HEALTH CARE: MAKING THE BEST OF A BAD BARGAIN

WORKING DRAFT

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I. THE FACE OF HEALTH CARE: PRETTY UGLY.

The condition of our health care system is reminiscent of a tale told by Abraham Lincoln, who claimed he was the ugliest man in the world. One day in Springfield, he came upon a man standing in the street. Lincoln went into his office, pulled out a hunting rifle, went back into the street, and told the man: "Archie, say your prayers, for I am going to shoot you." "Why, Mr. Lincoln, what's the matter, what have I done?" "Well, I made an oath that if I ever saw an uglier man than me, I'd shoot him on the spot. You are uglier, so be prepared to die." Archie examined Lincoln's face and, after a couple of minutes, finally broke the silence: "Mr. Lincoln, do you really think I am uglier than you?" "Yes." "Well, if I am uglier, then fire away."

Our health care system is definitely a candidate for Abe's extreme makeover. In fact, it's not only ugly, it is statistically challenged. The Minnesota Department of Planning estimates that health care costs Minnesotans more than $19 billion each year.[1] Indeed, the United States spends more per person on health care than any other nation.[2] Roughly 15% of the U.S. Gross Domestic Product for 2003--$1.5 trillion--was spent on health care.[3] This is approximately double the percentage of the gross domestic product of other advanced countries.[4]

In Minnesota, health premiums have doubled over the past seven years. The average Minnesota household currently pays $11,000 per year in premiums, out-of-pocket costs and taxes for health care.[5] On a national level, today's average annual premium for a family insurance policy--$9,086--represents 21% of the median household income.[6] Some of the health care costs are less obvious. For example, U.S. automakers currently pay about $1,400 for each car they manufacture to provide health insurance for their employees.[7] This

extra expense means consumers pay more for American-made cars, and it provides automobile manufacturers with a powerful incentive to build cars outside this country. This additional cost has a similar impact on other American-made products, and the problem continues to grow.

Do we get our money's worth? The United States ranks behind 47 other countries in life expectancy and behind 41 other countries in infant mortality.[8] It ranks twelfth among 13 industrialized nations in 16 health indicators.[9] A recent study by Dartmouth researchers indicates that nearly a third of the $1.6 trillion spent on health care in the United States goes to duplicative care or fails to improve patient health.[10] While Americans pay more, they receive fewer services than other countries. In 2001, the United States had 2.7 doctors and 2.9 hospital beds per 1,000 people, compared with a median 3.1 doctors and 3.9 hospital beds per 1,000 people in countries in the Organization for Economic Cooperation and Development.[11] Health care debt is the second leading cause of personal bankruptcy filings in America,[12] with the cost of the debtor's health care being shifted to, with a consequent increase in premium on, those people who can pay for insurance.

Ironically, a patient without health insurance pays double, sometimes triple, the cost paid by an insurer for the same treatment.[13] This is because insurers negotiate a pricelist with health providers, and have the financial clout to extract financial concessions from providers on hospital care, surgeries, physician visits, or even a prescription.[14] In contrast, the uninsured, the least able to pay inflated charges, do not have the ability to negotiate a discount.

The American health care delivery system is structured so that there is little accountability in how

the dollar is spent. While consumers and employers are overwhelmed by the financial burden of health care, United HealthCare paid its chief executive officer over $92 million last year, and its top six executives were reportedly paid a total of $200 million.[15] Similarly, two prominent Minnesota health plans, Medica[16] and Blue Cross,[17] both recently announced they had accumulated too much money in their reserves, yet raised their premiums.[18]

The waste in our health care structure is demonstrated by the Emergency Medical Treatment and Labor Act ("EMTALA"), which was enacted to prevent hospitals from "dumping" impoverished patients by refusing to provide emergency care. EMTALA requires all hospitals that operate an emergency room ("ER") to treat any patient who arrives at the ER and requests treatment.[19] The purpose of EMTALA is laudable. The irony is that, because the uninsured do not have access to much more efficacious (and cheaper) primary care clinics, they must defer treatment until their medical conditions worsen and they are admitted to a hospital emergency room. ER care is much more expensive and less efficient than primary care clinics.[20] For example, a 1999 study indicates that 75% of patients admitted to New York City hospital emergency rooms who were treated on an outpatient basis could easily have been treated in a primary care setting.[21] Nationwide, ER visits climbed by 14% between 1997 and 2000 and by another five percent between 2000 and 2001, despite the fact that over 800 emergency rooms nationwide closed during that same period of time.[22] This influx into the ER has led to overcrowding, and correspondingly longer treatment delays,[23] as well as revenue problems for hospitals serving low income communities.[24] According to Dr. Dave Ores of New York City: "Actually we do

have a nationalized health plan. It's called the emergency room."[25]

Rather than undergoing an Abraham Lincoln makeover, the American health care system is determined to preserve the status quo and has had great success in making itself even more convoluted. But such success should be expected when the industry spends more than any other industry (out of our health premiums) on lobbying, public relations, and advertising.[26] United HealthCare, whose CEO was paid $92 million in 2003, made the largest political contributions of any Minnesota corporation, with $50,000 paid to the Republican Governors Association, $45,000 to the Republican Leadership Council, and $25,000 to the Democratic Governors Association.[27] In 2002 the pharmaceutical industry alone, which gets almost 18% of the health dollar,[28] hired over 650 lobbyists in Washington and retained over 1,000 lobbyists at the state level.[29] Since 1997, the pharmaceutical industry alone spent over $450 million on lobbying, campaign contributions, political advertising, and public relations.[30]

Unfortunately, our policymakers go along with the industry's proposals and "fixes." After all, the industry exerts considerable clout in the election process.

Two Norwegian brothers, Hans and Ole, lived on the farm during the depression. One day, Hans walks out to the outhouse and sees Ole coming out, wearing a big frown. "What's Wrong, Ole?" "Well, when I was pulling up my pants a silver dollar rolled out of my pocket and fell down the hole." Hans walked into the outhouse, looked down the hole, and scratched his head. He then took out his pocket watch and dropped it down the hole. "Hans, why did you drop your watch?" "Ole, you don't expect me to crawl down there just to save a dollar, do you?"

Our policymakers are a lot like Hans when it comes to health care: spending a lot to save a system that may not be worth it.

II. Overview Of American Health Care Delivery System.

A. Government-Sponsored Health Coverage.

Although many Americans assume that private insurance pays for most medical care, the total amount of coverage provided by private employers or purchased by private policyholders is less than half of the total funds expended on health care in the United States. According to the U.S. Census Bureau, in 2002, approximately 3.5% of Americans utilized military health care, 13.4% utilized Medicare (the federal program that provides health care to those over 65 and the disabled), 11.6% utilized Medicaid (the joint state and federal program that provides health care to low income Americans), and, in Minnesota, approximately four percent received government coverage through state-subsidized programs such as MinnesotaCare, the State Children's Health Program, the Minnesota Comprehensive Health Association (MCHA), or "waivered programs" through the Tax Equity Fiscal Responsibility Act of 1987 (TEFRA).[31] In addition, almost 15% of the population receives government health coverage through employment at the federal, state, municipal, and school district levels. Nationwide, another 15.2% of the population had no insurance for the entire year. The government funded programs include:

1. Medicare.

Medicare is a federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease.[32]

About 41 million beneficiaries are enrolled in Medicare, which spent $240 billion in the year 2000, or $6,213 per enrollee. Medicare spending comprises

approximately three percent of the gross domestic product.[33] By 2020, the Medicare population will balloon to 61 million,[34] and by 2030, 77% of the population will be eligible for Medicare.[35] These demands will be made at a time when there will be a decrease in the number of workers whose taxes will support each beneficiary. In 1965, there were five workers per Medicare beneficiary. By 2030, there will be only two workers per beneficiary.[36]

Medicare is made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part D will be added in January 2006, which provides a limited policy for prescription drug coverage. Part A of Medicare, which provides hospital coverage, could be insolvent by 2013.[37] Part D is expected to incur a deficit of $500 billion by 2013.

In short, the fiscal integrity of the Medicare program can be summed up as government-by-Visa-card.

2. Medicaid.

Medicaid is a public health insurance program for low income Americans, providing benefits to 50 million people.[38] In 2002, it provided coverage for 24 million children, ten million low income parents, eight million people with disabilities and five million low income seniors. The total Medicaid expenditures in 2002 were $210 billion. Medicaid accounted for 17% of all personal health care spending, 17% of hospital care, 12% of physician care, 17% of prescription spending, and half of all nursing home care. The federal share of Medicaid ranged from 50-77%, depending upon the state, with 57% being average. (Minnesota received 50% participation from the federal government for its Medicaid program.) Although 75% of the Medicaid recipients were low income children and parents, only 29% of Medicaid funding was allocated for this population. The estimated Medicaid spending in 2002 per child

enrollee was $1,483. The spending per working parent enrollee was $1,948. Two-thirds of these children and parents were from working families. The average amount spent per disabled enrollee was $11,468, and the average spent per senior citizen was $12,764.[39]

Medicaid provides coverage in two forms. The first is the Prepaid Medical Assistance Program ("PMAP"), in which the Minnesota Department of Human Services ("DHS") pays the premium to a private insurer. PMAP is utilized for most non-disabled children. The second form is fee-for-service ("FFS") in which DHS pays the provider directly for the service.

