT AND ENFORCEMENT.] The tax imposed by this  
17 section is subject to the audit, assessment, and collection  
18 provisions applicable to the taxes imposed under Minnesota  
19 Statutes, chapter 297F. The commissioner of revenue shall  
20 deposit the revenue from the tax imposed under this section in  
21 the health care access fund in the state treasury.

22 [EFFECTIVE DATE.] This section is effective January 1, 2006.

23 Sec. 18. [IMPLEMENTATION PLAN.]

24 The commissioner shall develop an implementation plan for  
25 the children's health security coverage program and shall  
26 present this plan, any necessary draft legislation, and a draft  
27 of proposed rules to the legislature by December 15, 2005. The  
28 commissioner shall evaluate the provision of services under the  
29 program to children with disabilities and shall present  
30 recommendations to the legislature by December 15, 2007, for any  
31 program changes necessary to ensure the quality and continuity  
32 of care.

33 Sec. 19. [FEDERAL APPROVAL.]

34 The commissioner shall seek all federal waivers and  
35 approvals necessary to implement this chapter including, but not  
36 limited to, waivers and approvals necessary to:

1 (1) merge medical assistance and MinnesotaCare coverage for  
2 children into the children's health security program;

3 (2) use federal medical assistance and MinnesotaCare  
4 dollars to pay for health care services under the children's  
5 health security program; and

6 (3) maximize receipt of the federal medical assistance  
7 match for covered children, by increasing income standards  
8 through the use of more liberal income methodologies as provided  
9 under United States Code, title 42, sections 1396a and 1396u-1.

10 Sec. 20. [RULEMAKING.]

11 The commissioner shall adopt rules to implement this act.

12 Sec. 21. [APPROPRIATION.]

13 \$..... is appropriated from the children's health  
14 security account to the commissioner of human services for the  
15 fiscal year ending June 30, 2006, to develop and implement the  
16 Children's Health Security Act.

- 1.1 Senator ..... moves to amend S.F. No. 20 as follows:
- 1.2 Page 2, lines 11 and 18, delete "2006" and insert "2008"
- 1.3 Page 2, line 16, delete "Children who"
- 1.4 Page 2, delete line 17 and insert "Children in families with income equal to or less
- 1.5 than 300 percent of the federal poverty guidelines are"
- 1.6 Page 2, line 20, delete "2008" and insert "2010"
- 1.7 Page 7, line 24, delete "2006" and insert "2007"
- 1.8 Page 8, lines 2 and 9, delete "2006" and insert "2007"
- 1.9 Page 9, lines 14, 21, 28, 31, and 34, delete "2006" and insert "2007"
- 1.10 Page 10, lines 3, 4, 11, 14, and 22, delete "2006" and insert "2007"
- 1.11 Page 10, line 21, delete "health care access fund" and insert "children's health
- 1.12 security account"
- 1.13 Page 10, line 27, delete "2005" and insert "2006"
- 1.14 Page 10, line 30, delete "2007" and insert "2008"
- 1.15 Page 11, line 15, delete "2006" and insert "2007"

## **CHILDREN'S HEALTH SECURITY ACT Draft Actuarial Cost Model – Assumptions and Limitations**

**Alexander M. Tava, FSA, MAAA  
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The following are selected assumptions, data sources, summaries, and limitations for the draft Actuarial Cost Model developed by Cirdan Health Systems, Inc. for the Children's Health Security Act (CHSA), on behalf of the Children's Defense Fund of Minnesota. A memorandum will accompany the final model with more detailed descriptions of these factors, and may contain material changes from the draft model.

### **Changes from Status Quo to Phase One**

1. The basic structure of the current Prepaid Medical Assistance Program will be used as the infrastructure for Phase One of the CHSA Program. The Minnesota Department of Human Services will contract with health plans, county-based purchasing entities, and healthcare provider networks to administer coverage.
2. All children and dependent young adults up to 300% of the federal poverty level will be eligible for the CHSA Program.
3. Coverage will be at a Medicaid-equivalent level, with no copayments and no premiums.
4. Total Phase One enrollment is projected to be approximately 631,000, including 330,000 from Medicaid and other public programs, 223,000 from commercial insurance, and 78,000 formerly uninsured. Approximately 808,000 children and dependent young adults will not be covered by the CHSA Program in Phase One.
5. Utilization of services will be unchanged for current public program enrollees, but is projected to increase for children and dependent young adults previously covered by commercial insurance or uninsured.
6. For current levels of service, aggregate reimbursement to healthcare providers for children and dependent young adults covered in Phase One will be unchanged from current levels. Additional reimbursement will apply for increased service levels, at Medicaid-equivalent levels. Overall reimbursements will reflect a blend of Medicaid and commercial rates. Previously uncompensated services will be reimbursed for Phase One enrollees, but the value of uncompensated care is considered a cost inherent in the current system.

### **Savings Estimates for Phase One**

1. Medical management – Medical cost savings of 0.8% are projected from more intensive management of asthma, and overall improved continuity of care.
2. Administration – Administrative costs savings of 0.9% are projected from program consolidation.
3. Other – Additional and changed savings projections will apply in Phase Two of the CHSA.

### **Data Sources**

Estimates of enrollment, medical costs, administrative costs, and other factors were derived from a wide variety of sources, including but not limited to: Minnesota Department of Health; U.S. Census Bureau; U.S. Bureau of Labor Statistics; Kaiser Family Foundation; American Academy of Pediatrics; Rand Institute; Urban Institute; and the Minnesota State Data Center.



**Children's Health Security Act  
Detailed Cost and Enrollment Projections - Phase One, Fiscal 2006 Dollars**

**STATUS QUO**

Sector	Enrollment	Premium (or equivalent)		Out-of-Pocket		Total Costs	
		PMPY*	Total	PMPY	Total	PMPY	Total
Medicaid, MinnesotaCare, Medicare	329,580	\$3,541	\$1,166,988,929	-	-	\$3,541	\$1,166,988,929
Commercial Insurance	1,010,896	1,914	1,934,483,337	\$290	\$292,829,865	2,203	2,227,313,202
Uninsured	98,233	-	-	941	92,435,647	941	92,435,647
<b>TOTAL</b>	<b>1,438,709</b>		<b>3,101,472,266</b>		<b>385,265,512</b>	<b>2,424</b>	<b>3,486,737,778</b>

\* Per member per year

**PHASE ONE**

Sector	Enrollment	Premium (or equivalent)		Out-of-Pocket		Total Costs	
		PMPY	Total	PMPY	Total	PMPY	Total
Children's Health Program	630,967	\$2,785	\$1,757,426,123	-	-	\$2,785	\$1,757,426,123
Commercial Insurance	787,541	1,913	1,506,280,886	\$290	\$228,129,768	2,202	1,734,410,654
Uninsured	20,201	-	-	941	19,008,999	941	19,008,999
<b>TOTAL</b>	<b>1,438,709</b>		<b>3,263,707,009</b>		<b>247,138,767</b>	<b>2,440</b>	<b>3,510,845,776</b>

**PHASE ONE DETAIL**

<b>Children's Health Program</b>							
Sector	Enrollment	Premium (or equivalent)		Out-of-Pocket		Total Costs	
		PMPY	Total	PMPY	Total	PMPY	Total
Medicaid, MinnesotaCare, Medicare	329,580	\$3,604	\$1,187,863,654	-	-	\$3,604	\$1,187,863,654
Commercial Insurance	223,355	1,716	383,211,623	-	-	1,716	383,211,623
Uninsured	78,032	2,388	186,350,846	-	-	2,388	186,350,846
<b>TOTAL</b>	<b>630,967</b>		<b>1,757,426,123</b>		<b>-</b>	<b>2,785</b>	<b>1,757,426,123</b>

<b>Non-Enrollees</b>							
Sector	Enrollment	Premium (or equivalent)		Out-of-Pocket		Total Costs	
		PMPY	Total	PMPY	Total	PMPY	Total
Medicaid, MinnesotaCare, Medicare	-	-	-	-	-	-	-
Commercial Insurance	787,541	\$1,913	\$1,506,280,886	\$290	\$228,129,768	\$2,202	\$1,734,410,654
Uninsured	20,201	-	-	941	19,008,999	941	19,008,999
<b>TOTAL</b>	<b>807,742</b>		<b>1,506,280,886</b>		<b>247,138,767</b>	<b>2,171</b>	<b>1,753,419,653</b>



**Children's Health Security Act  
Summary Cost Projections - Phase One, Fiscal 2006 Dollars**

	<u>STATUS QUO</u>	<u>PHASE ONE [1]</u>
<b>Healthcare System</b>		
Total Costs for Children [2]	\$3,486,737,778	\$3,510,845,776
Change from Status Quo (\$)	----	24,107,998
Change from Status Quo (%)	----	0.7%
<b>Total Costs by Sector</b>		
Children's Health Program [3]	----	1,757,426,123
Medicaid, MinnesotaCare, Medicare [4]	1,166,988,929	----
Commercial Insurance [5]	2,227,313,202	1,734,410,654
Uninsured	92,435,647	19,008,999
<b>Total Costs</b>	<b>\$3,486,737,778</b>	<b>\$3,510,845,776</b>
<b>Healthcare Provider Reimbursements [6]</b>		
Total Reimbursements	\$3,120,069,316	\$3,147,343,446
Change from Status Quo (\$)	----	27,274,130
Change from Status Quo (%)	----	0.9%
<b>Administrative Costs</b>		
Total Administrative Costs	\$366,668,462	\$363,502,330
Change from Status Quo (\$)	----	(3,166,132)
Change from Status Quo (%)	----	-0.9%
<b>Group Health Premiums [7]</b>		
Total Premiums	\$1,826,428,168	\$1,426,355,561
Change from Status Quo (\$)	----	(400,072,608)
Change from Status Quo (%)	----	-21.9%
Employer Contributions	\$993,576,923	\$775,937,425
Change from Status Quo (\$)	----	(217,639,498)
Change from Status Quo (%)	----	-21.9%
Employee Contributions	\$832,851,245	\$650,418,136
Change from Status Quo (\$)	----	(182,433,109)
Change from Status Quo (%)	----	-21.9%

[1] Phase 2 of the Children's Health Security Act is scheduled to begin in Fiscal 2010. Phase 2 cost modeling will be incorporated in the final actuarial exhibits.  
 [2] "Children" include ages 0-18 and full-time students ages 19-24.  
 [3] The program created by the Children's Health Security Act.  
 [4] Includes approximately \$20.7 million in enrollee premiums.  
 [5] Includes employment-based coverage, other group insurance, and individually-purchased insurance.  
 [6] Includes payments for covered services and products to all categories of eligible healthcare providers.  
 [7] Employment-based group coverage, with contributions to premium from employers and employees, respectively.



**ORGANIZATIONS THAT SUPPORT  
MINNESOTA CHILDREN'S HEALTH SECURITY ACT  
(SF 20 – Prettner Solon, HF 132 – Thissen )  
As of March 2, 2006**

1. American Academy of Pediatrics, Minnesota Chapter
2. American Cancer Society
3. American Heart Association
4. American Lung Association
5. Children's Defense Fund Minnesota
6. City of Minneapolis
7. Congregations Concerned for Children
8. Family & Children's Service of Minneapolis
9. Hotel Employees and Restaurant Employees Union Local 117
10. Jobs NOW Coalition
11. Joint Religious Legislative Coalition
12. Lutheran Coalition for Public Policy
13. Lutheran Social Service of Minnesota
14. Minnesota Catholic Conference
15. Minnesota Coalition for Battered Women
16. Minnesota Community Action Association
17. Minnesota Nurses Association
18. Minnesota Smokefree Coalition
19. Minnesota Social Service Association
20. Minnesotans for Affordable Health Care
21. National Multiple Sclerosis Society, Minnesota Chapter
22. Office For Social Justice, Archdiocese of St. Paul-Minneapolis
23. Portico Healthnet
24. Prevent Child Abuse Minnesota
25. Service Employees International (SEIU) Union State Council
26. SEIU Local 113
27. SEIU Local 26
28. SEIU Local 284
29. SEIU Local 63
30. Sheltering Arms Foundation
31. United Food and Commercial Workers Local 789
32. West Metro Faith Communities in Action

# FACTS AND FREQUENTLY ASKED QUESTIONS MINNESOTA CHILDREN'S HEALTH SECURITY ACT (SF 20-Prettner Solon; HF 132-Thissen)

## BACKGROUND

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### **What is the Minnesota Children's Health Security Act?**

The Minnesota Children's Health Security Act is legislation that has been introduced in the Minnesota House (HF#132) and Senate (SF#20). The Act would ensure universal health care coverage in a two-phase approach by 2010 for all children living in Minnesota. All children through age 18 as well as young adults under age 25 who are students and still dependents would be eligible for the program. The first phase of the Act would place all children whose family income is below 300% of the Federal Poverty Guidelines (FPG), approximately \$56,000 for a family of four, into one purchasing pool by 2008. Phase I would cover all children currently covered by public programs as well as some children covered by private insurance. The second phase would open the program to all Minnesota children in 2010. Coverage through the children's health pool would be voluntary.

