

Testimony of Kip Sullivan, on behalf of Health Care for All Minnesota, to the Senate Health and Human Services Committee

February 15, 2023

I am submitting this statement in support of SF 404, a bill to permit Medical Assistance enrollees to opt out of HMO coverage. [SF 404 as introduced - 93rd Legislature \(2023 - 2024\) \(mn.gov\)](#)

I will describe two reasons why you should vote for SF 404: A moral reason; and an economic reason.

The moral reason is that Minnesota's Medical Assistance (MA) enrollees were never asked if they wanted to be forced to choose between joining an HMO or not getting any medical coverage at all. They were simply forced to make that choice as the privatization of Medicaid spread throughout the state between the late 1980s and late 1990s. (I'll use the word "privatization" to refer to the shifting of the insurance function from the Department of Human Services (DHS) to a handful of HMOs.)

I call your attention to the fact that Congress never inflicted that harsh choice on Medicare beneficiaries. Congress has always given Medicare beneficiaries a choice between receiving their medical care from the traditional Medicare program, in which beneficiaries can choose any doctor they want, or from what is today called Medicare Advantage. Medicare Advantage is the program in which overpaid insurance companies, most of which are HMOs, utilize limitations on patient choice of provider and other cost-containment tactics known collectively as "managed care."

SF 404 gives this committee the opportunity to undo the injustice inflicted on MA enrollees years ago. This bill amends the law to give MA enrollees the same freedom current federal law gives Medicare enrollees.

I turn now to the *economic* rationale for voting for SF 404. The insertion of HMOs into the Minnesota Medicaid and MinnesotaCare programs obliterated transparency, and almost certainly raised rather than lowered total MA spending. I have to say "almost certainly" because a rigorous evaluation of the claims made for the HMOs has never been done.

The privatization of our MA program began in three counties in 1987 after Minnesota received a waiver from what was then called the Health Care Financing Administration (HCFA). In the waiver application, the Department of Public Welfare (DPW, now DHS) stated: "The major hypothesis of the demonstration is that a health system based on private marketplace competition is more cost-effective than the current fee-for-service system...."^[1] DPW promised it would conduct a rigorous evaluation to determine whether HMOs reduced MA spending (the application made no claims about HMO quality). The HMOs, however, made it impossible for DHS to carry out the evaluation, first in the late 1980s when they refused to turn over all necessary data to DPW, and again in 1993 when they persuaded an assistant DHS Commissioner to suppress a study of HMO performance. On March 13, 1994, under the headline, "Study shelved after HMOs complained," the Minneapolis *Star Tribune* reported: "Minnesota officials suppressed a study raising questions about HMO care for poor people.... The study was the first attempt by the Minnesota Department of Human Services to see whether the state was saving money by sending Medical Assistance patients to health maintenance organizations...."^[2]

In 2004, DHS Commissioner Kevin Goodno replied to a letter from Rep. Matt Entenza inquiring whether privatization had saved money with this statement: "There no longer remains a credible comparison group of fee-for-service recipients against whom to compare the groups now enrolled in managed care. We do not have a methodology that could accurately assess whether managed care has cost us more or less than fee-for-service."[\[3\]](#)

The evidence we do have indicates privatization raised the total cost of the MA program. It did so primarily by driving up administrative costs. Administrative costs rose (1) because DHS's cost of administering the MA program rose; (2) because clinic and hospital administrative costs rose; and (3) because the HMOs skim off 15 percent of the tax dollar they receive from DHS to pay for their administrative costs before passing on the remaining 85 cents to doctors and hospitals (with strings attached). I'll review each of these three categories of new administrative costs briefly.

DHS's overhead as a percent of total Medicaid spending was 4 to 5 percent of total spending prior to privatization. Here is a quote from the 1991 report of the Minnesota Health Care Access Commission: "In studying private and public health programs ..., the Commission found a wide variation in administrative costs – from a low of 4-5 percent for Minnesota's Medical Assistance program, to highs of over 20 percent in some private insurance plans." [\[4\]](#) Research done in other states indicates privatization doubles Medicaid agency overhead costs from 4 to 5 percent to 10 to 12 percent. [\[5\]](#) Researchers who have studied Medicaid privatization report that "Medicaid managed care programs have proven enormously taxing for state Medicaid agencies to put into operation and then manage effectively."[\[6\]](#)

The second source of increased administrative costs – the overhead costs generated by HMOs – is the largest of the three sources I am discussing here (DHS's overhead, HMO overhead, and provider overhead). HMOs that contract with Medicaid agencies and with the Centers for Medicare and Medicaid Services (CMS, the federal agency that runs Medicare and Medicaid) devote, on average, 15 percent of the payments they receive to administrative costs (marketing, network creation, utilization review, etc.). As the Lewin Group, a subsidiary of United Health Group, put it in a review of privatized Medicaid, "MCOs [managed care organizations] must typically achieve roughly a 15 percent savings on overall medical costs vis-à-vis the FFS setting simply to break even."[\[7\]](#)

This same problem has plagued the privatization of Medicare. Congress inserted HMOs into Medicare in 1972. Medicare HMOs have never been able to reduce utilization of medical services by 15 percent to offset their administrative costs. That is why the Medicare Payment Advisory Commission (MedPAC) has had to report to Congress every year that Medicare Advantage has never reduced Medicare spending. "The Medicare Advantage program has been expected to reduce Medicare spending since its inception," reported MedPAC in its March 2022 report, "... but private plans in the aggregate have never produced savings for Medicare..."[\[8\]](#)