Medicaid has recently suffered dramatic financial setbacks, standing first on the chopping block as state governments throughout the country have attempted to address growing budget deficits. For example, in 2003, all 50 states reduced or froze Medicaid payments to participating providers, 25 states reduced or restricted eligibility and another 18 states reduced benefits.[40] This trend continued in 2004, with states cutting an additional 1.2 to 1.6 million low income individuals from Medicaid and other state health insurance programs.[41]

3. State Children's Health Insurance Program.

As part of the Balanced Budget Act of 1997, Congress created the State Children's Health Insurance Program (SCHIP) to address the growing problem of uninsured children in low income families. SCHIP was designed as a federal/state partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but not enough money to purchase private insurance. SCHIP, which expended over $3 billion in federal money in 2002 (and a similar amount by the states), is the single largest expansion of health insurance coverage for

children since the initiation of Medicaid in the mid-1960s.[42] A "targeted low-income child" under SCHIP is one who resides in a family with income below 200% of the Federal Poverty Level (FPL) or whose family has an income 50% higher than the state's Medicaid eligibility threshold. Some states have expanded SCHIP eligibility beyond the 200% FPL limit, and others are covering entire families and not just children.[43]

4. Minnesota Comprehensive Health Association.

The Minnesota Comprehensive Health Association (MCHA) was established in 1976 to offer individual health insurance policies to Minnesota residents who have been turned down for health insurance by the private market due to pre-existing health conditions. MCHA is sometimes referred to as Minnesota's "high risk pool" for health insurance. Currently, about 30,000 Minnesota residents are insured by MCHA throughout the State of Minnesota.[44]

The premium charged by MCHA is approximately 25% higher than the cost of an average health insurance policy sold to a person in the same age bracket.[45] Without MCHA, these people would lack insurance coverage to pay for medical treatment, and many of them eventually would lose their homes and savings by being forced to "spend down" their assets to qualify for Medicaid.

Because MCHA generally insures only Minnesotans who have poor health, MCHA loses money. Its claims are much higher than the premiums paid by enrollees. The losses sustained by MCHA are paid for by an assessment to all health insurers and HMOs doing business in Minnesota, which in turn is added to the rates charged to private policyholders.[46] Most health coverage in Minnesota is provided by larger corporations (over 100 employees) through

self-insured plans. Self-insured plans, which are established under the Employee Retirement Income Security Act (ERISA), are generally not subject to state regulation and do not have to pay any assessment to MCHA. As a result, individuals and smaller companies that buy private insurance and private HMO coverage, but not larger employers who self-insure, pay for these losses and subsidize the MCHA coverage.

5. Tax Equity and Fiscal Responsibility Act of 1982.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) allows states to extend Medicaid coverage to certain disabled children. To qualify for TEFRA benefits, a child must be disabled according to the Supplemental Security Income (SSI) definition of disability and must meet the medical-necessity requirement for institutional care. Children must also reside at home; children who live in institutions or who receive extended care in institutions are not eligible for TEFRA.

Parental income and resources are not considered. Only the income and resources of the child are counted. Children who receive SSI but lose coverage intermittently due to fluctuating parental income, therefore, may be eligible for TEFRA benefits in the months they do not receive SSI.[47] The estimated cost of care in the home, however, cannot exceed the estimated cost of care for the child in an institution.

6. General Assistance Medical Care.

General assistance medical care (GAMC) pays for the medical care for some 31,000 low income Minnesotans who do not qualify for Medicaid or other state or federal health care assistance programs. These are primarily low income adults between the ages of 21 and 64 who do not have dependents. GAMC is funded entirely by the State.

7. MinnesotaCare.

MinnesotaCare was created in 1992 by the Minnesota Legislature. MinnesotaCare is a subsidized health insurance program for Minnesotans who do not have access to health insurance. It has limited coverage, and its premium is based upon enrollees' income and family size. MinnesotaCare is funded by a combination of enrollee premiums and the MinnesotaCare tax imposed on health care providers. A certain amount of federal dollars are also paid into the program. MinnesotaCare's income and program guidelines are rather restrictive. For instance, an individual's monthly gross income must not exceed $1,310 to qualify for coverage.

B. The Uninsured.

Many Americans and their families cannot afford health coverage, yet do not qualify for government health care programs. Others have health insurance which has very limited coverage, or which excludes coverage for particular diseases. The Robert Wood Johnson Foundation determined that almost one-third of Americans (74.7 million) under the age of 65 were uninsured during 2001-2002,[48] of which two-thirds were uninsured for at least six months.[49] Of the 74.7 million uninsured Americans, approximately 20.2 million were children, which is almost 30% of all children in the United States.[50] Approximately half of the families with incomes between the poverty level ($15,000) and 200% of the poverty level ($30,000) are uninsured.[51]

Most uninsured Minnesotans are members of working families. Eighty-four percent of unemployed Minnesotans have at least one person in their immediate family who works either full or part time.[52] More than half have an immediate family member who works full time.[53] These working Minnesotans do not have access to health insurance either because

it is not offered to them or because they cannot afford it.

Families suffer greatly when they do not have insurance coverage.[54] Not surprisingly, they forego needed medical care. In 2000, approximately 40% of uninsured people postponed care due to cost as compared to only ten percent of those with insurance.[55] Without access to outpatient care, the uninsured wait until a medical condition festers into a major problem, and they then incur expensive hospital care. Because of the lack of coverage, approximately eight million uninsured who have chronic illnesses receive fewer services, suffer worse outcomes, and experience increased morbidity. Approximately 18,000 of the uninsured die prematurely during each year.[56] The economic value lost because of poorer health and earlier deaths among uninsured Americans is between $65 billion and $130 billion per year.[57]

Currently, individuals without health insurance pay about 35% of their medical bills themselves. The remaining costs of uncompensated care are borne either by taxpayers through subsidies to hospitals and clinics or through other payers.[58] Ironically, the inflated prices charged to the working poor discourage them from attempting to pay for their care. "It is a reflection of the insanity of the system. The most vulnerable members of society are being asked to pay cash at list," stated Bruce Vladeck, a hospital policy expert who ran Medicare in the 1990s.[59] "Pricing makes no sense, we all know that," stated Mark Mundy, president and chief executive of New York Methodist Hospital.[60]

C. Employer-Sponsored Insurance Coverage.

The employer-sponsored health care system was created during the 1940s, when employers offered fringe benefits, such as health coverage, as a way around a government imposed wage freeze.

Evolving from this beginning, the primary cost of health care in America has been assumed by employers through the latter part of the twentieth century. In the past several years, however, there has been a steady decline in the amount of health coverage offered by employers.[61]

The decline of employer-sponsored health coverage is directly related to its escalating cost. Rising insurance costs have caused employers to shift expenses to employees in the form of increased monthly premiums, increased co-payments, excluded benefits, and excluded coverage for spouses and children.[62] The cost of health insurance has risen approximately 50% in three years[63] and has grown three-and-one-half times faster than workers' wages and over four times faster than the rate of inflation.[64] It is estimated that, by 2010, the average cost for health insurance in a Minnesota household will reach $22,000--a sum out-of-reach for many working families.[65] The administrative expenses for employer-sponsored health coverage are at least two-and-one-half times higher than those for public programs.[66]

The cost of employer-sponsored health coverage creates perverse effects on social and economic policy, especially for those employers who have chronically ill employees or dependents. For instance, the Americans with Disabilities Act encourages employers to accommodate those with disabilities. Yet, when the owner of a small Minnesota engineering firm with 25 employees wanted to hire an engineer who has a child with spina bifida, he discovered that employer-sponsored health coverage created a huge disincentive to hire the engineer. He checked with his insurance broker and was told that if he hired the engineer, his health insurer would likely not renew the policy. The president of the engineering firm had a dilemma: on

the one hand, he wanted to hire the engineer, provide a family with income, and be able to expand his own company. On the other hand, by hiring the engineer he might deprive his other employees of necessary health benefits.

Another anecdote involves a human resources director whose company told him to draw up a list of employees who had received chemical dependency treatment. The president had been told that the cost of chemical dependency treatment was a principal reason for the company's substantial increase in health insurance premiums. The director was concerned that, in receiving such information, the president would "conserve costs" by terminating such employees or that, if the employees learned about the inquiry, no employee would seek chemical dependency treatment in the future.

Employers should be permitted to succeed by using their capital and ingenuity to produce new products and services, and in the process hire more people to help them do it. Employer sponsored health coverage, however, undermines this goal. Employees should also be permitted to take their own ideas and go out and start up new companies to replenish the economy. Many employees cannot do so, however, because of the fear of not being able to obtain health coverage if they leave their employer.

III. EMPLOYER-SPONSORED HEALTH POLICY: BEING UGLY IS NOT ONLY SKIN DEEP.

A. Introduction.

A *Newsweek* columnist recently wrote about his wife who had a stroke while in France.[67] He was stunned that, after receiving 17 days of hospitalization, with all services included, his wife received a simple one page invoice that set forth a per diem cost, adding up to approximately 20,000 Eurodollars. He was told that French hospitals bill only on a per diem basis, with all hospital, diagnostic, physician, and therapist costs included, except food.

In contrast, when she was taken back to the United States, and after 56 days of hospitalization and rehabilitation, he was swamped in paperwork for "extras," right down to additional charges for the arm rest, foot pedal, anti-tip bar, seat belt, and brake extension on the wheelchair. He lamented:

> At one New York hospital, we received bills from doctors we'd never heard of, including one who charged for an office visit when Meg couldn't even get out of bed. The managed care provider's computer sent him a check without question. Had he not billed us for the co-payment I never would have noticed the error. Over the past few months, I spent hours clearing up these kind of mistakes. A doctor friend who heads a department in a large hospital admitted that these kinds of complaints are all too common.
>
> Meg's medical tab has reached nearly $300,000, which seems monumental, even given the nature of her catastrophic injury. Thankfully, we were covered for most of it. Yet $90,000 of that figure had little or nothing to do with patient care. Roughly 30 cents of each health care dollar goes to administration, or the processing of paperwork.
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> Billing administrators barely raised an eyebrow when I told them I had spent too much time on hold and would no longer bother calling to dispute the charges. …I've checked with others who have had protracted negotiations with health care providers and insurers….They echo my frustration. Why is it incumbent on the recipient to spend countless hours

rectifying the medical administration's mistakes?