### **Why is the Minnesota Children's Health Security Act important?**

Ensuring the health of our state's children is an investment in the well-being of families and children as well as a strong future workforce and economy. The fragmented, complicated health care system creates real barriers to health care coverage. The number of uninsured children in Minnesota has increased to 68,000 – twice the total of the population of Mankato. Not only has this number risen in recent years, but the number of children without insurance in the developmentally critical ages of 0-5 increased by 11,000 between 2001 and 2004.

The Minnesota Children's Health Security Act proposes systemic change that would have broad reaching benefits. Creating a children's health care pool would move the state in the direction of a simplified, affordable health care system and send the message that our children's health is a top priority.

This legislation would benefit children, their families, and employers, while containing health care costs.

#### *Children & Families*

Linking children's health care coverage to parents' employment creates inconsistent, arbitrary and in many cases unaffordable health care coverage. All children deserve access to quality, affordable health care. Creating a universal coverage program would provide consistent, continuous care for children, promote preventive care and remove high premiums and out-of-pocket costs that limit coverage and access.

#### *Employers*

The responsibility of ensuring that children have health care coverage will no longer be placed on employers. Removing the cost of providing coverage for employees' children will relieve some of the financial burden for employers as health care costs skyrocket.

#### *Health Care System*

Creating one purchasing pool for children would increase efficiency and eliminate administrative complexity, which would ultimately lower costs and eliminate confusion. In addition, universal coverage will reduce uncompensated care, which totaled \$74 million for children alone in 2004.

## FREQUENTLY ASKED QUESTIONS

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### 1. How will the Minnesota Children's Health Security Act be funded?

Phase I would be funded through a cigarette tax increase and/or other excise taxes. Phase II funding has not yet been determined, but will be broad-based and sustainable.

#### Current Spending Structure

Approximately \$3 billion is spent annually on children's health care by the state, parents and employers. According to 2004 data from the Minnesota Department of Health, parents pay over \$1 billion in premiums and out-of-pocket health care costs; employers pay \$884 million in premiums for dependent children; and the state spends approximately \$845 million for children covered by MinnesotaCare and Medical Assistance (MA), Minnesota's Medicaid program.

#### Proposed Minnesota Children's Health Security Act Spending Structure

Phase I will replace employer and parent spending for all children under 300% of poverty with cigarette and/or excise tax increases. This new revenue would be combined with the existing public spending on our health care programs to create the initial pool. Phase I will cover all children in Minnesota under 300% of poverty, including children who are currently covered by MinnesotaCare or MA and the large number of uninsured children under 300% of poverty. The two-phase approach would allow Minnesota to pursue federal matching funds that would maximize federal funding and reduce state costs during the first phase.

Phase II will open the program to all children in Minnesota and would be funded through a broad-based tax. This tax would replace the current employer/employee premiums for children receiving employer-based coverage.

### 2. Why only children?

We need to move toward universal coverage for all Minnesotans, but it is difficult to achieve universal coverage all at once. Universal coverage for children is attainable. The Minnesota Citizens Forum on Health Care Costs, Chaired by former U.S. Senator David Durenberger, recommended universal coverage as a key solution to addressing health care costs, "with a priority of covering all children." Children are less costly to cover (about 60-70% the cost of adult coverage) making children a feasible starting point for universal coverage. In addition, public support for universal children's coverage has also been very strong and consistent. Over 80% of the public supports universal coverage for all children in Minnesota.

## IMPORTANT FACTS

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- ✓ Phase I of the Act would bring Minnesota to near universal coverage for children by ensuring coverage for children under 300% of FPG.
- ✓ The Children's Health Security Act would provide access to affordable, quality coverage for the 68,000 uninsured children in Minnesota.
- ✓ Overall, the legislation would ensure coverage for approximately 620,000 Minnesota children in Phase I (this includes the 320,000 currently covered under MinnesotaCare and MA).
- ✓ Creating a single pool for children will increase efficiency and ultimately reduce total spending on children's health care.
- ✓ Continuity of care and access to preventive care for children will produce millions of dollars in savings due to better health outcomes.
- ✓ The bill is voluntary and would offer a comprehensive benefit set and provider choice.

**Senate Counsel, Research,  
and Fiscal Analysis**

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**Senate**

State of Minnesota

**S.F. No. 1695 - Mental Health Care Records  
(Delete-Everything Amendment)**

**Author:** Senator Wes Skoglund

**Prepared by:** Katie Cavanor, Senate Counsel (651/296-3801)



**Date:** March 9, 2006

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S.F. No. 1695 authorizes a health care provider providing mental health care to disclose information about a patient to a family member of the patient or another person under limited circumstances.

**Section 1 (144.335, subdivision 3d), paragraph (a)**, authorizes a provider providing mental health care to provide information about a patient to a family member or other person if:

- (1) the request is in writing;
- (2) the family member or other person lives with, provides care for, or is directly involved in monitoring the treatment of the patient;
- (3) this involvement is verified by the mental health care provider, the patient's attending physician, or a person other than the one requesting the information;
- (4) before the disclosure, the patient is informed in writing of the request, the name of the person requesting the information, the reason for the request, and the information being requested;
- (5) the patient agrees to the disclosure, does not object to the disclosure, or is unable to consent or object; and
- (6) the disclosure is necessary to assist in the provision of care or monitoring treatment.

**Paragraph (b)** states that the information disclosed is limited to diagnosis, admission to or discharge of treatment, the names of medications prescribed, side effects of the medication, consequences of failure of the patient to take the prescribed medication, and a summary of the discharge plan.

**Paragraph (c)** states that if a provider determines that releasing information under this subdivision would be detrimental to the physical or mental health of the patient or is likely to cause the patient to inflict self harm or harm to another, the provider must not disclose the information.

**Paragraph (d)** states that this subdivision does not apply to disclosures for a medical emergency or to family members as authorized or required under subdivision 3a, paragraph (b), clause (1), or paragraph (f).

KC:ph

Senators Skoglund, Berglin and Sams introduced--  
S.F. No. 1695: Referred to the Committee on Health and Family Security.

1                                   A bill for an act.

2           relating to health; modifying access to health care  
3           records; amending Minnesota Statutes 2004, section  
4           144.335, by adding a subdivision.

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

6           Section 1. Minnesota Statutes 2004, section 144.335, is  
7           amended by adding a subdivision to read:

8           Subd. 3d. [FAMILY INVOLVEMENT.] (a) Notwithstanding  
9           subdivision 3a, a provider providing mental health care and  
10           treatment may provide information about a patient to a family  
11           member of the patient or other person if:

12           (1) the family member or other person lives with, provides  
13           care for, or is directly involved in monitoring the treatment of  
14           the patient;

15           (2) the involvement under clause (1) is verified by the  
16           patient's mental health care provider, the patient's attending  
17           physician, or a person other than the person requesting the  
18           information;

19           (3) the patient agrees to the disclosure or does not object  
20           to the disclosure or it is determined, based on professional  
21           judgment, that the patient does not object;

22           (4) the provider determines, based on professional  
23           judgment, that the disclosure is in the best interests of the  
24           patient if the patient is not present, the patient is  
25           incapacitated, or emergency circumstances exist;

1 (5) the disclosure is necessary to assist in the provision  
2 of care or monitoring of the patient's treatment;

3 (6) prior to the disclosure, the patient is informed in  
4 writing of the request, the name of the person requesting the  
5 information, the reason for the request, and the specific  
6 information being provided;

7 (7) the request for information is in writing, except in an  
8 emergency as determined by the mental health professional; and

9 (8) the information disclosed is limited to diagnosis,  
10 admission to or discharge from treatment, the name of the  
11 medications prescribed, side effects of the medication,  
12 consequences of failure of the patient to take the prescribed  
13 medication, and a summary of the discharge plan.

14 (b) If a provider reasonably determines that providing  
15 information under this subdivision would be detrimental to the  
16 physical or mental health of the patient or is likely to cause  
17 the patient to inflict self harm or to harm another, the  
18 provider may withhold the information from the person requesting  
19 information.

1.1 Senator ..... moves to amend S.F. No. 1695 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "Section 1. Minnesota Statutes 2004, section 144.335, is amended by adding a  
1.4 subdivision to read:

1.5 Subd. 3d. Release of records for family and caretaker involvement in mental  
1.6 health care. (a) Notwithstanding subdivision 3a, a provider providing mental health care  
1.7 and treatment may disclose health record information described in paragraph (b) about a  
1.8 patient to a family member of the patient or other person who requests the information if:

1.9 (1) the request for information is in writing;

1.10 (2) the family member or other person lives with, provides care for, or is directly  
1.11 involved in monitoring the treatment of the patient;

1.12 (3) the involvement under clause (2) is verified by the patient's mental health care  
1.13 provider, the patient's attending physician, or a person other than the person requesting  
1.14 the information;

1.15 (4) before the disclosure, the patient is informed in writing of the request, the name  
1.16 of the person requesting the information, the reason for the request, and the specific  
1.17 information being requested;

1.18 (5) the patient agrees to the disclosure, does not object to the disclosure, or is unable  
1.19 to consent or object; and

1.20 (6) the disclosure is necessary to assist in the provision of care or monitoring of the  
1.21 patient's treatment.

1.22 (b) The information disclosed under this subdivision is limited to diagnosis,  
1.23 admission to or discharge from treatment, the name and dosage of the medications  
1.24 prescribed, side effects of the medication, consequences of failure of the patient to take the  
prescribed medication, and a summary of the discharge plan.

1.26 (c) If a provider reasonably determines that providing information under this  
1.27 subdivision would be detrimental to the physical or mental health of the patient or is

2.1 likely to cause the patient to inflict self harm or to harm another, the provider must not  
2.2 disclose the information.

2.3 (d) This subdivision does not apply to disclosures for a medical emergency or to  
2.4 family members as authorized or required under subdivision 3a, paragraph (b), clause  
2.5 (1), or paragraph (f)."

2.6 Delete the title and insert:

2.7 " A bill for an act  
2.8 relating to health; providing for access to mental health care records by family  
2.9 members and caretakers in certain cases; amending Minnesota Statutes 2004, section  
2.10 144.335, by adding a subdivision."



LEAGUE OF  
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**STATEMENT FOR THE SENATE HEALTH AND FAMILY SECURITY  
COMMITTEE**

**S.F. 1695, the Family Involvement Bill**

**March 9, 2006**

**Barbara Flanigan, LWVMN Mental Health Lobbyist**

The League of Women Voters of Minnesota urges support of S.F. 1695, the Family Involvement Bill.

The League position supports “a comprehensive and coordinated system of programs and services for mentally ill adults and emotionally disturbed children and adolescents.” We are convinced that to serve these people effectively it is often essential that family members be involved as part of the treatment team. They will be much more efficient if they have a basic knowledge of their loved one’s illness and the effects of medications which have been prescribed. In addition, their frustration with this serious and long-term illness will be somewhat relieved.

We are aware, of course, that persons with mental illness deserve to have their privacy protected. We believe that in this bill needed privacy is protected, since the bill contains limits on information that can be shared and also allows physicians to decide not to share information.