The third source of increased administrative costs is the provider sector. Research indicates that the spread of managed care drove up provider costs. [\[9\]](#) Here are excerpts from two studies:

"Almost all respondents ... reported increased costs from [Medicaid] managed care. Several noted that the increased administrative responsibilities are especially difficult for the solo and small-group practices more typical in rural areas."[\[10\]](#)

"[M]anaged care imposes requirements on substance abuse treatment facilities that significantly increase their administrative burden." [11]

Robbing MA enrollees of their freedom to choose might be justifiable if HMOs were able to reduce costs without harming patients. That has not happened. HMOs raised costs and they damaged quality of care. [12] I urge this committee to vote in favor of SF 404.

Thank you.

[1] Minnesota Department of Public Welfare, *Proposal for a Competitive Medicaid Demonstration Project*, April 30, 1982, 4.

[2] Joe Rigert and Carol Command, "Study shelved after HMOs complained," *Star Tribune*, March 13, 1994, A1. "Minnesota officials suppressed a study raising questions about HMO care for poor people, including a key finding that women on Medicaid get far fewer cancer detection tests than women who can afford to pay their own HMO charges" (A1). "The ... study of HMO care found that women on Medicaid got only 36 percent as many mammograms as other women, and 79 percent as many Pap smears" (12A).

[3] Letter from DHS Commissioner Kevin Goodno to Rep. Matt Entenza, December 16, 2004.

[4] Minnesota Health Care Access Commission, *Final Report to the Legislature*, January 1991, St. Paul, MN, p 78.

[5] According to a study comparing the overhead costs of Arizona's privatized Medicaid program with those of surrounding states that had not yet privatized their Medicaid program, Arizona's Medicaid agency spent 12 percent of total spending on its own overhead costs versus 5 percent in surrounding states. (Nelda McCall et al., "Managed Medicaid cost savings: The Arizona experience," *Health Affairs* Spring (II) 1994, 234-245, 240.) The study concluded: "[O]verall [Arizona Medicaid] administrative costs ... in fiscal year 1991 ... was 11.6 percent [of total costs].... By contrast, administrative costs for a traditional Medicaid program ranged from 4 percent of ... costs in fiscal year 1991 to 5 percent in fiscal years 1983-1988."

[6] Deborah A. Freund and Robert E. Hurley, "Managed care in Medicaid: Selected issues in program origins, design, and research," *Annual Review of Public Health* 1987;8:137-163, 153. Michael Sparer wrote in 1998: "Medicaid managed care actually increases the state's regulatory role. State Medicaid officials need to select health plans, determine capitation rates (and struggle with risk adjustment), supervise the marketing and enrollment process, ensure quality of care, consider whether to adopt special programs to protect safety-net providers during the transition to managed care, and so on. ("Devolution of power: An interim report card," *Health Affairs* 1998;17(3):7-17, 10.)

[7] The Lewin Group and the Association for Health Center Affiliated Plans, *Comparison of Medicaid Pharmacy Costs and Usage between the Fee-for-service and Capitated Setting*, 2003. The Department of Public Welfare appeared to be very concerned about the HMOs' high overhead costs. In their 1982 waiver application, DPW proposed to subsidize the HMOs. One method DPW proposed was to permit the HMOs to cover fewer medical services in the experimental (privatized) counties. At page 17 of the application, DPW stated: "There is a possibility that benefit levels may need to be reduced because existing per capita

payment levels may prove insufficient to cover the full scope of Medicaid services under a prepaid arrangement.”

[8] Medicare Payment Advisory Commission, *Report To Congress*, Washington, DC, March 2022, 411.

[9] David U. Himmelstein and Steffie Woolhandler, “Who administers? Who cares? Medical administrative and clinical employment in the United States and Canada,” *American Journal of Public Health* 1996;86:172-178; Linda H. Aiken et al., “Downsizing the hospital nursing workforce,” *Health Affairs* 1996;15(4):88-92.

[10] Suzanne Felt-Lisk et al., “Medicaid managed care in rural areas: A ten-state follow-up study,” *Health Affairs* 1999;18(2):238-245, 243.

[11] Jeffrey A. Alexander and Christy Harris Lemak, “The effects of managed care on administrative burden in outpatient substance abuse treatment facilities,” *Medical Care* 1997;35:1060-1068, 1067.

[12] The DHS study that the HMOs suppressed in 1993 demonstrated the HMOs were providing fewer preventive services to MA enrollees than their private pay patients, and that HMOs in Hennepin and Dakota counties (two of the original experimental counties) were providing fewer mammograms than doctors in adjacent counties paid fee-for-service. Former Attorney General Mike Hatch’s investigation of Blue Cross uncovered a policy of frustrating enrollees by delaying treatment. To my knowledge, I published the most comprehensive review of HMO performance. My review found HMO quality of care was inferior to the quality of care offered by doctors paid fee-for-service (Kip Sullivan, “Managed care plan performance since 1980: Another look at two literature reviews,” *American Journal of Public Health* 1999;89:1003-1008).