A single payer system is easier and cheaper to run.

Another anecdote involves a Seattle physician, Dr. Vern Cherewatenko, who switched to a cash-only practice because he was "drowning in paperwork and red ink, accepting more than 300 different insurance plans with 7,500 different medical codes" and losing $80,000 a month.[68] Dr. Cherewatenko states that by not taking insurance, "[w]e have lowered our fees anywhere from 30 to 50% on some of our services, which is incredible, and it's really charging less and making more."[69]

Writing in the *New England Journal of Medicine,* economist Henry Aaron nicely summarized the current administrative system: "Like many other observers, I look at the U.S. health care system and see an administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reason, as well as [a] staggeringly complex public system with mind-boggling administered prices and other rules expressing distinctions that can only be regarded as weird."[70]

B. The Medical Transaction Does Not Have The Economic Efficiency of a Consumer Transaction.

In an ordinary consumer transaction, the purchaser makes the decision of what product to purchase and what payment to make, with the payment coming directly from the purchaser's pocket. A consumer entering an automobile dealership does not simply pay the list price that is glued to the window of a car; rather, the consumer negotiates the price and the accessories, and in the end makes an economic decision based upon the consumer's finances and preference. This "economic tension" is missing when a patient visits a physician. For example, assume a parent brings a daughter to the

emergency room after she fell from a bunk bed during a slumber party, breaking her jaw. The doctor looks at the jaw and states that an x-ray could be taken to determine the degree of the fracture. He also says that he could order an MRI to ensure that there is no tear in the membrane that surrounds the brain cavity. He opines, however, that a tear is highly unlikely, given the type of fracture. The cost of an MRI is approximately $1,200, and the cost of the x-ray is approximately $150. The parent with insurance coverage will undoubtedly want the MRI. All parents want "Cadillac treatment" for their child, especially when they only have to pay a $50 deductible, regardless of whether the treatment is an x-ray or an MRI. In other words, the economic tension that would ordinarily be involved in a consumer transaction is absent. As important, the consumer does not have the expertise to determine the need for a particular treatment. And, of course, the physician is a professional who wants to prescribe the best treatment. Who has ever bragged that they have a cheap physician?

Our health care structure lacks discipline. It is rife with conflicts of interest and promotes inefficiency, yet regulators do little to check it. Even though many people are upset with the cost of health care and the system's excesses (e.g. $92 million compensation paid to one HMO executive), there is currently no vehicle through which an employer, an employee, a physician, a hospital, or a patient can tighten the reins on it.

For example, in 2001, a Compliance Report of Allina Health System ("Allina") and Medica Health Plans ("Medica")[71] described a pervasive pattern of waste and abuse at the company.

The organizations paid approximately ten different bonus, savings, and deferred compensation plans to "supplement" six-figure salaries. When

executives failed to meet goals under their original compensation agreements, they retroactively altered the agreements so they could be paid the bonus. Even though they already were employed by the organizations for many years, executives paid themselves six-figure "signing bonuses" and "retention bonuses" on their anniversary dates. Medica and Allina additionally squandered tens of millions of dollars on consultants who never documented any work, including one California consultant who was paid $850,000 in one year, in addition to a luxury SUV, luxury lakefront condominium, and other incidentals such as maid service and utility bills. Another consultant was paid $1.9 million to "coach" top executives at sleepover conferences, where executives watched movies, played ring-toss, and searched for their "inner-selves." While issuing unqualified audits for Medica and Allina, an "independent" auditor was paid over $30 million in consulting fees.

They additionally squandered millions on travel, entertainment, and gifts. They spent $89,000 to send executives, board members, and their spouses to the Phoenician Inn in Arizona to study "health care reform," where tens of thousands of dollars were spent on food, alcohol, green fees, tennis fees, and spa charges. The executives spent $42,000 to tour vineyards in Napa Valley, California, where they incurred green fees of $16,000. They also paid for memberships in dozens of country clubs and golf clubs, as well as season tickets for virtually all professional sporting events in Minnesota. The executives also purchased gifts for each other, including $3,000 sculptures, $1,000 golf clubs, and first-class tickets around the world.

In 2003, a Compliance Report on HealthPartners, another integrated health care system,

described similar problems with accountability.[72] Like Allina and Medica, executives were offered multiple savings and retirement plans, such as "split dollar" life insurance, retention bonuses, mutual fund option purchase plans, capital accumulation plans, supplemental executive retirement plans, and 401(k) plans. Concerned with how the media and legislature would view such benefits, HealthPartners took deliberate steps to conceal the payments and even omitted deferred compensation paid to its executives from certain IRS filings.

HealthPartners also engaged in lavish spending on travel and entertainment. It spent over $17,000 for its CEO to attend "trade missions" in Brazil, Chile and Ireland, even though HealthPartners does business only in Minnesota and western Wisconsin. It paid $9,000 for its CEO to travel to an Australian conference to find out: "Are we pricing ourselves out of health care?" All together, it paid for over 100 trips to 30 countries on six continents. Like Allina and Medica executives, the HealthPartners executives received memberships in country clubs, golf clubs, and hunting clubs. Season tickets for professional sporting events were purchased. Executives also purchased gifts for each other, including $1,000 kayaks. They paid for massages at board meetings, and masseuses were implored to "bring more oil" to the next meeting.

Even though these reports documented system-wide abuses by the HMOs and hospital systems, their primary regulator, the Minnesota Department of Health, took no action to correct the problems.

C. The Non-Treatment Professionals.

Three people arrive at the pearly gate in heaven. St. Peter asks each one what they did for a living. The first one says, "Health care. I was a physician serving a mission in Africa." St. Peter

opened the gate to let her in. The second one said, "Health care. I was a nurse in a charity hospital." St. Peter let her in. The third one said "Health care. I was an executive at a managed care organization." St. Peter opened the gate and said, "You have preauthorization for two days, and then you go to hell."

Because the health transaction does not have the financial tension that makes a consumer transaction efficient, up to a third of the health care dollar is spent on professionals who never treat a patient but instead attempt to make those who do treat patients more accountable. In 1999, at least $294 billion, or 24% of U.S. health costs, were allocated to administrative costs.[73] In the case of our health care system, there seems to be more hands not knowing what they are doing than *Spiderman's* Dr. Octopus out on a hot date with Devi, the Hindu goddess. Many of these hands, a myriad of non-treatment professionals who cost a great deal of money, are perhaps best depicted by the many organizations that represent them, which include: The Academy of Managed Care Pharmacy, The Alliance of Claims Assistance Professionals, The American Academy of Medical Administrators, The American Academy of Procedural Coders, The American Accreditation HealthCare Commission, The American Association for Medical Transcription, The American Association of Medical Assistants, The American Association of Medical Billers, The American Association of Medical Review Officers, The American Association of Preferred Provider Organizations, The American College of Health Care Executives, The American College of Healthcare Information Administrators, The American College of Medical Quality, The American College of Physician Executives, The American Health Insurance Plans, The American Health Lawyers Association, The American Health

Planning Association, The American Health Quality Association, The American Managed Behavioral Healthcare Association, The American Medical Billing Association, The American Medical Directors Association, The American Medical Informatics Association, The American Society of Healthcare Publication Editors, The Association of the Advancement of Medical Instrumentation, The Association of Worksite Health Promotion, The Association of Healthcare Internal Auditors, The Association of Medical Directors of Information Systems, The Case Management Society of America, Coalition for Healthcare e-Standards, The College of Healthcare Information Management Executives, The Employee Benefit Research Institute, The Employers' Managed Health Care Association, The Healthcare Billing and Management Association, The Health Care Compliance Association, The Healthcare EDI Coalition, The Healthcare Financial Management Association, The Healthcare Information and Management Systems Society, The Health Industry Group Purchasing Association, The Health Technology Center, The Institute of Certified Healthcare Business Consultants, The Insurance Information Institute, The International Association of Privacy Professionals, The International Foundation of Employee Benefit Plans, The International Health Economics Association, The Medical Group Management Association, The Medical Outcomes Trust, The Medical Records Institute, The Medical Transcription Industry Alliance, The National Association for Healthcare Quality, The National Association of Health Consultants, The National Association of Health Data Organizations, The National Association of Health Services Executives, The National Association of Health Underwriters, The National Association of Health Unit Coordinators, The National Association of Healthcare Access

Management, The National Association of Managed Care Regulators, The National Association of Medical Staff Services, The National Association of State Medicaid Directors, The National Association of State Mental Health Program Directors, The National Council for Prescription Drug Programs, The National Council on Patient Information and Education, The National CPA Health Care Advisors Association, The National Electronic Billers Alliance, The National Forum for Health Care Quality Measurement and Reporting, The National Health Care Anti-Fraud Association, The National Healthcare Cost and Quality Association, The National Institute for Health Care Management, The National Uniform Claim Committee, The Pharmacy Benefit Management Institute, The Professional Association of Health Care Office Managers, The Self-Insurance Institute of America.

While these non-treatment professionals might perform necessary functions in the complex administrative structure of our health care system, many of the functions they perform, designed to make treatment more efficacious, could be unnecessary if the structure were changed. For instance, the functions to price an employer's group policy may include: actuarial opinions, financial audit reports, quality assurance reviews, insurance brokerage, large case management analyses, claims review consultants, community care network administration, disease management consulting, hospital and clinic audits, behavioral health service management, physician practice management, pharmaceutical benefit management, professional standards review, stop loss insurance, third party administration, and medical staff credentialing. Most of these functions and their costs are dramatically reduced in other health care systems.