This is a small step toward addressing the needs of families of persons with mental illness but, we are convinced, an important one. Please cast your vote for S.F. 1695.

Senators Berglin, Fischbach, Higgins, Foley and Wergin introduced—  
S.F. No. 2532: Referred to the Committee on Health and Family Security.

A bill for an act  
relating to health; removing the expiration date for radiation therapy facility  
construction limitations; amending Minnesota Statutes 2004, section 144.5509.

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

Section 1. Minnesota Statutes 2004, section 144.5509, is amended to read:

**144.5509 RADIATION THERAPY FACILITY CONSTRUCTION.**

(a) A radiation therapy facility may be constructed only by an entity owned,  
operated, or controlled by a hospital licensed according to sections 144.50 to 144.56 either  
alone or in cooperation with another entity.

~~(b) This section expires August 1, 2008.~~

1.1 Senator Kelley moves to amend S.F. No. 2532 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "Section 1. **RADIATION THERAPY SERVICES AND FACILITIES STUDY.**

1.4 The commissioner of health, in consultation with the commissioner of human  
1.5 services and health care providers and facilities, shall study the provision and operation of  
1.6 radiation therapy services and facilities in Minnesota. The study shall include:

1.7 (1) a comprehensive inventory of radiation therapy services and facilities in the state  
1.8 of Minnesota, including, but not limited to, location, equipment, and capabilities;

1.9 (2) an analysis of the ownership of the facilities and financial agreements with other  
1.10 entities supporting the operation of the facilities;

1.11 (3) analysis of utilization for radiation therapy services and facilities in Minnesota,  
1.12 including, but not limited to, referral data, source of payment, patient and treatment  
1.13 volumes, waiting times, and operating hours;

1.14 (4) facility and provider charges and reimbursement for Minnesota radiation therapy  
1.15 services, including both professional and technical charges and reimbursement; and

1.16 (5) an assessment of future demand for and projected utilization of radiation therapy  
1.17 services and facilities.

1.18 To the maximum extent possible, all data shall be collected and reported on a  
1.19 facility- and provider-specific basis. Patient identifiable data must not be requested or  
1.20 collected. For the purposes of this study, all health care providers, facilities, and other  
1.21 entities owning, operating, or providing radiation therapy services or facilities shall  
1.22 provide all data requested by the commissioner. The commissioner of health shall submit  
1.23 a report to the legislature by December 15, 2006.

1.24 Sec. 2. **APPROPRIATION.**

1.25 \$..... is appropriated from the general fund to the commissioner of health for fiscal  
1.26 year 2007 for the purpose of conducting the radiation therapy services and facilities study."

2.1 Amend the title accordingly

*Sen. Berglin*

**Radiation Therapy Construction: 2003- Present**

- 1) Fairview Lakes (Wyoming) new Radiation Therapy Center
- 2) North Memorial (Robbinsdale) new Radiation Therapy Center
- 3) Regions (St. Paul) new Radiation Therapy Center
- 4) St. Joseph's (St. Paul) new CyberKnife Center
- 5) University of Minnesota (Minneapolis) new Gamma Knife Center
- 6) Maplewood Cancer Center (Maplewood) new Trilogy Linear Accelerator
- 7) St. Cloud Hospital (St. Cloud) new Radiation Therapy Center

**Comprehensive List of Minnesota Radiation Therapy Facilities**

- 1) Abbott Northwestern Hospital  
800 East 28th Street  
Minneapolis, MN 55407
- 2) Albert Lea Medical Center-Mayo Health System  
404 W. Fountain St.  
Albert Lea, MN 56007
- 3) Bemidji-Meritcare Clinic  
1233 34th St NW  
Bemidji, MN 56601
- 4) Douglas County Hospital  
111 17th Avenue East  
Alexandria, MN 56308
- 5) Fairview Lakes Health Services  
5200 Fairview Blvd.  
Wyoming, MN 55092
- 6) Fairview Ridges Hospital  
201 E. Nicollet Blvd.  
Burnsville, MN 55337
- 7) Fairview Southdale Hospital  
6401 France Ave. S.  
Edina, MN 55435
- 8) Fairview University Medical Center- Mesabi  
750 East 34th Street  
Hibbing, MN 55746
- 9) Hennepin County Medical Center  
701 Park Ave.  
Minneapolis, MN 55415

10) Immanuel St. Joseph's - Mayo Health System  
1025 Marsh St.  
Mankato, MN 56002

11) Maplewood Cancer Center  
1580 Beam Avenue  
Maplewood MN 55109

12) Mayo Clinic- Rochester Methodist Hospital  
201 West Center Street  
Rochester, Minnesota 55902

13) Mercy Hospital  
4050 Coon Rapids Blvd. NW  
Coon Rapids, MN 55433

14) Methodist Hospital Park Nicollet Health Services  
6500 Excelsior Blvd.  
St. Louis Park, MN 55426

15) Miller-Dwan Medical Center  
502 East Second Street  
Duluth, MN 55805

16) North Memorial Medical Center  
3300 Oakdale Ave. N.  
Robbinsdale, MN 55422

17) Regions Hospital  
640 Jackson St.  
St. Paul, MN 55101

18) Rice Memorial Hospital  
301 Becker Ave. SW  
Willmar, MN 56201

19) Ridgeview Medical Center  
500 S. Maple St.  
Waconia, MN 55387

20) St. Cloud Hospital  
1406 6th Ave. N.  
St. Cloud, MN 56303

21) St. Francis Regional Medical Center  
1455 St. Francis Ave.  
Shakopee, MN 55379

22) St. John's Hospital  
1575 Beam Ave.  
Maplewood, MN 55109

23) St. Joseph's Hospital  
69 W. Exchange St.  
St. Paul, MN 55102

24) St. Luke's-Duluth  
1001 East Superior St.  
Duluth, MN 55802

25) United Hospital, Inc.  
333 N. Smith Ave.  
St. Paul, MN 55102

26) Unity Hospital  
550 Osborne Road NE  
Fridley, MN 55432

27) University of Minnesota Cancer Center  
420 Delaware St. SE  
Minneapolis, MN 55455

28) VA Medical Hospital  
1 Veteran Drive  
Minneapolis, MN 55417



**Testimony of Lawrence Massa  
Chief Executive Office, Rice Memorial Hospital, Willmar, Minnesota  
On Behalf of the Minnesota Hospital Association**

My name is Lawrence Massa and I am the Chief Executive Officer of Rice Memorial Hospital in Willmar, Minnesota. In December of 2005, I completed a year serving as Board Chair of the Minnesota Hospital Association and I am here today testifying on behalf of the Minnesota Hospital Association and our 134 members.

I am here today to express our strong support of Senate File 2532, a bill that would remove the 2008 sunset from current statutory language regarding the construction of new radiation therapy facilities in Minnesota.

This law has encouraged collaborative relationships and projects between hospitals and physicians that are high quality, cost effective and have introduced the latest technology to Minnesotans seeking treatment for cancer.

This collaborative approach is good public policy. It allows these services to be developed in the most cost-effective way for patients, physicians and hospitals. Radiation technology is one of the most expensive investments made in healthcare. Patients are best served when that technology is provided in partnership, where hospitals and physicians can share precious resources and maximize efficiencies. This is accomplished without charging patients or government payers more than non-hospital settings.

This issue has been discussed for several years in Minnesota and the language that was passed in 2003 has not halted new cancer treatment development or stifled innovation as some had feared. Minnesota has many fine physicians providing various cancer treatment therapies and hospitals have good working relationships with many practice groups. The language has not resulted in an unfair advantage for one physician group over another.

The law itself does not specify the nature of the collaboration, or dictate a percentage ownership relationship. Hospitals can negotiate and partner with physician groups to construct an agreement that is mutually beneficial or hospitals can pursue the offering of radiation therapy services alone.

The law is short and obviously not very prescriptive, but still of great benefit to hospitals. Let me explain the situation in Willmar, from a patient's perspective and a hospital financing perspective. We have provided radiation therapy services on site at Rice Memorial Hospital since 1986. This is a great service to our patients particularly those with advanced cancer treatment needs, because they avoid the need to be transported to a separate facility for cancer treatments. Their cancer treatment can go on without interruption when they are in the hospital receiving care.

We have a strong collaborative relationship with Affiliated Community Medical Centers, our community's multi-specialty physician group, where medical oncology and

chemotherapy services are available. Together, we have developed a cancer program that is accredited by the American College of Surgeons Commission on Cancer, no small undertaking in a rural community like Willmar. We are currently discussing the potential of further integrating our services in the future through a joint venture arrangement. I believe this is an excellent example of the type of collaboration encouraged by the current statute, and I fear the kind of collaboration we would see less of, if this law is allowed to sunset.

If this law were not in place, and a separate, independent physician owned radiation facility were built in Willmar it would pull patients away from the hospital facility and duplicate costs. This equipment is expensive and a certain volume is needed to help pay for the investment. Having two competing facilities in Willmar could result in neither facility being able to maintain a high enough patient utilization to remain viable and for us to offer the wide variety of cancer services currently available in our community. This would not be in the best interest of our hospital or the patients we serve.

Under a competitive model, hospitals would likely have the larger volume of uninsured and Medicare patients. Hospitals would also likely lose out on ancillary services, like imaging and other diagnostic tests that are often associated with cancer treatments. Hospitals provide many services that receive reimbursements that are less than the costs of providing that service --- mental health, emergency room, trauma care and hospice – to name just a few. Hospitals are often financially dependent on revenues generated from surgical procedures and ancillary diagnostic tests associated with cancer treatments to help maintain other important patient care functions.

The cooperative model that this law encourages allows hospitals to continue to provide a wide array of services.

I hope my comments today illustrate to you that this issue is of importance to the Minnesota hospital community. Thank you for your consideration.

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**Hospitals**

- St. John's Hospital
- St. Joseph's Hospital
- Woodwinds Health Campus
- Bethesda Hospital

**Clinics**

- Family Practice
- Internal Medicine
- Pediatrics

**Medical Home Care**

- Home Care
- Hospice Care

**Outpatient Care**

- Urgent Care
- Digestive Care
- Pain Care
- Optimum Rehabilitation/Physical Therapy
- Radiology Care
- Surgery Centers
- Vascular Center

**Residencies**

**Residences and Care Centers**

- Assisted Living
- Skilled Nursing
- Memory Care
- Adult Day Care

**Special Services and Education**

- Behavioral Care
- Breast Care Center
- Cancer Care
- Diabetes Care
- Heart Care
- Orthopaedic Care
- Sleep Care
- Medical Laboratory

**Transportation/Ambulances**

**Foundation**

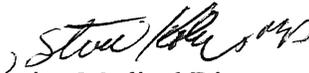


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DATE: March 8, 2006

TO: Members of the Senate Health Committee

FROM: Steve Kolar, FACP,   
Vice President, Executive Medical Director

RE: S.F. 2532—Radiation Oncology

On behalf of the HealthEast Care System, I am writing in support of S.F. 2532. HealthEast hospitals and clinic staff are committed to providing high quality, compassionate, affordable health care. On a daily basis, we balance the need to meet the needs of all our patients in this very competitive and volatile health care climate.

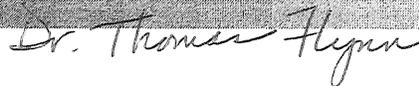
Coordinating the construction of new radiation/oncology facilities with hospitals makes sense. Eliminating the duplication of services, equipment and personnel, maximizes the use of this continually emerging and expensive technology, which will ultimately reduce the costs to patient without comprising quality. In addition, this collaborative model allows hospitals and providers to offer the full range of both inpatient and outpatient services, care coordination, patient education, and patients support services. While these so called "soft services" are critical to patients, payers do not reimburse them, therefore as a nonprofit hospital, it allows us to spread the revenue from this technology to offset the cost of these critical individual patient services.

Market forces that currently exist will continue to provide competition, while minimizing the financial incentives that may not be in the best interest of patients. This is one small step in reforming the health care system—as it forces hospitals and providers to work together on behalf of patients to provide the technology and services they're demanding, while we begin to sort out the inequities and negative financial incentives in our current reimbursement system at both the state and federal level across the entire health care delivery system.