D. The Non-Treatment Transactions.

Rube Goldberg was a Pulitzer Prize winning cartoonist for the New York *Evening Mail.* His cartoons depicted machines designed to make simple tasks amazingly complex. Dozens of arms, wheels, gears, handles, cups, and rods were put in motion by balls, canary cages, pails, boots, bathtubs, paddles, and live animals for simple tasks such as squeezing an orange for juice. He described his cartoons as symbols of the human capacity for exerting maximum effort to accomplish minimum results. Although he died at the age of 87 in 1970, dozens of contests are still held around the world each year where contestants try to build the most ridiculously complicated machine that performs the most mundane task.

If submitted in one of these contests, the American health insurance system would be a surefire winner. Instead of monkeys, balls, tubes, switches, and robots, the *Rube Goldberg Health Insurance System* would depict the non-treating professionals engaged in transactions:

1. Between financial intermediaries (HMO/insurer/third party administrator) and employers.

2. Between preferred provider organizations and financial intermediaries.

3. Between employers and insurance brokers.

4. Between employers and insurance brokers with benefit design managers.

5. Between employers and financial intermediaries with actuaries and underwriters.

6. Between financial intermediaries and employers with managing general underwriters and stop loss insurers.

7. Between financial intermediaries and employers with pharmaceutical benefit managers.

8. Between pharmaceutical benefit managers and pharmaceutical companies, distributors and pharmacists.

9. Between financial intermediaries and "specialty" managers including managed behavioral health companies and physical therapy management companies.

10. Between clinics and physician practice management companies.

11. Between clinics and physician practice management companies with financial intermediaries and preferred provider organizations.

12. Between provider claims staff and financial intermediary claims staff and audit consultants.

13. Between patients and providers and financial intermediaries as to preauthorization or payment.

14. Between employers and employees as it relates to COBRA, deductibles, co-payments, and dependent coverage.

15. Between government agencies and providers and financial intermediaries and patients.

The above transactions capture the skepticism of Rube Goldberg. He believed that there were two ways to do things: the simple way and the hard way, and he believed that a surprising number of people prefer doing things the hard way.

E. The Non-Treatment Functions.

Some of the functions undertaken by the non-treatment professionals might also be traced back to Greek mythology. The Hydra of Lernaea was a snake who had up to 100 heads springing from her body. When Hercules axed off one head, two heads grew in its place. Our health system has a myriad of functions that don't treat patients but instead monitor the treatment. Like Hydra, when you get rid of one of these functions, two more sprout up. According to mythology, Hydra would exhale a poison that killed all around her. While these functions are not

poisonous, they do suck the dollars out of health care premiums.

Non-treatment functions include calculation of insurance rates, where underwriters, actuaries, brokers, and case managers predict the frequency and severity of future claims. These professionals are not unlike Trophonius, the oracle in ancient Greece. Trophonius was an insightful oracle who would have been very effective in the current health care system. Everyone who consulted him forever after lived in terror of the future, never to smile again. Like Trophonius, the modern insurance professionals mystically analyze risk factors and risk loads as they determine actuarial ratings, community ratings, adjusted average per capita cost (AAPCC), administrative costs, base capitation, benefit package design, benefit limitations, case mix index, composite rates, global rates, experience-rated premiums, claims experience, incurred but not reported losses (IBNR), large claim pooling, stop loss premium, loss ratios, modified community ratings and patient origin studies. Once again, most of these functions are greatly curtailed in other health care systems.

Interestingly, before Trophonius became an oracle, he was a crooked architect. He designed the treasury building for King Hyrieus in such a manner that he could easily steal from it. One wonders if our modern day Trophonius similarly constructed the treasury of our insurers and HMOs.

In addition to establishing the premium rate, insurers, HMOs and third party administrators (TPAs) need to contract with providers and hire other non-treatment professionals. These professionals negotiate with preferred provider organizations, managed care networks, hospitals, specialty clinics, laboratory, radiology, and diagnostic clinics, physical therapy and mental health professionals, and other treatment professionals. These contracts establish

"carve outs" for managed care organizations, case rate compensation, exclusive provider arrangements, gatekeeper arrangements, independent practice associations, and outcomes management protocols.

A provider who enters into an agreement with an HMO, insurer, or TPA must also hire some of the Hydra professionals to consider factors such as activity based costing, adjusted community rates, allowable charges, approved charges, average wholesale prices, balanced billing, base capitation, case rate payments, case mix index, coding, assignments of benefits, clinic decision support programs, coordination of benefits programs, diagnostic related group systems, discounted fees, international classification of disease (ICD) systems, per diem provider agreements, physician current procedural terminology (CPT) systems, stop loss coverage, uniform billing code regulation, and the maximum allowable actual charges.

After receiving a bill from a provider, the insurer, HMO, or TPA then retains Hydra professionals to adjudicate the bill, determine allowable amount, determine average wholesale price, engage in concurrent review, provide preutilization approval, determine conversion factors (which are used to modify the relative value schedule), determine coordination of benefits with other coverage, determine covered benefits, determine the customary, prevailing and reasonable treatment, determine current procedural terminology (CPT) use by the specific provider for concurrent review, review the use of diagnostic related group (DRG) descriptions, negotiate and review drug formularies, engage in drug utilization review, determine eligibility of enrollees, determine elimination periods, waiting periods and other conditions of a policy, prepare explanation of benefit forms, negotiate fee schedules with independent practice associations, utilize International

Classification of Disease (ICD) schedules, apply National Drug Coding (NDC), apply standards of the National Committee for Quality Assurance, determine outcomes management, contract or adjudicate bills with out-of-network providers, determine out-of-area benefits, review per diem rates, apply Professional Standards Review Organization guidelines, determine resource relative value units, and utilize uniform billing code systems. Once again, many of these functions are greatly contained in other health systems.

In order to maintain a relationship with HMOs, insurers, and TPAs, clinic providers also engage in their own non-treatment oversight of individual providers. This entails the utilization of a number of other Hydra professionals who review database systems, decision support systems, diagnostic related group billings, disease management programs, medical care evaluation studies (MCE), implement peer review committees, engage in quality assurance (most of which will follow the National Committee for Quality Assurance) and engage in utilization review and utilization management. Once again, in other health systems these functions are greatly contained.

Every state has regulators with the authority to disapprove the rates charged for a health insurance policy. These regulators also have the authority to examine the expenditures of HMOs and insurance companies and issue remedial orders. Unfortunately, the culture of regulation involving health insurance is so lax that health commissioners (who typically regulate HMOs) and commerce or insurance commissioners (who typically regulate insurers) rarely, if ever, exercise such authority.

Winston Churchill was once at a dinner at Blenheim castle and spent the whole evening arguing ferociously with Lady Astor. Exasperated, Lady

Astor proclaimed, "Winston if I were your wife, I would put poison in your coffee." Churchill retorted, "Nancy, if I were your husband, I would drink it." Our health care system has already been served poison. The following proposals cannot hurt.

IV. FIRST, LET'S ESTABLISH A UNIFIED AND PUBLIC MENTAL HEALTH SYSTEM.

1. The System is Broken.

The President's New Freedom Commission on Mental Health characterized the nation's mental health system as a "shambles."[74] A St. Paul police officer told one task force that the number one problem in street crime is untreated and undiagnosed mental illness. A teacher told another task force that the number one problem for students in the classroom is untreated and undiagnosed mental illness. Our mental health system has no coordination between government and private treatment options, or between inpatient, outpatient and community treatment. The mental health system is also woefully underfunded, as evidenced by widespread shortages of beds and mental health care providers. These shortages discourage individuals from getting needed care, and force patients and their families to suffer long delays in getting treatment. Society in general suffers from the system's failings, through lost economic productivity and increased substance abuse, suicide, homelessness, crime, and heavy burdens on law enforcement and emergency rooms. In addition, treatment models and insurance coverage continue to be inadequate, with payers often denying necessary coverage for early assessment, intervention, and post-discharge care.

2. Mental Illness is Prevalent.

The U.S. Surgeon General reports that one in five adults in the United States is affected by mental illness in any given year.[75] The Minnesota Psychiatric Society ("MPS") reports that about one million people in Minnesota experience mental illness in a year, and

one in ten children has a severe emotional disturbance.[76]

The demand for mental health treatment also continues to increase every year. Inpatient psychiatric and chemical dependency visits in Minnesota rose 16% from 1997 to 2001, compared to an increase of ten percent for all other admissions.[77] From 1999 to 2001, emergency psychiatric visits increased by almost 40%.[78] Youths accounted for an astounding percentage of this emergency care. During this period, emergency mental treatment for youths fourteen and under increased approximately 50%,[79] and treatment for fifteen to twenty-year-olds increased by 68%.[80]

3. Untreated Mental Illness Has High Social Costs.

Mental illness is one of the most costly and disabling illnesses facing Americans. The Surgeon General reports that the direct costs of mental health services in the United States totaled $69 billion in 1996.[81] The indirect costs are much larger. The annual societal cost of depression in the United States is estimated to be $44 billion.[82] The annual societal cost of anxiety disorders is estimated to be $42 billion,[83] and the annual cost of schizophrenia is estimated to be $32 billion.[84] The estimated cost of alcohol abuse and alcoholism is an estimated $100 billion per year,[85] and the total societal cost of alcohol is estimated to be $300 billion per year.[86]

According to a report issued by the World Health Organization, the World Bank, and Harvard University,[87] major depression is the leading cause of disability worldwide among persons age five and older.[88] Of the ten leading causes of disability worldwide in 1990, five were mental health conditions: unipolar depression, chemical abuse, bipolar affective disorder, schizophrenia, and obsessive-compulsive disorder.[89]

In addition to economic loss, mental illness places a great burden on our schools. The Surgeon General reports that one in five children has a mental or addictive disorder.[90] In 1999, the Minnesota Department of Children, Families & Learning (CFL) estimated that 234,000 children suffered from mental illness, but that 155,000 never received treatment.[91] Illnesses included mood disorders, panic disorders, anxiety disorders, eating disorders, ADHD, depression, chemical abuse, obsessive compulsive-disorders, schizophrenia, suicide and Tourette's disorder.[92]

Elected officials have proposed laudable policies for mental health in our schools, but do little to implement them. At the federal level, there is *The No Child Left Behind Act*, *The Individuals with Disabilities Education Act (IDEA)*, and the President's New Freedom Commission on Mental Health. These efforts have done little for mental health in our schools. In 1999, CFL estimated that 18% of children met the criteria of having an Emotional and Behavioral Disorder (EBD), which would qualify them for some assistance under these laws, and that five percent were severely disturbed.[93] Only two percent of the children, however, received EBD assistance.[94] The report concluded that EBD services were not effective. Similarly, there has been little success under the IDEA. Where 13% of enrolled children receive assistance due to disability, but less than ten percent of these children -- only one percent of all enrolled children -- are identified as having a mental illness.[95] State government policies have had similar experiences. By statute, the Commissioner of the Minnesota Department of Human Services was to implement by 1993 a unified, accountable, and comprehensive children's mental health system.[96] The CFL report points out that no such system exists. Under a different statute, the Minnesota

Commissioner of Education and Commissioner of Human Services were to establish a system by 1996 that maximized Medicaid reimbursement for school-based treatment.[97] The CFL report found that this did not occur. The Chairman of the President's New Freedom Commission on Mental Health sums up our policy on mental health in schools as a failure of science, policy, and money.[98]

Indeed, the recent education initiative that requires schools to meet standardized academic levels is counterproductive to attacking mental illness. Schools are under increasingly tighter budgets, and money expended in diagnosing mental health problems under IDEA or state law are counter-productive to meeting those academic standards. Mental illness costs money and time to diagnose, and if a child is diagnosed with a disorder, the school is penalized because it must pay for ancillary services that could otherwise be used to improve test scores.[99] Even if a diagnosis is made, insurance coverage for treatment is generally inadequate, and public facilities for inpatient, residential, and outpatient treatment are insufficient.[100] As a result, most children never get treatment,[101] and in the end, entire classrooms are disrupted because the diagnosis of an ADHD child is deferred, because an ill-equipped teacher must focus energy on an autistic child who cannot get treatment or because a parent cannot navigate the mental health system for an EBD child. The failure of our mental health system to provide treatment results in higher public school costs. It also causes other parents to remove their "lower maintenance" children from public schools and place them in private schools that have far fewer children with behavioral problems. This adverse selection process, if unchecked, undermines the foundation of our democracy--a strong public education system.

As troubling, law enforcement personnel, rather than trained health professionals, are increasingly forced to take on the principal role of community mental health workers in dealing with mental health crises and problems. A congressional study issued in July 2004 determined that 15,000 children with psychiatric disorders, some as young as seven years of age, were improperly incarcerated last year because no mental health services were available.[102] More than 340 detention centers, two-thirds of those that responded to the congressional survey, reported that mentally ill youths were locked up because there was no place for them to go for treatment. Seventy-one centers in 33 states said they were holding mentally ill youngsters with no charges.[103] A New Mexico official pointed out that, by not providing adequate community health services, the American society has reverted to criminalizing mental illness.[104]

Substance abuse rates among the mentally ill are far higher than for the general population, and many individuals with mental illness end up in prison at a cost of $28,000 per year. More than 90% of suicide victims have a diagnosable psychiatric illness and 80% of suicides are committed by persons who have a depressive illness.[105] Police officers state that many street crimes, including assault, terroristic threats, domestic abuse, and theft, could be reduced if first time offenders had access to a mental health professional. One officer told a task force that he has detained mentally ill vagrants, some of whom are poorly treated veterans of the armed services, on cold nights so that they can get a warm bed and a meal in jail. Other officers say that, lacking treatment facilities, many chemically dependent people are caught in a revolving door of being arrested, brought to a shelter, then released, and then rearrested because there is no treatment available.

4. Mental Illness is Treatable.

Despite its prevalence and cost to society, mental illness is treatable. Treatment success rates for depression and anxiety range from 50-90%.[106] When severe depression is treated with anti-depressant medication and psychotherapy, the success rate approaches 85%, according to the U.S. National Advisory Mental Health Council. These treatment response rates are higher than those for many other common physical health treatments, such as angioplasty.[107]

5. The Mental Health Care System is Underfunded.

Funding for mental health care has decreased significantly in recent years, while total health care spending has increased. From 1992 to 1999, total health care expenditures *increased* 23%,[108] while mental health and substance abuse expenditures *decreased* 20%.[109] The portion of the health insurance premium spent on mental health treatment in 1988 was 6.1%. By 1998, it decreased to 3.2%.[110] By 2002, it dropped to 2.6% of private health premiums.[111] From 1981 to 1990, mental health expenditures composed 2.1% of state budgets. Even though the cost of psychotropic drugs has increased by 9.9% annually,[112] the percentage of state budgets devoted to mental health had slumped to 1.8% by 1997.[113]

Insurance coverage for mental health remains exclusionary, unfair, and inadequate. Insurers have for many years restricted mental health treatment by creating stringent standards for "medical necessity," by restricting the availability of mental health providers in their networks, by negotiating payment levels so low that hospitals and clinics were encouraged to reduce or eliminate mental health services, by utilizing pre-existing conditions and treatment exclusions to discourage mental health

usage, and by using underwriting standards to avoid policyholder groups that have higher risk populations.

For example, the Minnesota Hospital and Healthcare Partnership ("MHHP") reports that the average cost of treating a psychiatric patient in a hospital in 2000 was $1,388, and the average payment by health plans was $678.[114]

Inequities and inadequate coverage are not limited to the private sector. Public health programs, whose recipients utilize mental health services at higher rate than the overall population,[115] are subject to limited coverage and high co-pays. For example, Medicare recipients seeking outpatient psychiatric services must pay a 50% co-payment, [116] while co-payments for most other types of medical services are significantly less, at 20%.

Lack of federal funding is also a problem for mental health hospitals. As Institutions for Mental Disease ("IMD"), psychiatric hospitals with more than 16 beds are not eligible to receive federal Medicaid funding, except for very limited services.[117] Dependent entirely upon state funding, a record number of state hospitals have closed in recent years due to budget stress.

Mental health treatment is further undermined by the amount of time that providers must squander with the Hydra personnel in managed care companies, attempting to explain the need for a particular treatment. Unlike many physical illnesses, which can be objectively diagnosed, mental illnesses are typically diagnosed based on subjective symptoms, making it easier for managed care companies to second guess treatment recommendations. As problematic as the Hydra personnel is the recent imposition of "case rate" compensation by HMOs and insurers, where a provider signs an agreement that pays the provider a fixed amount per patient regardless of the number of treatment sessions needed

by the patient. This system provides a financial incentive to minimize treatment even when it is not in the patient's best interest. When paid a flat rate, mental health professionals typically cut back on the number of times that they see their patients by 20 to 25%.[118] The irony of a case rate system is that it provides a strong economic inducement for providers to avoid patients who need the most treatment.

Underfunding has also created an acute shortage of mental health beds. Despite an increasing demand for psychiatric services, the number of licensed mental health beds in Minnesota has decreased by over 15% from 1996 to 2001.[119] For instance, over the past ten years, Kindred Hospital closed approximately 40 beds; Mercy Hospital closed a 12-bed unit; the University of Minnesota closed two units of 12 each; Wilson Hospital of Faribault closed 20 to 30 beds; and Eitel Hospital closed approximately 60 beds. In 2001, the Mayo Clinic converted a 23-hour observation unit of ten beds into an acute care unit because most people admitted required longer hospitalization than 23 hours.[120] Allina Health System, the largest health system in Minnesota with almost one-third of the hospital beds, previously had a dozen behavioral health clinics. It now has only three.[121]

Lack of bed space and appropriate treatment options also contribute to the overload in emergency room admissions, which are expensive, and often ill-suited to effective mental health treatment. In a recent joint survey by several medical associations, 70% of emergency room physicians nationwide report an increase in people with mental illness "boarding." Boarding means that patients admitted to the hospital are forced to wait in the emergency room until inpatient beds are available in the hospital.[122] Boarding reduces the availability of emergency room staff, decreases available emergency room beds,

causes longer waits for all emergency patients, creates patient frustration, and increases ambulance diversion to other hospitals.[123]

Lack of bed space has forced families to travel great distances to find mental health beds for short-term emergency or urgent care treatment. Psychiatrists in South Dakota complain that children from the Twin Cities area are being shipped to Sioux Falls due to lack of facilities in Minnesota. News articles point out that it is not unusual for psychiatric patients to be left stranded for up to 72 hours in emergency rooms in the Twin Cities area, only to be then transported hundreds of miles from their families to Duluth, Winnipeg, Des Moines and Fargo.[124] These placements are expensive and stressful for patients and family members, and undermine the necessary continuum of treatment after discharge.

The Minnesota Psychiatric Society argues that, if Minnesota had adequate outpatient treatment options, we could reduce mental health hospitalizations by approximately 10 to 30%.[125] Minnesota could save money and lives if it had outpatient centers for mental health diagnostics, for triage and screening, for intervention, for treatment, and for post-discharge transitioning back into the community.