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## Cancer Patient Survival Improvement Is Correlated With the Opening of a Community Cancer Center: Comparisons With Intramural and Extramural Benchmarks

Robert O. Dillman, MD, and Sherri D. Chico, CTR

Hoag Cancer Center, Newport Beach, California

### Abstract

**Purpose:** We sought to determine whether survival of patients managed at a large community hospital improved after an affiliated facility opened and its associated programs were initiated.

**Methods:** Survival data for patients with invasive cancer was obtained from the Hoag Hospital tumor registry for the successive periods 1986-1991 and for 1992-1999 for historical intramural comparisons; national Surveillance, Epidemiology, and End Results (SEER) program data for the same periods were used for contemporary and historical extramural comparisons.

**Results:** We observed survival improved significantly during 1992-1999 compared with 1986-1991 for all patients with invasive cancers ( $P < .0001$ ), and specifically for cancers of the breast ( $P = .026$ ), lung ( $P = .012$ ), prostate ( $P < .0001$ ), stomach ( $P = .006$ ), pancreas ( $P = .0001$ ), and oral cavity ( $P = .024$ ), with strong trends for improved survival for leukemia ( $P = .051$ ) and rectal cancer ( $P = .063$ ). Relative 5-year survival rates increased

from 63% during 1986-1991 to 71% during 1992-1999, and were higher for 22 of 24 tumor types during the more recent period ( $P < .0001$ ). Compared with SEER data, Hoag relative survival for all patients with invasive cancer was 63% versus 58% during 1986-1991, and 71% versus 64% during 1992-1999. Survival for Hoag patients was better than SEER rates for only 50% of malignancies (12 of 24) during 1986-1991 compared with 87% (21 of 24) during 1992-1999 ( $P = .013$ ). In the most common tumor types, there were substantial improvements in survival for patients with regional disease at diagnosis. Improved survival was associated with earlier diagnosis and increased use of systemic treatment and combined modality therapy.

**Conclusion:** Patients with invasive cancer who were treated at an integrated community cancer center had better survival compared with historical survival and patients from the SEER registry. The findings are consistent with the hypothesis that the accelerated dissemination of new information resulted in earlier adoption of improved screening, diagnostic, and multidisciplinary treatment approaches, leading to higher survival rates.

### Introduction

Little objective evidence supports the premise that cancer centers are associated with better patient outcomes. Phrases used to define cancer centers include "multidisciplinary group of research scientists and/or physicians," "unity of purpose," "share concepts, facilities, and other resources," "organizational structure,"<sup>1</sup> "organization of diverse and complementary specialists who work on the cancer problem together," "sufficient central authority to focus efforts and organize resources," and "patient care and/or research."<sup>2</sup> Most early cancer centers were organized around basic and animal research because of limited treatment options.<sup>3</sup> The concepts of comprehensive cancer centers and clinical cancer centers, to facilitate and centralize patient care, education, and research, evolved after passage of the National Cancer Act in 1971. Large federal construction grants and core grants were administered by the National Cancer Institute (NCI).<sup>4,5</sup> Most NCI-designated and -funded cancer centers are involved in patient care, education, and research, but emphasis varies depending on mission and funding. Many community hospitals have created cancer centers that focus on patient care, since few have a mission for laboratory-based research or education.<sup>2,6</sup> In as much as the vast majority of cancer care is delivered in the community by private practitioners, centers in this setting might enhance education and communication opportunities to accelerate transmission of new in-

formation and facilitate multidisciplinary management and treatment decisions.

We wished to determine whether the existence of our community hospital-based programs were associated with improvements in survival rates for patients with invasive cancer. The impetus for this study derived from questions regarding whether the investment in money, space, and operations for the center had been associated with improved survival for patients diagnosed with invasive cancer. We chose survival as an indicator of overall quality of cancer management, because it is influenced by early detection procedures, cancer-directed treatment by various cancer specialists, and medical management of comorbid medical conditions by practitioners. The date of diagnosis of invasive cancer can be ascertained from pathology reports and tumor registry abstracts, and date of death is a well-documented vital statistic. One measure of quality improvement is survival outcome compared with an earlier era, but historical comparisons can be misleading because of changes in patient populations. Because of limitations associated with historical populations, we also compared our observations to contemporary populations, which necessitated comparisons to external data. To determine whether the existence of our center was associated with improved outcomes, we measured survival rates for patients with invasive cancer for the time periods immediately preceding and following opening of

the center, and made comparisons with intramural and extramural benchmarks.

## Methods

### Institution and Cancer Program

Hoag Cancer Center is both a facility and program of Hoag Hospital, a 400-bed, not-for-profit hospital, located in the coastal community of Newport Beach, in Orange County, California, which is bounded by the counties of Los Angeles to the north, San Diego to the south, Riverside to the east, and the Pacific ocean to the west. Hoag Hospital has a primary service area that includes about 1 million people living within a 10- to 20-mile radius. The hospital does not offer training for medical house staff. In the mid 1980s, hospital leadership decided to pursue oncology as a "center of excellence" for the treatment of adult patients with cancer. After successful fund-raising efforts, in late 1990 a 65,000 square foot structure, the Patty and George Hoag Cancer Center, was constructed with a tunnel connecting it to the main hospital. A medical director was recruited from outside the institution for a full-time position that included oversight of clinical quality of cancer care, oncology education, laboratory and clinical cancer research and administrative responsibilities. An administrative director with oncology experience was also recruited from outside the institution and she assembled a staff for various programs. Since the opening of the center in the winter of 1991, the annual numbers of new patients accessioned into the tumor registry has been among the highest in southern California, with an annual growth rate of 4.4% per year, and between 2,100 and 2,200 patients per year in recent years.

From 1992 to 1999, the Patty and George Hoag Cancer Center facility was a three-story building that included three linear accelerators and other radiation oncology equipment, examining rooms, and offices on the first floor. An outpatient treatment center, administrative offices, patient resource library, blood donor/pheresis center, and a multipurpose conference room occupied the second floor. Medical oncology physician offices and a 4,000-square-foot cell biology laboratory were on the third floor. Specific program changes to enhance patient care included establishing an inpatient oncology unit in the hospital, opening a cancer outpatient treatment center, facilitating advanced treatment programs including high-dose interleukin-2 therapy, high-dose chemotherapy with autologous hematopoietic stem cell rescue, intrahepatic chemoembolization, acquisition of state-of-the-art radiation therapy equipment, developing programs for cancer prevention, early detection, and hereditary cancer, and extensive patient support programs including physical fitness and psychosocial support programs. External-beam adapted stereotactic radiosurgery was introduced in 1994. Gamma knife therapy, prostate radioactive seed implant therapy, and sentinel lymph node staging were all introduced in 1997. For educational purposes, weekly mid-day oncology education conferences, weekly morning multidisciplinary tumor board case conferences, and a monthly edu-

cational newsletter with state-of-the art reviews on specific cancers or treatment modalities were initiated to facilitate dissemination of cancer information and to facilitate collegial interaction. The existing clinical trials program was expanded to include cooperative group trials supported by the NCI, clinical trials of promising new agents sponsored by pharmaceutical companies, and trials regulated by the U.S. Food and Drug Administration, which utilized patient-specific products developed in the local cell biology laboratory. Products developed in the cell biology laboratory have included various types of autologous lymphocyte therapy,<sup>7-9</sup> and autologous tumor cell vaccines.<sup>10-13</sup> The laboratory has also been responsible for processing and cryopreservation of autologous hematopoietic stem cells for an autologous transplant program.<sup>14</sup>

### Historical Intramural Survival Benchmarks and Therapy

We used adjacent time periods, 1986-1991 and 1992-1999, before and after the opening of Hoag Cancer Center, for intramural survival comparisons. Those specific years were chosen because the center opened during 1991, and those were the same intervals used by the NCI's Surveillance, Epidemiology, and End Results (SEER) program in recent reports.<sup>15,16</sup> The analysis focused on patients with invasive cancer. Per SEER methodology, basal cell and squamous cell carcinomas of the skin, and in situ carcinomas were excluded, except for in situ bladder cancer. Data for Hoag cancer patients was compiled from the Hoag tumor registry, which included follow-up clinical information during 2004 on more than 90% of patients in the registry dating back to 1980. Analyses were limited to "analytical cases" (i.e., patients who were diagnosed at the institution and/or who received cancer therapy at the institution within 4 months of diagnosis). Registry data included the following general treatment classifications: none, surgery, radiation therapy; chemotherapy; hormonal therapy; and biologic response modifiers (BRMs) such as interferon- $\alpha$ , interleukin-2, Bacille-Calmette-Guerin (BCG), tumor vaccines, and cell therapies.

### Contemporary Extramural Survival Benchmarks

Because of eligibility restrictions in clinical trials and changing definitions of tumor stage, most medical publications are not useful for survival comparisons to the general population of cancer patients. Similarly, survival data from large referral centers can be misleading because patients who travel to such centers are not representative of the general population, and the make up of such populations may change over time because of reputation, or because of specific high-volume clinical trial programs. Data from the SEER program was selected for external benchmark comparisons because of consistency of stage definitions over time, the size and diversity of patients sampled, and the annual publication of survival data. Comparisons between Hoag and SEER relative survival figures were made for both of the two consecutive periods, 1986-1991 and 1992-1999. Historically, SEER data have been derived from a sample of about 10% of the cancer population, which did not include patients

**Table 1. Characteristics of Hoag cancer patients diagnosed with invasive cancer\* during 1986-1991 (n = 5,487) and 1992-1999 (n = 10,548)**

Category	1986-1991	1992-1999	P
% White	97.2	95.8	< .0001
% Asian	1.9	3.0	.0001
% African American	.38	.36	.171
% female	52.7	52.8	.603
Median age, years	65.0	65.8	—
Mean age, years	62.3	63.4	.928
% < age 20 years	0.49	0.39	.171
% ≥ age 90 years	0.74	1.4	.0009
% local	45.3	50.8	< .0001
% regional	24.4	21.8	.0004
% distant	22.7	21.8	.190
% unknown general stage	7.6	5.4	< .0001
% diagnosed and treated at Hoag	81.2	84.0	< .0001
% diagnosed elsewhere, treated at Hoag	17.1	14.7	.0001
% diagnosed at Hoag, treated elsewhere	1.7	1.3	.032
% diagnosed by histopathology	93.1	91.2	.0001
% diagnosed by cytology only	5.0	6.3	.002

\* Includes tumors classified as "unknown stage"; excludes "in situ" except for bladder.

from Orange County, California. Because the proportion of African American patients at Hoag was less than 1% in both periods, comparisons were limited to the white population in the SEER data.

### Statistical Considerations

For the Hoag patient populations in the two successive periods, estimates of observed survival were generated by the method of Kaplan and Meier and compared for significance using the two-tailed unadjusted log-rank test.<sup>18</sup> The methodology used by SEER was adopted for comparisons to the SEER data; so, for those analyses survival data is reported as relative survival, the ratio of observed survival for cancer patients to the expected survival for the general population with adjustments for competing causes of mortality based on age, race, and sex.<sup>19</sup> Relative 5-year survival rates were calculated using the SEER methodology with a computer software program designed specifically for this purpose (Electronic Registry Systems, Inc., Cincinnati, Ohio). Fisher's exact test was used for comparisons of proportions using two-tailed tests of probability. The two-tailed *t* test for paired samples was used to compare relative 5-year survivals for the 24 different tumor types.

For the most prevalent cancers (lung, breast, colorectal, and prostate) subset comparisons were also made by stage. The staging systems of the American Joint Committee on Cancer (AJCC) have continually evolved; so they were not useful for these comparisons, and would have required retrospective efforts to redefine stage.<sup>20</sup> Instead, comparisons were made using the general staging classifications defined by SEER, because they have utilized consistent definitions of local, regional, and distant metastatic disease stages, enabling comparisons between different eras.