Inadequate mental health funding also contributes to the severe shortage of mental health providers, including psychiatrists, psychologists, and counselors. For instance, Minnesota has one psychiatrist for every 10,000 people,[126] which is approximately 33% fewer psychiatrists per capita than the national average.[127] Since 30% of the population will need to see a psychiatrist at some point in their lives, this is an enormous shortfall.[128] Psychiatrists are among the lowest paid medical specialties and are paid 10-40% less than primary care physicians for

equivalent outpatient work under typical third-party payor contracts. [129]

This shortage is much worse outside of the metro area. According to the Minnesota Department of Health, 70 of the state's 87 counties currently have a shortage of psychiatrists, and rural patients face a three-to four-month wait for mental health services.[130]

While Minnesota's shortage of psychiatrists is particularly acute, it is reflective of a national trend. One study estimates that by 2020, the nation will have only 8,312 child psychiatrists, a third less than the 12,624 psychiatrists that will be needed.[131]

6. A Unified Mental Health System.

Lack of Coordination and Integration of Mental Health Services. A recent report described Minnesota's mental health care system as follows: "Minnesota's mental health care system as a whole often falls short -- because there is no 'whole.'"[132] Public and private providers and programs operate without any overall coordination or integrated scheme or plan. Mental health providers, facilities, and services are regulated and licensed by several different state agencies and boards with little coordination among them.[133] In addition, patients requiring more than minimal care move through various evaluation, inpatient, outpatient, and community services and programs without coordination. The lack of integration and coordination among these systems, programs, and services results in an unnecessary duplication of services in some areas, and failure to provide needed services in others.[134]

Our Current System Does Not Want To Provide Mental Health Treatment. The current shortage of mental health facilities makes it clear that private providers cannot meet the current mental health care demands of this state. Hospitals indicate that the per diem payment for mental health care is so

low that they must devote their resources to higher compensated services such as cardiac care. Similarly, the lack of mental health clinics, providers, halfway houses, diagnostic assessment centers, and intermediate treatment facilities can be tracked back to underfunding by the current compensation system.

Similarly, employers have not indicated an interest in funding mental health treatment through employer-sponsored plans, be they self-funded, insured, or HMO. The difficulty in getting legislation enacted at both the federal and state level concerning mental health parity underscores the reluctance of the private sector to fund such activity. The consistent drop in the percentage of premium allocated to mental health care, at a time that mental health treatment is in higher demand, also supports this conclusion.

Finally, HMOs, insurers, and self-insured plans have demonstrated that, under the guise of cost containment, they aggressively oppose efforts to adequately fund mental health care through mandated coverage. Instead, they discourage treatment through the aggressive use of case rate compensation, mental health "management companies," reduced provider networks, and repeated refusals to pay for treatment.

The Public System Does Not Want To Provide It Either. As the private system has retreated from mental health care, government programs have been tightened in the face of tightened government budgets. Vice President Hubert H. Humphrey once said that a society is measured by what its government does for those in the shadows of life. Minnesota is failing this standard. Regional treatment centers are closing, intermediate care facilities are going bankrupt, and Medicaid coverage is scaling back. Both the public and private sectors have discovered that the vulnerable in our population, including those with mental health problems, are the

least able to speak up when a program or benefit is cut.

The Cost Shifting Between the Public and Private System is Destructive. The current mental health system induces the private system to shift the mental health population onto the public welfare system, and the public welfare system is induced to shift the mental health population onto the criminal justice system. In 2001, the Attorney General's Office entered into settlements with the state's largest HMOs and insurers over their failure to pay for mental health and chemical dependency treatment as provided under their policies.[135] During the lawsuit, it was determined that, over a six year period of time, the Minnesota Department of Human Services and Minnesota counties paid over $75 million for court-ordered treatment that should have been covered by insurance policies issued by HealthPartners, Medica and Blue Cross Blue Shield Minnesota. The damage to the State was not just the $75 million. Its families also sustained misery and financial losses due to lack of treatment of a loved one. Indeed, the General Accounting office reported in April 2003 that at least 12,700 families had to relinquish custody of their children to child welfare or juvenile justice systems so they could receive mental health care services.[136] And the State paid unnecessary costs to incarcerate patients whose "conduct disorders" resulted in violations of the law. This litigation revealed that the Hydra professionals were utilized by HMOs and insurers to frustrate treatment and deny claims and to shift the cost of mental health care onto the criminal justice system.

The shifting of mental health costs could be avoided with a unified system which is funded and overseen by the State. A single entity should coordinate, fund and regulate mental health services. The agency could impose a fee on insurers and self-

insureds equal to the funds currently allocated by insurers for mental health care. The State could combine this money with the hundreds of millions it spends through its social service and criminal justice systems on conduct disorders, chemical dependency treatment and correctional custody.

The State should establish a multi-faceted mental health system composed of adolescent mental health diagnostic centers, regional treatment centers, outpatient and day services, social workers, psychologists and psychiatrists. Mental health professionals in schools, county social services departments, private practice and public and private facilities should coordinate care under a single umbrella program. A limited number of hospitals could be designated "centers of excellence" for inpatient mental health care, and the others could act as triage and referral centers.

The goal of a unified mental health system should be to ensure that treatment is efficiently and humanely accessible to all Minnesotans. Treatment stages could be coordinated from the assessment stage to inpatient and to outpatient service. There should be no financial incentive to dump a mentally ill patient.

Increase funding, resources, and quality of care. A number of specific changes could be made to the present system to increase funding, resources, and the quality of care for mental illness:

- Increase Medicaid reimbursement rates for mental health services.
- Enact legislation to repeal or modify IMD exclusion to provide federal funding for psychiatric care at state hospitals.
- Limit the "case rate" reimbursement system.

- Repeal the Medicare Mental Health Outpatient Treatment Payment Limitation, which limits psychiatric payment to 50% of the Medicare fee schedule (compared with most other medical services that are 80% covered).
- Encourage broader insurance coverage for psychotherapy, residential treatment placements, early diagnosis, prevention, screening, and intervention, and rehabilitation services.

V. SECOND, LET'S DO SOMETHING FOR OUR CHILDREN.

The United States is the wealthiest nation in the world. Since 1965, it has provided health coverage for its seniors, yet it does not provide similar care for its children. According to one study, the United States has 20.2 million children without health insurance, 27.9% of all children in the nation.[137] In Minnesota, at least 71,100 children are uninsured.[138] Ironically, the annual compensation paid to the chief executive officer of one Minnesota-based HMO--$92 million--could provide comprehensive health insurance to *all* Minnesota's uninsured children for at least three years.[139]

Children suffer without health care coverage.[140] They forego screenings and preventive care, resulting in easily treated childhood illnesses such as sore throats, earaches, and asthma festering into permanent damage and even death.[141]

One in five uninsured children has untreated vision problems.[142] Uninsured children, compared with insured children, are 2.3 times less likely to obtain medical treatment[143] and 2.5 times less likely to receive dental care.[144] Less than half of uninsured children receive well-child care.[145]

Even with access to insurance, many children do not get access to health care. In some cases this relates to poverty or cultural issues, where parents have rigid work schedules and no access to transportation.[146] In other cases the parents may not recognize that the problem needs medical attention.[147]

In yet other cases, the parents simply do not have access to a provider due to language, co-payment, or cultural barriers.[148]

Children without cultural barriers and with insurance, however, also fail to get necessary health treatment. In one study, 18% of adolescents reported that they did not receive what they believe was needed health care during the previous year.[149] Children between 10 and 19 have the lowest utilization rate for health care and are the least likely to show up at a primary care provider's office.[150] Oddly enough, they also have a higher emergency room admission rate than any group below the age of 75,[151] using about 15% of emergency room services.[152] This is probably because they forego necessary primary care treatment, and delay matters until the condition festers.[153]

For a variety of reasons, be it lack of insurance, cultural issues, or just being a child, the next generation is creating unnecessary expense at the emergency room and not getting adequate care at the physician's clinic. There are several steps that can be taken to improve the insurability of our children, to improve their education outcomes, and to provide them better and less expensive health care.

A. School-Based Health Care.

In order to eradicate the spread of polio, measles, and small pox, the government in the 1950s implemented a system of administering physicals and immunization shots to students in schools. These "clinics" were a cheap and effective way to control the spread of communicable disease. In the 1970s, school based clinics were once again utilized in a limited manner, generally in impoverished areas where health care utilization was low.[154] They were quite successful, and the number of school based health clinics (SBHCs) rapidly grew to approximately 1,500 by 2002, serving approximately 1.1 million children.[155] This is an increase of 650% since 1990,

when approximately 200 SBHCs existed. The SBHCs are found in 43 states, with 20 located in Minnesota. All but one of Minnesota's SBHCs is located in the urban area of Minneapolis and St. Paul.[156] Fourteen of these SBHCs are located in high schools, and fourteen of them are staffed with primary care providers at least 25 hours per week[157]. The vast majority of the Minnesota SBHCs offer comprehensive health assessments, medication prescriptions, asthma treatment, nutrition counseling, immunizations, mental health assessments and therapy, and laboratory services.[158]

SBHCs are endorsed by a number of health organizations, including The American Academy of Pediatrics, the Society for Adolescent Medicine, the National Association of School Nurses, and The American School Health Association.[159] Governor Arne Carlson's Department of Children, Families and Learning strongly supported SBHCs, noting that they benefit the student, the family, the school, the health providers, and the insurance system. The Department pointed out that, in contrast to other models, SBHCs have better attendance for clinic appointments, earlier diagnosis of disease, better coordination of services, and improved health and education outcomes.[160] The Surgeon General points out that SBHCs improve mental health treatment access and outcomes.[161]

SBHCs are consistently found to improve health care for our adolescent population. Virtually every study concludes that SBHCs have high utilization and high enrollment.[162] Several studies have concluded that SBHCs reduce emergency room admissions and inpatient treatment at hospitals. One study of asthmatic children in Denver compared outcomes of children in a SBHC school with one that had no center. The rate of hospitalization for asthma was almost 70% more for students who did not have access to an SBHC.[163] The leading cause of school

absenteeism is asthma, and asthmatic children at the SBHC school averaged three more days of attendance each year.[164] Similarly, a comparative study of two schools in Georgia showed dramatic results as it related to hospitalization. The average annual cost per child for inpatient hospitalization at the SBHC school was $197.24, while the average for the non-SBHC student was $748.97. Similarly, the average annual cost per child for emergency room treatment at the SBHC school was $52.97, while the average for the non-SBHC student was $143.64.[165] Other studies make similar findings of increased use of primary care physicians, decreased use of emergency departments, and decreased hospitalizations.[166]

SBHCs also have dramatic results in the area of mental health. Adolescents with access to SBHCs are ten times more likely to make a mental or substance abuse visit.[167] The Surgeon General notes that 70% of children in need of mental health treatment do not get it,[168] and that about 70% of those who got services received them in the schools, not from health providers. Mental health counseling is repeatedly identified as the leading reason for visits by adolescents,[169] and several studies note that the barriers experienced in traditional mental health settings -- stigma, non-compliance, inadequate access -- are overcome with SBHCs.[170]

SBHCs dramatically improve the quality of life for a child and the school in other ways. SBHCs have much better vaccination rates with students.[171] They have more effective tobacco control programs.[172] The students who utilize SBHCs have fewer disciplinary problems.[173] They increase preventative health care for students who typically go without, decrease school absenteeism, reduce parents' time off from work, and reduce substance abuse.[174]

Perhaps most important in a budget cutting era, a number of studies indicate that SBHCs probably

save money. One study noted that the annual Medicaid cost per child at a SBHC school was $898, compared to a cost of $2,360 for a non-SBHC student.[175]

SBHCs in Minnesota are primarily funded by private non-profit organizations and local departments of health. They also get limited funds from the Title V Maternal and Child Health Block Grant, and some are able to bill Medicaid.[176] These SBHCs should be reviewed for efficacy and, where savings in lives and money can be shown, they should be replicated throughout the state.