## Results

### Characterization of Cancer Patients

During 1986-1991, the Hoag tumor registry accessioned 6,301 new diagnoses of cancer, 5,487 invasive (including 60 in situ bladder) and 814 in situ. Comparable figures for 1992-1999 were 11,803 new diagnoses of cancer, 10,548 invasive (including 223 in situ bladder) and 1,255 in situ malignancies. The proportions of nonbladder in situ cases in the successive eras decreased from 12.9% to 10.6%, respectively (*P* < .0001).

The characteristics of Hoag patients with invasive cancer (including in situ bladder) diagnosed during 1986-1991 and 1992-1999 are summarized in Table 1. There was a decline in numbers of patients classified as white, associated with an increase in patients classified as Asian. A similar majority of patients were female in both eras. During 1992-1999 there were higher proportions of patients ≥ 90 years of age, an increase

**Table 2. Initial treatment for Hoag patients with invasive cancer (including in situ bladder) diagnosed 1986-1991 (n = 5487) and 1992-1999 (n = 10,548). Data shown are percentages of patients receiving such therapy**

Treatment	1986-1991	1992-1999	P
Surgery only	36.9	31.0	< .0001
Surgery + radiation therapy	9.0	8.3	.095
Radiation therapy only	8.5	7.0	.003
Systemic therapy only*	8.6	9.5	.082
Surgery + systemic therapy	9.3	10.8	.003
Radiation + systemic therapy	8.6	9.9	.004
Surgery, radiation & systemic therapy	6.7	11.9	.0008
Received a biologic therapy	1.7	6.7	< .0001
Received any systemic therapy	24.6	42.1	< .0001
No anticancer therapy	10.4	11.6	.019

\* Chemotherapy, hormonal therapy, biologic response modifier.

in the proportion of patients with local disease at diagnosis, and an increase in the proportion diagnosed and treated at Hoag.

### Treatment of Invasive Cancer

Initial treatment for Hoag cancer patients in the two periods is summarized in Table 2. There was a statistically significant increase in the use of systemic treatment in combination with other therapies, and in the use of biologic response modifiers alone or in combination with other therapy. The proportion of patients receiving systemic therapy nearly doubled. There was also an increase in the proportion of patients receiving no therapy. There were decreases in the use of local therapeutic modalities (surgery and/or radiation therapy) alone without systemic treatment.

### Survival Comparisons With Intramural and Extramural Benchmarks

Table 3 shows the number of patients and observed 5-year survival rates and median survivals for Hoag patients diagnosed during 1986-1991 compared with 1992-1999. Median follow-up was more than 5 years in both groups. As shown in Figure 1, for all patients, actuarial 5-year survival rates increased from 52% to 58% and median survival increased by more than 2 years from 70 to 96 months ( $P < .0001$ ). For individual cancer types, there was significant improvement in survival for cancers of the breast ( $P = .026$ ), lung ( $P = .012$ ), prostate ( $P < .0001$ ), stomach ( $P = .006$ ), pancreas ( $P = .0001$ ), and oral cavity ( $P = .024$ ), with strong trends for improved survival for leukemia ( $P = .051$ ), and rectal cancer ( $P = .063$ ). There were no tumor types for which there was a statistically significant decrease in survival over time.

**Table 3. Observed 5-year survival rates by Kaplan-Meier estimate for cancer patients at Hoag Hospital during 1986-1991 vs. 1992-1999**

Tumor Type	No. of Hoag Patients		Hoag 5-Year Survival (%)		Hoag Median Survival (months)		Log-Rank Test
	1986-1991	1992-1999	1986-1991	1992-1999	1986-1991	1992-1999	P
Breast	917	1986	79	84	NR	NR	.026
Colon	430	573	51	53	65	71	.575
Rectal	147	211	55	65	74	107	.063
Esophagus	46	77	2	12	11	11	.430
Liver	27	60	4	12	5	4	.184
Melanoma	228	362	78	79	NR	NR	.984
Pancreas	137	202	1	5	6	6	.0001
Stomach	62	130	12	23	9	18	.006
Thyroid	49	133	90	93	NR	NR	.303
Cervix	150	183	66	68	NR	NR	.849
Uterus	198	297	78	75	NR	NR	.497
Ovary	191	270	39	49	36	57	.276
Bladder	203	389	64	64	103	101	.453
Kidney	104	185	54	55	89	91	.646
Prostate	702	1539	73	85	NR	NR	< .0001
Testis	68	100	88	95	NR	NR	.308
Lung	807	1455	16	19	11	13	.012
Larynx	44	75	68	67	107	110	.944
Oral cavity	151	213	49	59	54	98	.024
Brain	127	267	25	22	13	13	.682
Hodgkin's	47	73	90	80	NR	NR	.849
Leukemia	97	373	24	34	13	16	.051
Lymphoma	210	453	54	54	71	72	.912
Myeloma	23	108	30	28	34	32	.834
All patients	5,487*	10,548*	52	58	70	96	< .0001

\* Excludes in situ cancer, except for bladder cancer; includes unknown stage at diagnosis, and other less common tumor types that are not listed in the table; so columns do not add up to the numbers on the bottom line.  
NR, not reached.

**Figure 1. Observed survival for Hoag patients with invasive cancer for 1986-1991 vs. 1992-1999. For 1986-1999, n = 5,487, median age 65.0 years, mean age 62.3 years, 60% deceased. For 1992-1999, n = 10,548, median age 65.8 years, mean age 63.4 years, 47% deceased**

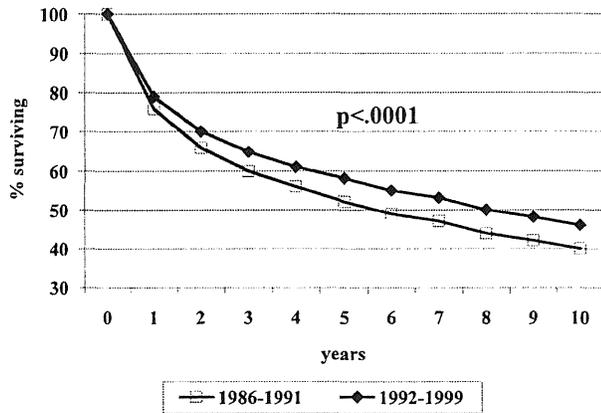


Table 4 shows the number of patients and relative 5-year survival rates for Hoag patients for 1986-1991 and 1992-1999, and relative 5-year survival rates for white patients from SEER data for those periods. For the Hoag cancer patient populations, differences in survival between the two eras by tumor type are shown in Figure 2. There was an eight-percentage-point increase in the relative 5-year survival rate from 63% to 71% for Hoag patients between eras. During the more recent era, the 5-year relative survival rates for Hoag patients were higher for 22 of the 24 specific cancer types ( $P < .0001$ , paired  $t$  test). The national SEER data during these two time periods also showed an six-percentage-point improvement in relative 5-year survival from 58% to 64%, and survival also was higher for 22 of 24 tumor types ( $P = .0001$ , paired  $t$  test).

Differences in survival for Hoag compared with contemporary SEER data are shown in Figure 3 for 1986-1991 and for 1992-1999. During the pre-cancer center era, relative survival rates for Hoag patients were the same as or higher than SEER in only 12 (50%) of 24 malignancies compared with 21 (87%) of 24 after opening of the cancer center ( $P = .013$ , Fisher's exact test). The relative 5-year survival rates for the 24 different tumor types did not differ significantly between the SEER and Hoag populations during 1986-1991 ( $P = .85$ ), but during 1992-1999 the relative 5-year survival rates for the 24 different tumor types were higher in the Hoag population compared with the SEER population ( $P = .001$ , Fisher's exact test).

As shown in Figure 4, compared with 1986-1991, the difference in relative survival percentages (Hoag minus SEER) increased or stayed the same for 19 of 24 tumor types during 1992-1999 ( $P = .010$ , Fisher's exact test). The differences in prostate cancer were scored as 0 because Hoag relative 5-year survival was already 100% during 1986-1991. Thus, the rate of improvement in proportions of patients with a relative survival of at least 5 years, by individual tumor type, was faster for the Hoag cancer patients than nationally.

### Specific Tumor Stage Subset Comparisons

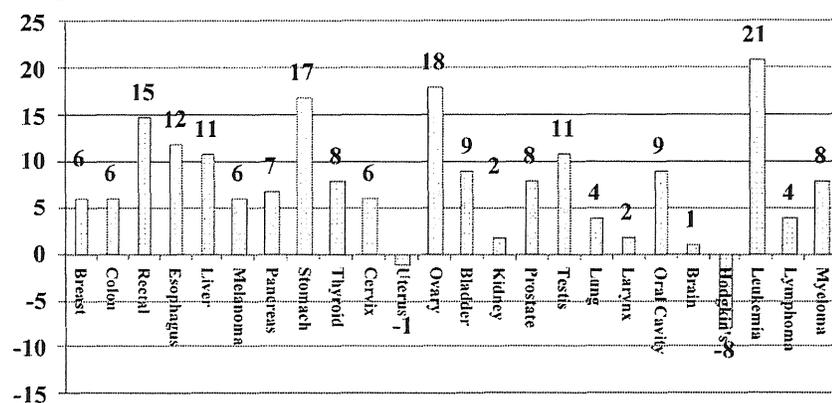
Table 5 shows the results for subset analyses that were carried out for the cancers for which there were more than 500 Hoag patients in both eras: lung, breast, colorectal, and prostate. In the intramural historical comparisons of proportions, in lung cancer during 1992-1999, more patients had local disease ( $P = .002$ ) and fewer regional disease ( $P = .026$ ) at the time of diagnosis. The proportion of lung cancer patients with a relative survival of more than 5 years increased ( $P = .032$ ), although none of the differences by stage in the proportion with relative survival of 5 years was statistically significant. In breast cancer,

**Table 4. Relative 5-year survival rates for patients with invasive cancer: Hoag and national SEER data for different time periods**

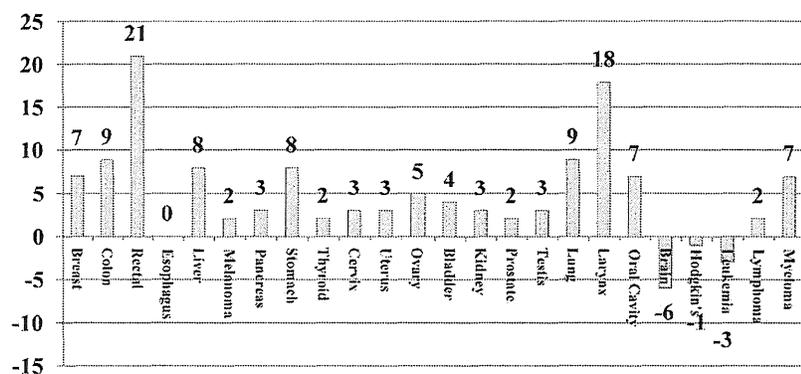
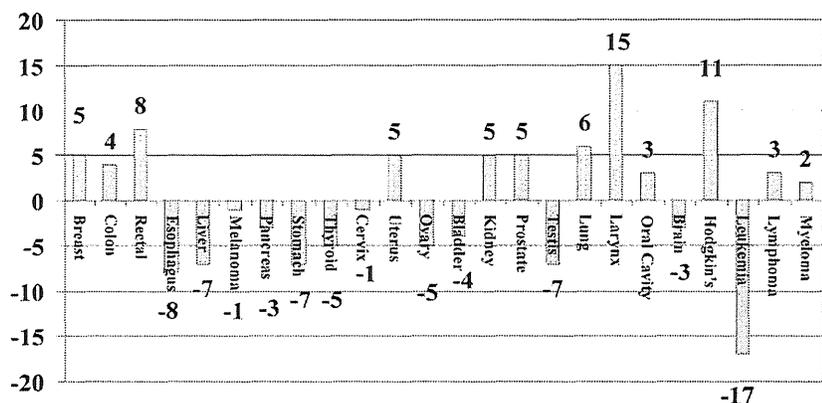
	Hoag Relative 5-Year Survival (%)	SEER Relative 5-Year Survival (%)	Hoag Relative 5-year Survival (%)	SEER Relative 5-Year Survival (%)
	1986-1991	1986-1991	1992-1999	1992-1999
Breast	89	84	95	88
Colon	66	62	72	63
Rectal	68	60	83	62
Esophagus	3	11	15	15
Liver	4	11	15	7
Melanoma	86	87	92	90
Pancreas	0	3	7	4
Stomach	12	19	29	21
Thyroid	90	95	98	96
Cervix	70	71	76	73
Uterus	90	85	89	86
Ovary	39	44	57	52
Bladder	78	82	87	83
Kidney	64	59	66	63
Prostate	92	87	100	98
Testis	88	95	99	96
Lung	20	14	24	15
Larynx	83	68	85	67
Oral cavity	58	55	67	60
Brain	25	28	26	32
Hodgkin's	92	81	84	85
Leukemia	24	41	45	48
Lymphoma	55	52	59	57
Myeloma	30	28	38	31
All patients	63	58	71	64

\* Excludes in situ cancer, except for bladder cancer; includes unknown stage at diagnosis, and other less common tumor types that are not listed in the table; so columns do not add up to the numbers on the bottom line.

**Figure 2. Percentage point differences in relative 5-year survival rates for Hoag cancer patients diagnosed during 1986-1991 vs. 1992-1999**



**Figure 3. Percentage point differences in relative 5-year survival rates for Hoag vs. SEER 1986-1991 (top) and 1992-1999 (bottom)**



there were no differences in stage distribution, but during 1992-1999, there was a higher proportion of patients with relative survival of more than 5 years for the group as a whole ( $P = .003$ ), and for subsets of patients with local ( $P = .002$ ) and regional ( $P = .006$ ) extent of disease. In prostate cancer there was an increase in the proportion of patients with local and regional disease ( $P < .0001$ ), a decrease in the proportion with distant metastases at diagnosis, and an increase in the proportion of patients with regional disease who had a 5-year relative

survival, and for all prostate cancer patients as a group ( $P < .0001$ ). In colorectal cancer, during 1992-1999 there were no significant changes in stage distribution, but there was an increased proportion of patients with 5-year relative survival for local ( $P < .0001$ ) and regional stages of disease ( $P = .020$ ), and for all patients collectively ( $P < .0001$ ).

In the extramural contemporary comparisons of proportions (data not shown), in lung cancer there were higher proportions of Hoag patients with local and distant disease, but a lower proportion with regional disease (all  $P < .0001$ ), while Hoag patients had a higher proportion surviving 5 years in all stages of disease: local ( $P < .0001$ ), regional ( $P = .015$ ), and distant ( $P < .0001$ ). In breast cancer there was no significant difference in proportions in various stages of disease, but Hoag patients had a higher proportion surviving 5 years for local and regional stages of disease (both  $P < .0001$ ). In prostate cancer Hoag had a higher proportion with local/regional disease ( $P < .0001$ ), but the survival differences in the subsets did not differ significantly. In colorectal cancer, a higher proportion of Hoag patients had regional disease at diagnosis ( $P = .011$ ), and a higher proportion survived more than 5 years in each subset: local ( $P < .0001$ ), regional ( $P < .0001$ ), and distant ( $P = .016$ ).

## Discussion

### Summary of Results

This study shows that the creation of a community hospital-based cancer center and its programs was associated with improvement in patient outcome, as measured by intramural comparisons of observed and relative 5-year survival rates for cancer patients diagnosed and/or managed at the center during 1992-1999 as compared with 1986-1991. Furthermore, survival rates were higher for the center's patients compared with a contemporary external comparator group, and the changes in

relative survival between the two periods were more pronounced for the center's patients than the survivor improvement observed nationally.

### Impact of Earlier Diagnosis and Systemic Therapy

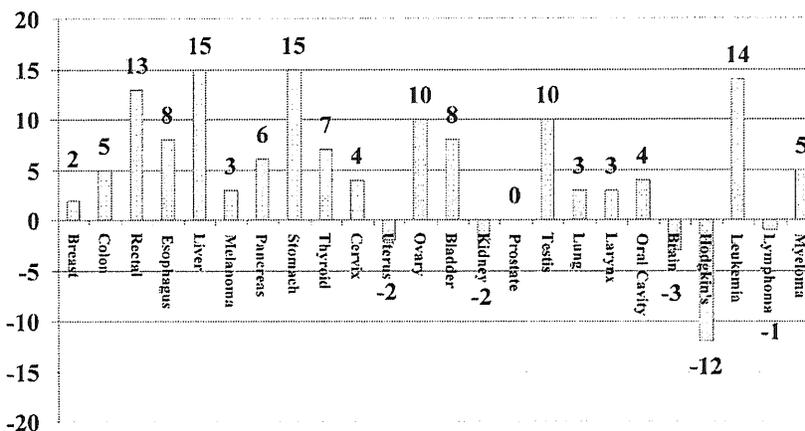
On the basis of the treatment changes identified in Table 2, and subset analyses in the most prevalent cancers, the improved survival appears to be due to a combination of detection of

disease during localized stage in a higher proportion of patients, increased application of multimodality approaches to regionally advanced cancer, and systemic therapy in patients with distant metastases. Earlier diagnosis due to increased use of screening procedures for cancers of the breast, prostate, and lung likely resulted in patients' having more limited local disease than in the earlier era, so that surgery alone had a greater chance of being potentially curative. In addition, there was improved survival in more advanced stages of disease in association with greater use of systemic therapy. Analysis of national survival data has also suggested that improved survival nationally has been due to a combination of both earlier diagnosis and more effective therapeutic interventions.<sup>21</sup>

### Limitations of This Study

The major limitation of this study is the lack of certainty regarding the comparability of the center's patient populations in the two periods of observation. Unfortunately, there is insufficient information available in these databases regarding prognostic variables other than those related to sex, age, race, and stage of disease. Some of the apparent improvement in survival is probably due to lead- and length-time bias. Lead-time bias may also account for the increased proportions of patients with

**Figure 4. Percentage point differences in relative 5-year survival rates for Hoag minus SEER for 1986-1991 compared to Hoag minus SEER for 1992-1999**



limited-stage disease for certain tumor types such as lung and prostate cancer. However, stage-to-stage comparisons showed improved survival for local and for regional breast cancer and for both local and regional colorectal cancer compared with the earlier period. There were corresponding trends toward increased survival in regionally advanced lung and prostate cancer.

### Importance of This Study

It has been estimated that 85% to 90% of cancer care in the United States is delivered in community settings.<sup>5</sup> One strength of this study is that it focuses on a community population of

**Table 5. Stage distribution and relative 5-year survival by stage for the four most prevalent malignancies for Hoag patients 1992-1999 compared to 1986-1991**

	% Stage 1986-1991	% Stage 1992-1999	P	% 5-Year Survival 1986-1991	% 5-Year Survival 1992-1999	P
<b>LUNG</b>	n = 807	n = 1,455		n = 807	n = 1,455	
Local	19	25	.002	61	60	.669
Regional	26	22	.026	20	23	.459
Distant	48	50	.365	5	6	.516
<b>BREAST</b>	n = 916	n = 1,987		n = 916	n = 1,987	
Local	65	66	.620	99	100	.002
Regional	28	29	.595	81	88	.006
Distant	5	4	.165	20	18	.620
<b>PROSTATE</b>	n = 702	n = 1,539		n = 702	n = 1,539	
Local	63	78	< .0001	100	100	1.00
Regional	19	12	< .0001	89	100	< .0001
Distant	9	3	< .0001	37	42	.480
<b>COLORECTAL</b>	n = 538	n = 931		n = 538	n = 931	
Local	31	36	.061	92	100	< .0001
Regional	46	42	.315	76	84	.020
Distant	20	19	.573	9	14	.303

Some cases were classified as "stage unknown," so percentages do not add up to 100%.

patients, most of whom receive their primary and cancer care through physicians on the medical staff at one hospital. This population has not experienced substantial changes in economic status, ethnic and racial mix, or age distribution during the 15 years covered in this analysis. Less than two percent of these patients were diagnosed at Hoag but went elsewhere for their primary cancer treatment, whereas more than 80% had their cancer diagnosed at Hoag and received their initial cancer treatment at Hoag. Our experience shows that a comprehensive community cancer center, with programs that enhance specialized patient care and promote and facilitate education, communication, and coordination of care among private practitioners, was associated with improved survival for cancer patients. Opening the Hoag Cancer Center facility was associated with both weekly multidisciplinary case conferences, as well as weekly oncology education programs. In addition, the physical proximity of offices for radiation and medical oncologists almost certainly facilitated communication among these specialists. We believe that Hoag Cancer Center outreach programs increased awareness of and compliance with cancer screening test recommendations in the lay population and also among primary care physicians.

In the last 20 years there have been many major advances in the management of cancer patients. First, there has been increased emphasis on early detection and acceptance of screening for various malignancies. Second, there have been tremendous improvements in diagnostic technology including mammography, computed tomography, magnetic resonance imaging, and photon emission tomography. These have contributed to earlier diagnosis, and more sensitive detection of regional and distant metastatic disease. Third, there has been increased acceptance of systemic therapy in general, and specifically in the adjuvant setting. The decade of the 1990s saw the emergence of biologic therapies, such as cytokines, including the hematopoietic growth factors and interleukin-2, and monoclonal antibodies, such as rituximab and trastuzumab, as important systemic modalities for the treatment of many cancer patients.<sup>22</sup> Existence of the Hoag Cancer Center likely accelerated adoption of many treatment advances and incorporation of new systemic agents into treatment regimens. We do not have specific data regarding which programs were most important in effecting these changes in practice, but it seems likely that changes did take place, at least in part, because of the transmission of new information in multidisciplinary case conferences and education programs, and the communication of survival outcomes and patterns of practice to the medical staff of Hoag Hospital. The improved survival associated with existence of Hoag Cancer Center may provide added impetus for other hospitals and communities to invest in creation of such physical facilities and comprehensive cancer programs.

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### Authors' Disclosure of Potential Conflicts of Interest

The following authors or their immediate family members have indicated a financial interest. No conflict of interest exists for drugs or devices used in a study if they are not being evaluated as part of the investigation. Employment relationship: Robert O. Dillman, Sherri D. Chico, Hoag Cancer Center.