B. Full Utilization of Existing Programs for Uninsured Children.

Two joint state and federal government programs provide health care for children in certain low income families: Medicaid and the State Children's Health Insurance Program (SCHIP).[177] These programs serve children and families with incomes below 200% of the federal poverty level.[178]

The existing programs do not fully reach their target audience. Approximately 36,000 low income Minnesota children (a little over half of the total number of uninsured children in Minnesota) are eligible for health insurance through Medicaid, yet remain uninsured due to the intricacies of the enrollment process, language barriers, immigration status, lack of awareness of eligibility, and other reasons.[179] One study explains that many children eligible for Medicaid and SCHIP are not enrolled because a parent cannot afford to pay the contributory premiums or cannot successfully navigate the myriad of paperwork necessary to obtain benefits.[180]

More aggressive outreach efforts, such as presumptive enrollment, should be undertaken to increase enrollment of uninsured Minnesota children eligible for the above programs. Presumptive

enrollment authorizes schools, day care centers, Head Start programs, and other child service agencies to directly enroll children who appear to qualify for Medicaid coverage. Once presumptively enrolled, children can receive immediate health care, while their families are given time to complete any necessary paperwork. The Minnesota Department of Education already utilizes automatic enrollment for similar poverty-based programs such as school lunch programs. Congress has approved the use of presumptive eligibility in Medicaid and SCHIP programs, yet only a handful of states use it.[181] Minnesota should immediately begin utilizing presumptive enrollment.

VI. THIRD, LET'S STOP STICKING IT TO SMALL BUSINESS.

A recent Michigan survey notes that 63% of small business owners favor universal health insurance and will pay more in taxes to get it.[182] While commentators were surprised at this result, it is explained by the difficulty rising health care costs place on small employers.

Some small employers cannot get a viable quote on a policy. An actuary who reviews the census data of 50 employees is unable to predict how many heart attacks, cancer onsets, or difficult baby births will occur over the next year.[183] A catastrophic illness for even one employee can disrupt stability and can force a small company to drop coverage.[184] Even larger companies feel the impact of a catastrophic illness. Dayton Rogers, a Minnesota precision metals company, has 300 employees and paid a 24% increase because of a few high-risk employees, one of whom incurred $1.4 million in care over the previous two years.[185] Not able to get a viable quote, smaller employers are forced to drop coverage.

Other small employers are able to maintain coverage, but do so only by passing on hefty increases to employees,[186] who often cannot afford it. In 1998,

the percentage of premium paid by employees of small companies was significantly higher than those at larger companies.[187] The spread between the percentage paid by workers of small and large companies has grown since 1998,[188] with workers in small companies paying 17% more for coverage.[189] In spite of this, small companies have higher premium increases. Companies under 200 employees averaged a 15.5% increase last year, while those with over 200 employees averaged a 13.2% increase.[190]

The disparity between large and small employers frustrates economic growth. It forces small business, the traditional engine of economic expansion, to cut back on capital investment, to reduce marketing efforts, and to freeze compensation.[191] Unable to offer a competitive benefit package, some have difficulty retaining valuable employees, who are lured to the benefit packages of larger employers.

The stem cell of economic growth are budding entrepreneurs at existing companies who dare to leave a bureaucracy, invest a nest egg in a new business, and join with others to research, develop, and market a better product. The risk of leaving a self insured bureaucracy to start a new business is daunting enough, and some are chilled with the added risk of a family's catastrophic illness and consequent high insurance premiums. As noted by Professor John Lanigan of the University of DePaul, Coleman Entrepreneur Center: "Entrepreneurs have really been pushed out of the market. They have this dream of having their own business, and yet in many cases there's really no way around the insurance hurdle."[192]

When it comes to health care, the plight of the uninsured and small business is closely intertwined. There are 5.8 million small employers that employ half of all workers.[193] Approximately 48% of businesses which employ less than 50 workers offer

health coverage, as do 40% of those with less than 10 workers.[194] In contrast, 97% of businesses with more than 50 employees offer health coverage.[195] The number of uninsured increased by 2.4 million in 2002,[196] which number coincides with the increase of uninsured small employers.[197] This is because 60% of the 44 million uninsured[198] live in a household where a member is employed by a small employer.

The President proposes the creation of Association Health Plans (AHPs) to address this inequity between small business and their larger competitors.[199] AHPs would allow companies throughout the country to band together in associations to negotiate a rate with insurers. Proponents argue that AHPs could save money by creating a blanket policy with fewer benefits, and that the bargaining power of the larger plan will cut administrative costs and add more clout in negotiating overall insurance rates. The problem, however, is that this concept has already been utilized with little success by Multiple Employer Trusts, Multiple Employee Welfare Plans, and intrastate employer associations. Employers in these groups were unable to contain costs, and many of the groups eventually failed when competing insurers "cherry picked" the healthier employers from existing associations and formed other groups. AHPs might work well for the Hydra groups, but they do little for the employer.

We can do better. An employer that buys group health insurance coverage ought not assume the societal cost of catastrophic health care. An employer ought to be able to buy group coverage for healthy employees and, for employees with a catastrophic injury or medical condition, be able to purchase health insurance for their employees at a subsidized rate. The rate and coverage for such employees could be similar to that of policies issued by the Minnesota Comprehensive Health Association ("MCHA"),

which presently offers insurance policies to persons who have been denied insurance through the private market due to preexisting conditions. Under the law, MCHA may not charge a policyholder more than 125% of the average price of a policy issued in policyholder's age bracket. By allowing employers to provide a subsidized insurance policy to high risk employees, the burden of catastrophic health care is transferred from a specific employer to the broader society.

The subsidy to cover these individuals could be provided through MinnesotaCare. MinnesotaCare is a subsidized health insurance program for Minnesotans who do not have access to health insurance. MinnesotaCare is funded by a combination of enrollee premiums and a tax imposed on health care providers and also receives some federal funding. MinnesotaCare will need additional funding to subsidize the cost of employee coverage as discussed above. It is more appropriate that government subsidize the cost of catastrophic care, however, rather than small businesses that become penalized for hiring employees who have or develop serious medical conditions.

VII. FOURTH, LET'S JOIN OTHER COUNTRIES IN CONTAINING THE COST OF PRESCRIPTION DRUGS.

Approaching 15% of the gross national product, health care is one of the largest sectors in the American economy. Prescription drug expenditures are the fastest growing segment in health care, approaching 18% of all health care expenditures.[200] According to the Kaiser Family Foundation, prescription drug spending doubled between 1995 and 2000, with expenditures reaching $122 billion in 2000.[201] Prescription drug spending grew at an average rate of 12.4% per year from 1993 to 1998, compared with a five percent average growth rate for overall health care expenditures, and compared with

growth rates ranging from 1.6 percent to 5.7 percent for all items on the Consumer Price Index.[202] This rapidly growing cost is particularly difficult for the senior population, which is especially vulnerable to the high cost of prescription drugs because it generally uses a higher volume of medicine. The cost of prescription drug coverage is expected to continue to escalate, with one estimate being that the Medicare population alone will spend $228 billion for prescription drugs in 2011.[203]

While almost all other industrialized countries regulate the price of prescription medication, and while prescription drug pricing has become a perennial issue in political campaigns at both the state and federal level, there has been little action taken to reign in the cost of prescription drugs. Commentators point to the millions of dollars that the pharmaceutical industry contributes to political candidates and parties as the primary reason that legislative efforts are repeatedly stalled or defeated. The political strategy of the pharmaceutical industry is clear: it opposes any government action which adversely affects its bottom line -- namely, its profits.

This is ironic because the pharmaceutical industry has been the most profitable industry in the United States for each of the past ten years.[204] In 2001, it was 5-1/2 times more profitable than the average of all other Fortune 500 companies.[205] In 2000, the profits of one drug company, Merck, were $6.8 billion -- larger than the combined profits of all of the Fortune 500 companies in the airline industry and in the entertainment industry.[206] With the top 12 pharmaceutical companies earning $27 billion in profits in 1999, the industry has an extraordinary profit margin, estimated by Fortune Magazine to be 18.6% in 1999.[207] It argues, however, that such margins are necessary because of the high cost of

research and development ("R&D") of new medicines.

Critics point out that the pharmaceutical industry neglects to consider the significant public support that subsidizes the R&D process, including the enormous tax breaks, tax credits and publicly funded research which benefits the industry.