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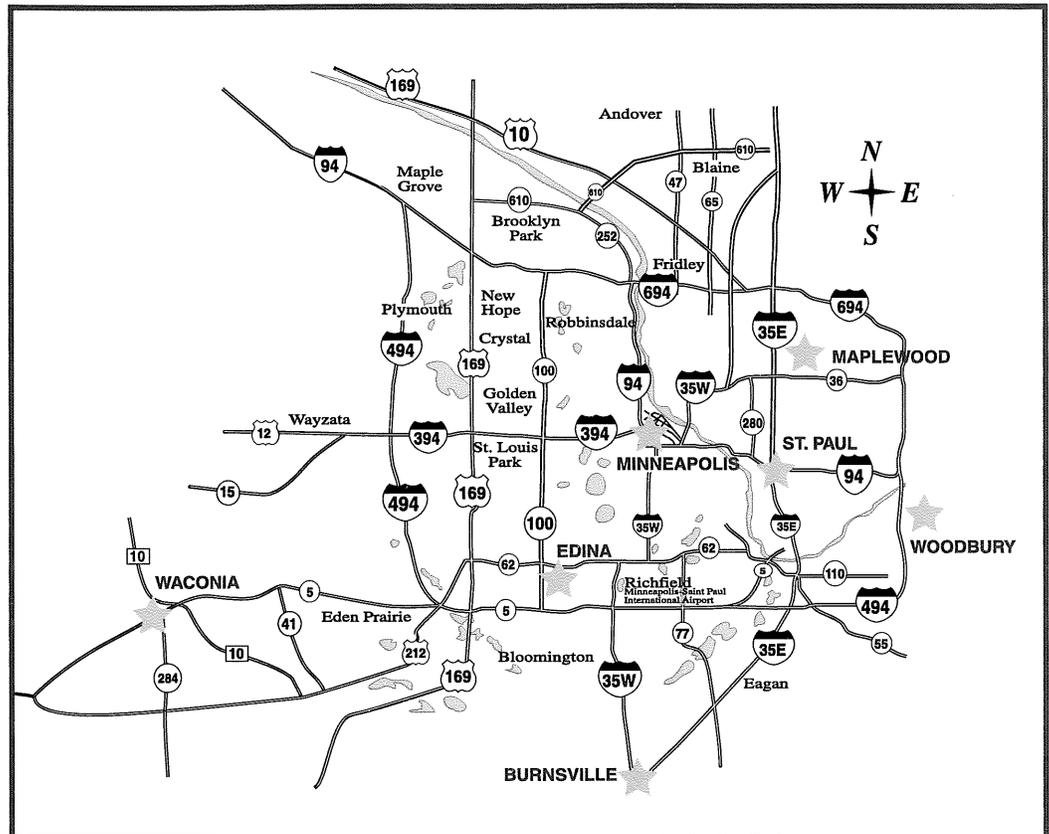
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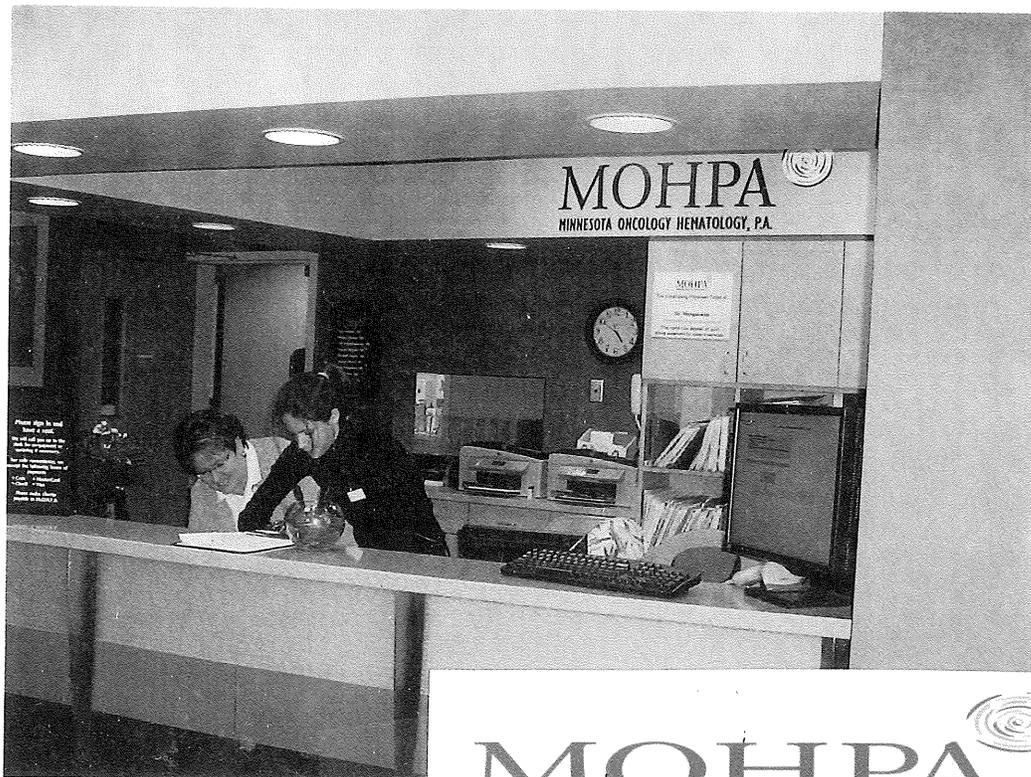
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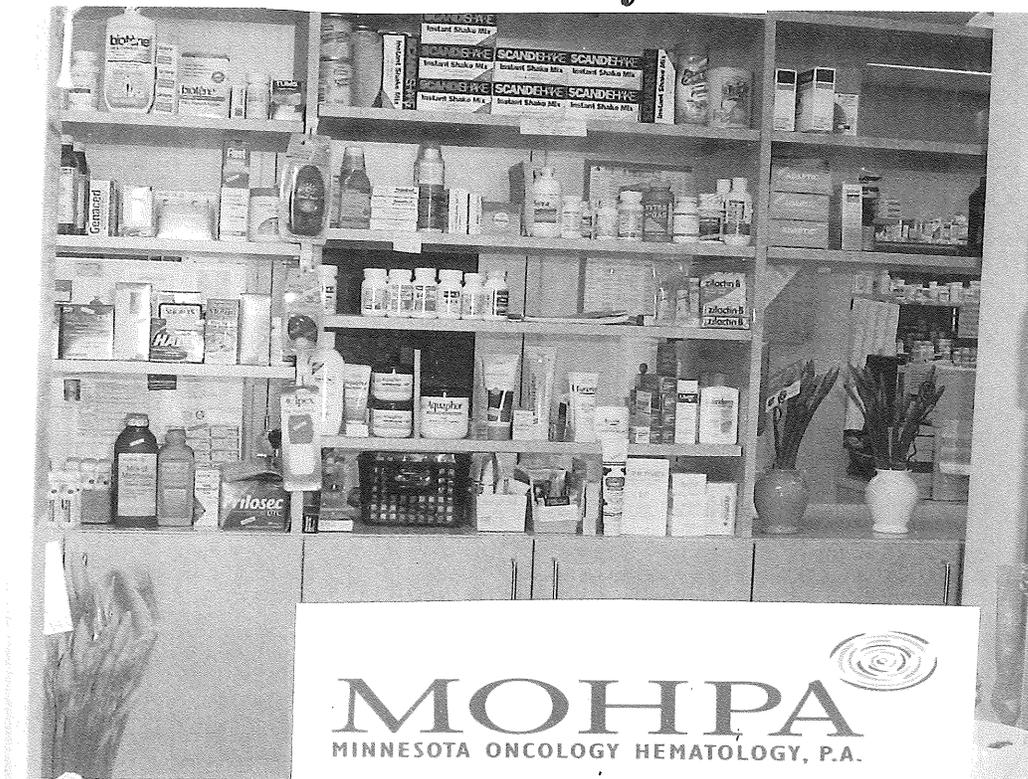


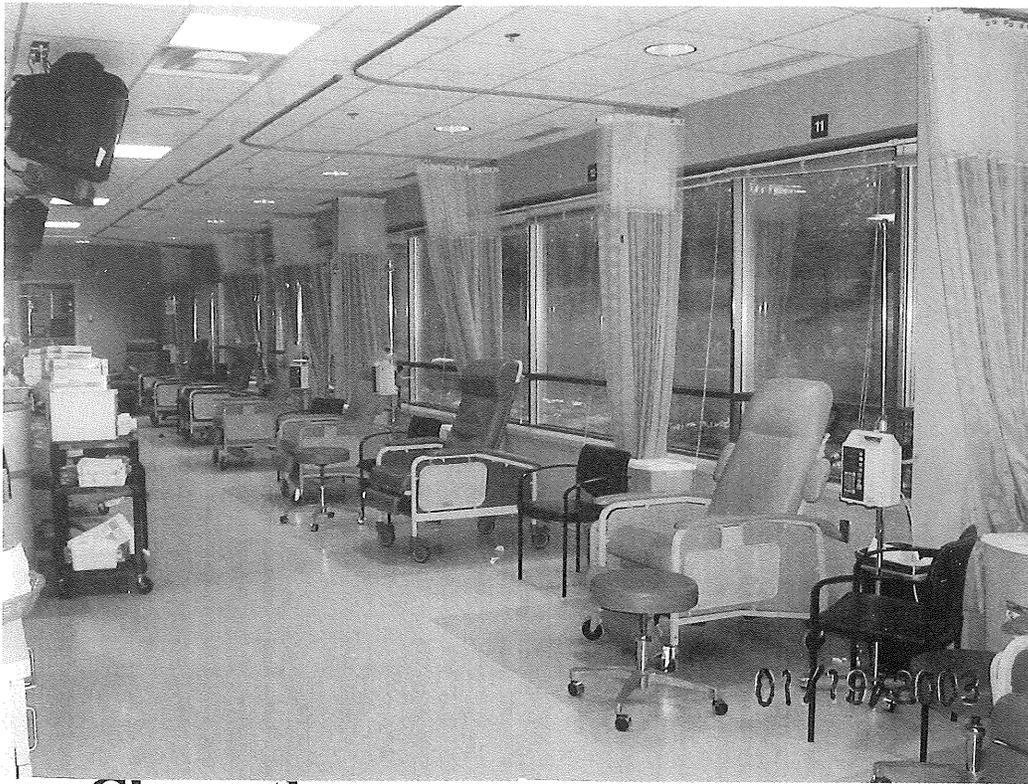
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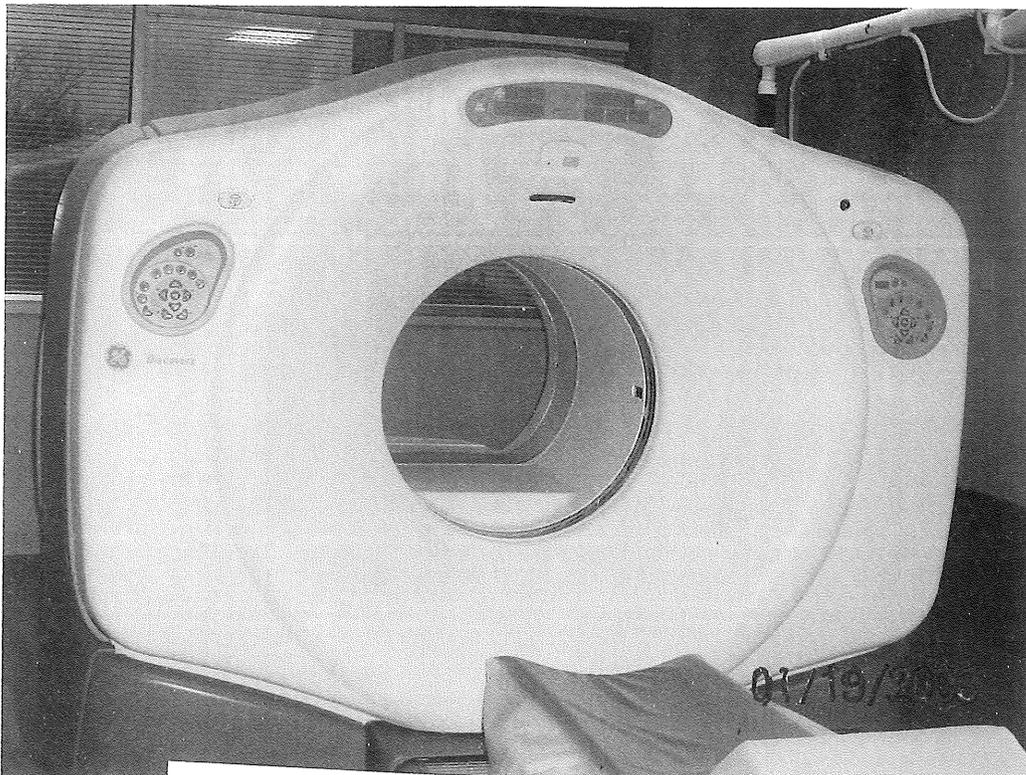
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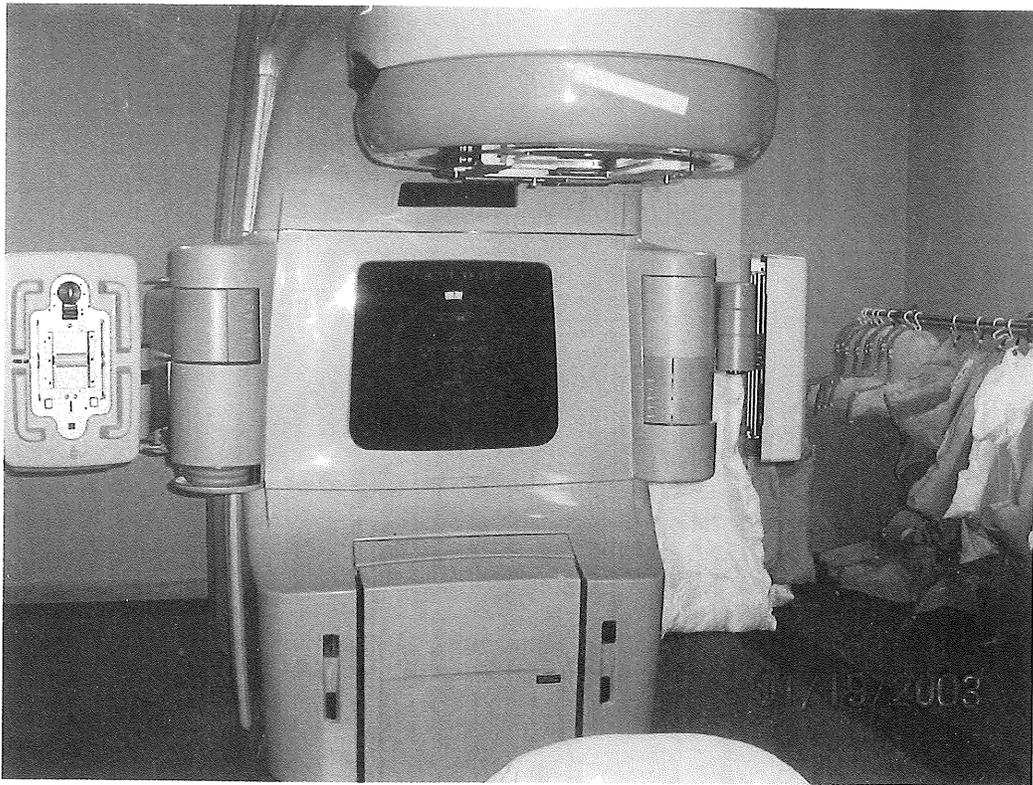




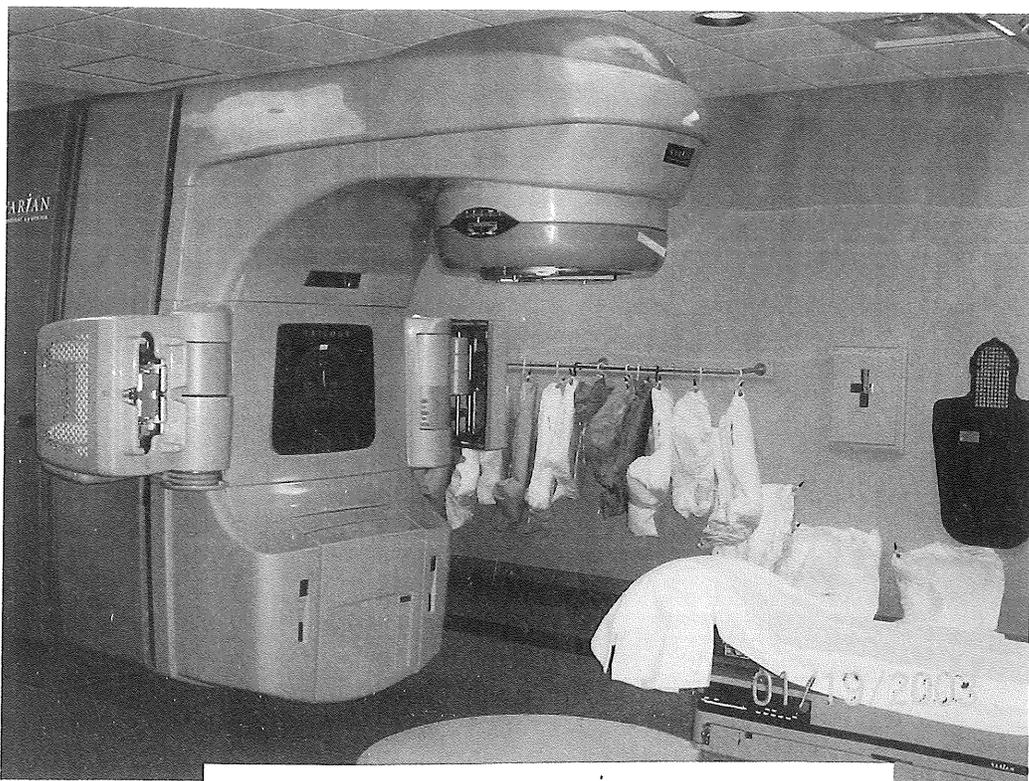
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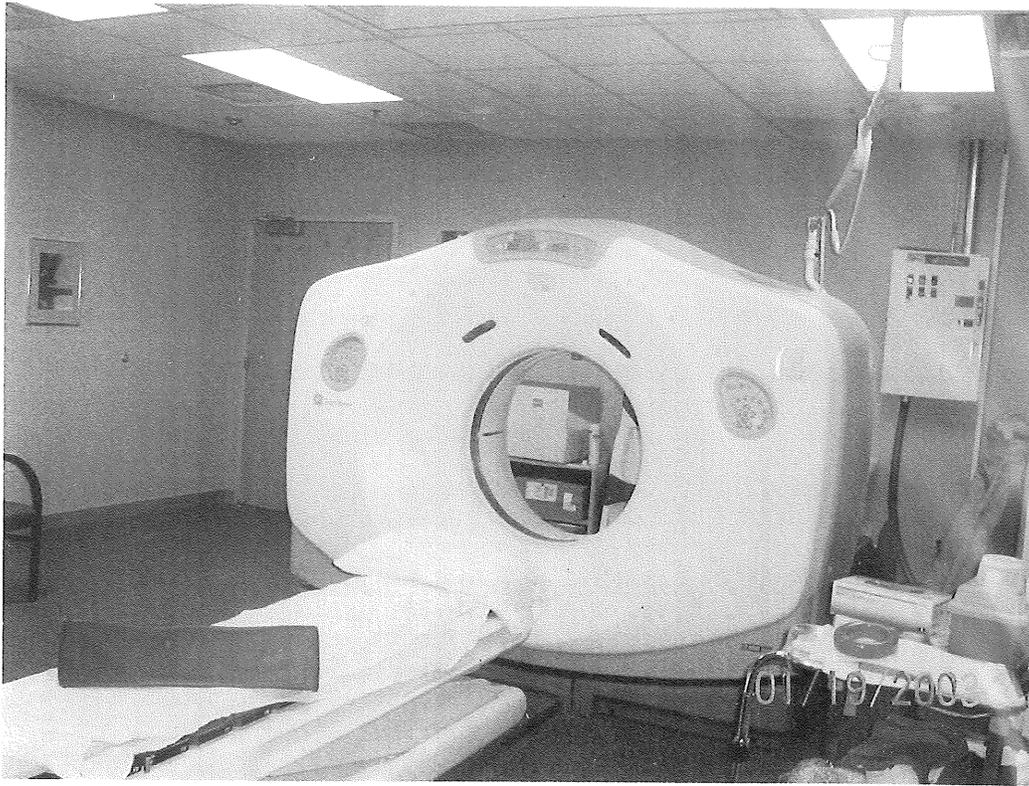
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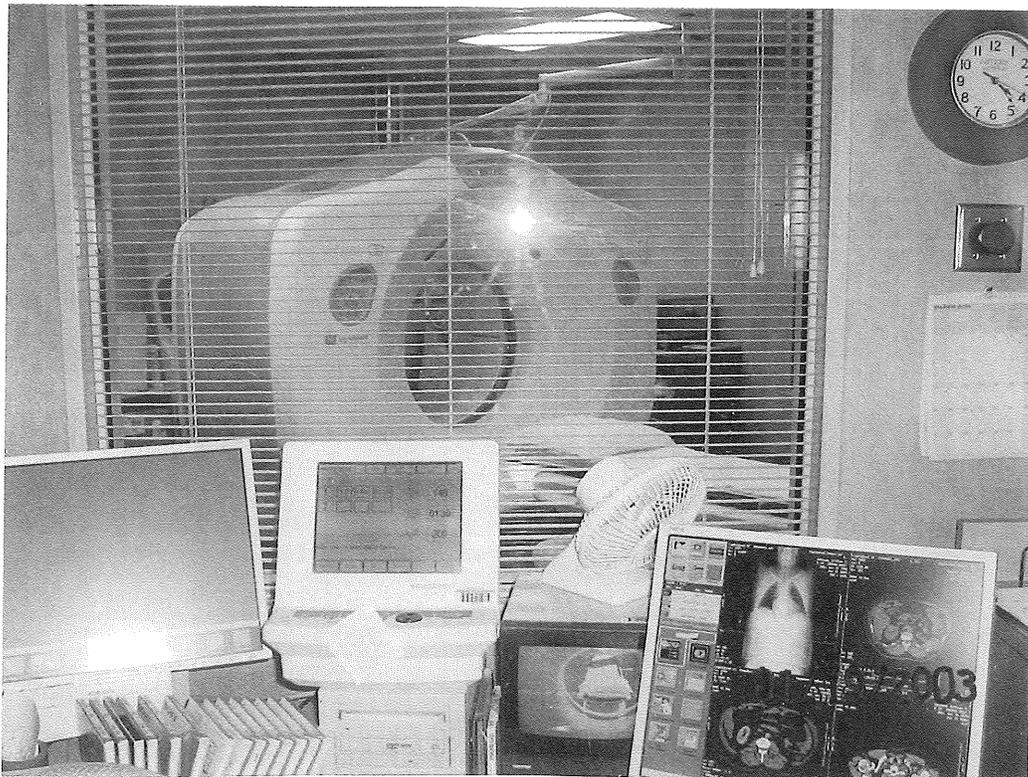


**Varian Trilogy**





**CT Scanner**





March 9, 2006

Members of the Senate Health and Family Security Committee,

The Minnesota Medical Association (MMA) representing more than 10,000 physicians, medical residents, and medical students throughout the state, urges you to oppose S.F. 2532, which would make the of current limitations on radiation therapy facility construction permanent, thus maintaining the requirement that a radiation facility may be constructed only by an entity owned, operated or in partnership with a hospital.

Like many of you, the MMA has watched with some concern the growth and expansion of health care facilities, particularly in the Twin Cities metropolitan area. Based on these trends, the MMA has examined both state policy and our own internal policies regarding health care facility development.

To help provide a more rational means by which the MMA can consider changes in health care supply, we have developed 18 principles to guide our analysis.

I would like to highlight a few of the MMA-developed principles that led to the MMA's opposition of SF 2532. The first, overriding principle states, "The principal driving force behind health care facility development should be the health of Minnesotans/members of the community." Any facility expansion, whether initiated by physicians, hospitals, or other facilities, should have at its core the interests of the members of the community.

Another principle states, "State public policy should encourage, not stifle, innovation in health care delivery." Absent a fundamental change in public policy, the health care system still relies on some basic competitive features to drive advancements and innovation. Many procedures that today are routinely performed in outpatient settings were only done in hospitals not too many years ago. This has resulted in more efficient, less costly, and more convenient care provided to patients. It is unclear to the MMA how mandating hospital ownership in radiation therapy facilities would do

anything to ensure appropriate growth of new facilities or ensure quality care. The requirement would, however, grant significant power and control to hospitals and limit how radiation therapy is delivered to Minnesota patients.

An additional principle is specifically addresses the issue raised by this legislation. It states that collaborative models of expansion should be explored. Physicians and institutions should explore opportunities to enter into joint ventures before proceeding with the formation of separately owned facilities. However, ownership or investment in a health care facility by any one entity should not be restricted nor should it be required.

By simply mandating specific, arbitrary investment or ownership requirements upon a new facility limits innovation. This requirement fails to consider the needs of the community and, instead, provides a significant advantage to current providers of such care.

Please remember, all stakeholders in any facility expansion discussion respond to financial incentives. Any attempts for one side to claim that it is more altruistic in its motivations that the other is suspect. The entity that is proposing a new delivery model is responding to financial incentives to provide a service in a way that they believe will be successful. The entity opposing a new delivery model is also responding to a financial incentive that they believe will negatively impact their ability to provide their services.

While the MMA does agree that a more rational means of considering all health care supply and need would be a benefit to Minnesotans, SH F 2532 fails to accomplish that.

The MMA asks you to oppose this bill because it is arbitrary, anti-competitive, independent of community need, and serves only to stifle innovation in health care delivery.

Sincerely,

David D. Luehr, MD  
President,  
Minnesota Medical Association