For instance, no sector receives better treatment under the tax code than the pharmaceutical industry. Federal tax credits include the Research and Experimentation Tax Credit, the Orphan Drug Tax Credit and the Possessions Tax Credit. A 1999 study conducted by the Congressional Research Service noted that between 1990 and 1996, just one tax credit alone saved drug companies $13 billion in federal taxes.[208] A tax credit, which is a dollar-for-dollar reduction on taxes, is substantially more lucrative than a tax deduction. The Research and Experimentation Tax Credit allows a pharmaceutical company to reduce its tax obligation on a dollar-for-dollar basis by claiming a tax credit equal to at least 50% of the R&D expended by the company during the year.[209] In other words, this tax credit alone publicly subsidizes 50% of all R&D research. Because of these tax credits, the pharmaceutical industry is the least taxed industry in the country.[210]

Given the fact that the pharmaceutical industry is the most profitable industry in the country, it is ironic that the industry's 16% effective tax rate is lower than that imposed on middle class Americans, who are generally subject to tax rates between 30 and 40%, or the average American business, which generally pays a federal tax of approximately 27%.[211]

In addition to tax credits, the pharmaceutical industry receives additional public tax dollars from federal medical organizations such as the National Institutes of Health ("NIH"). In 1950, the NIH had a total appropriation of $43 million.[212] By 1998, the

NIH received an appropriation of $13.6 billion.[213] Congress subsequently committed to double the budget of the NIH between 1998 and 2003.[214] By 2002, NIH's budget was almost $24 billion.[215] The majority of NIH funding -- approximately 80% -- is awarded to research centers and universities; ten percent of NIH funding is used for research conducted by the NIH itself.[216] At least one study of the 21 most important drugs introduced between 1965 and 1992 concluded that publicly funded research played a significant role in the development of 14 of the drugs.[217] The NIH examined the top five selling drugs in 1995, each of which had over $1 billion in sales, and concluded that taxpayer funded researchers conducted 55% of the published research projects on these drugs.[218] It also concluded that federal taxes also paid for approximately 30% of the published research of foreign academic institutions which participated in the development of these drugs.[219]

While other countries regulate the price of prescription drugs, our government has gone out of its way to avoid any type of regulation. This costs the American taxpayer billions of dollars. For instance, according to statistics compiled by the State's Medicaid program, its prescription drug costs have increased nearly 300% since 1996. These prescription products approach $1 billion per year, is the fastest growing category of Medicaid expenditures, and cost up to double what is paid in other industrial countries. While the states cannot effectively address the prescription drug problem on their own, there are some steps Minnesota can take.

A. Establish a Bulk Prescription Drug Purchasing Program.

In the prescription drug industry, size matters. Quite simply, high volume purchasers are able to extract the best prices from wholesalers and drug manufacturers. The State and its citizens should be able to get better prescription drug prices by pooling

together its and others' drug purchasing to take advantage of the enhanced bargaining power created by the aggregate demand.

There are several different types of bulk purchasing available. First, the State can aggregate the purchasing power on all State and other public drug purchasing programs that directly or indirectly buy prescription drugs. This includes, for example, the State Medicaid program, which alone spends approximately $800 million per year on drugs. It also includes State and local employee health plans, State correctional facilities, State hospitals and other medical treatment facilities, and State and other public educational institutions. Many other states are enacting similar intra-state prescription drug bulk purchasing programs.

Second, the State should engage in bulk purchasing with other states. There are numerous such inter-state bulk purchasing programs already in place that the State could join.

Third, the State should negotiate prescription drug prices for Minnesotans with Canadian pharmacies to get Minnesotans the lowest prices possible on their imported prescription drugs. The State should also consider purchasing prescription drugs from Canada on behalf of the public drug purchasers referenced in the above-described intra-state bulk purchasing program.

Finally, the State should aggregate its purchasing power with other willing private drug purchasers, such as health insurers, HMOs and large self-insured employers, to try to negotiate the best drug prices possible.

B. Establish and Enforce Price Reporting/Certification Requirements.

Many drug companies lie about certain prices they report for their drugs in order to increase their

sales and profits. These companies employ one or more fraudulent schemes. One involves the fraudulent reporting of Average Wholesale Prices ("AWPs"), which Medicaid and Medicare use to determine the amount to reimburse physicians and pharmacists for prescription drugs. This fraud scheme not only harms Medicaid and Medicare, it also harms Medicare beneficiaries who are required to make excessive co-payments for their prescription drugs. Another scheme involves the fraudulent reporting of a drug company's best prices and/or Average Manufacturer's Prices ("AMPs"), which are used to determine the drug company's liability to the State Medicaid program for rebates required under federal law.

There are many lawsuits against prescription drug companies pending around the country relating to these AWP and Medicaid rebate fraud schemes. The State of Texas is the only state in the country that requires drug companies to report certain pricing information directly to the state's Medicaid program. Minnesota should pass a law, similar to Texas' law, that would require drug companies to report certain pricing information directly to the Minnesota Medicaid program.

Not only should drug companies be required to report their truthful prices, but company executives should also be required to certify the accuracy of the reported prices. This certification requirement could be patterned after similar certification obligations that Congress recently imposed for the reporting of corporate financial records to the SEC.[220] A reporting and certification requirement will provide price transparency, a valuable weapon in combating fraud.

C. Repair/Expand the Minnesota Fair Drug Pricing Act.

Approximately 16% of Minnesota's population (800,000 people) do not have prescription drug coverage. Senior citizens and other cash paying

customers pay the highest drug prices. Manufacturers offer discounts on purchases to favored group customers such as health insurers, HMOs, the federal government, and pharmaceutical benefit managers (PBMs). Those who are unable to take advantage of these programs pay more, even though they often live on fixed incomes and have high health care expenses.

In 2003, the Minnesota Legislature passed the Fair Drug Pricing Act, which was designed to allow uninsured Minnesotans to purchase prescription drugs at the same price Medicaid pays.[221] This benefit was to be subsidized by supplemental rebates charged to prescription drug companies. While the aim of the law was admirable, the law was significantly watered-down before it was passed. The version of the Act which passed (1) severely limited the scope of the Act due to the inclusion of restrictive income requirements; (2) deleted the enforcement provision of the bill; and (3) included a sunset provision indicating that the law expires upon the effective date of a Medicare drug benefit -- which is only months away.

Although Congress passed a Medicare prescription drug benefit, that benefit does *not* assist Minnesotans without prescription drug coverage who are not enrolled in Medicare. Additionally, the Medicare prescription drug benefit is not fully effective until January 1, 2006, meaning that even seniors who are encompassed by its provisions will not receive any meaningful assistance with prescription drug costs for almost two years. Although drug manufacturer drug discount cards will be offered to Medicare seniors in the interim, these cards have long been available to seniors and provide no new benefit.

The legislature should repair and expand the Fair Drug Pricing Act. It should expand the benefit of the law to *all* Minnesotans without prescription drug

coverage. It should also add an enforcement provision and delete the sunset provision. This legislation would ensure that all Minnesotans without prescription drug coverage receive the benefit of Medicaid prices. Additionally, it would ensure that Minnesota seniors have the option to participate in the Minnesota Fair Drug Pricing Act program if they opt not to participate in the Medicare drug benefit because of the very modest benefits it provides most seniors.

D. Take Steps to Enable the State to Become A Medicare Prescription Drug Benefit Provider.

The newly enacted Medicare Prescription Drug, Improvement and Modernization Act of 2003 provides for a prescription drug benefit for Medicare beneficiaries beginning in 2006. This benefit will be administered by a number of approved plans which are expected to include health insurers, HMOs, PBMs, and others. The Medicare Act, however, expressly prohibits the federal government from negotiating favorable prices for the nation's seniors.

The State should seek to become a Medicare Act approved plan for the purpose of administering the new drug benefit. One potential advantage of this is the ability to leverage the State's aggregate buying power to get the lowest prices for seniors. That is, the State could do exactly what Congress will not let the federal government do -- negotiate with its bulk purchasing power.

E. Adopt Other Prescription Drug Legislation.

The Minnesota Legislature could enact other laws dealing with prescription drugs that would drive down the high cost of these drugs. For example, it could regulate the conduct of PBMs which typically manage the prescription drug benefit for an insurer or self-insured employer. In fact, these companies often engage in fraud driving up the health care costs for

everyone. One way PBMs engage in fraud is by extracting large rebates from drug companies for getting the companies' drugs on the formularies and then hiding those rebates from the insurers and self-insured employers on whose behalf they are purportedly acting. PBMs also sometimes commit fraud by charging insurers and self-insured employers inflated sums for prescription drugs the PBMs are able to acquire at much lower prices. PBMs have also been found to have engaged in fraudulent practices designed to get physicians and pharmacists to switch patients' drugs in order to make more money for the PBM.

Numerous states are proposing and enacting laws aimed at regulating PBMs. Minnesota should enact such a law which should, among other things: require PBMs to fully disclose to their clients any drug company rebates they receive; to pay such rebates to their clients if required by their contracts with their clients; to prevent PBMs from charging for drugs based on inflated AWPs; to prevent PBMs from profiting from the price spread on drugs with inflated AWPs; require the licensure of PBMs operating in the State; prohibit drug switching conduct that results in an increased price of a drug; prohibit the sale of private prescription information to anyone.

Conclusion

W.C. Fields had a number of detractors. Legend has it that Mr. Fields was at a dinner party and, by the time dessert was served, appeared to be "in his cups." A woman walked up to Mr. Fields and scolded him, "Mr. Fields, you are drunk." Mr. Fields replied, "Perhaps, but you are ugly. Tomorrow, I will be sober. Unfortunately, you will still be ugly."

The health care industry has more than a hangover. It is downright ugly and in dire need of President Lincoln's makeover. Yet, every meaningful proposal for structural change in our health care

system is ripped apart by the incredibly powerful industry. Each proposal costs too much, limits too much choice, or simply goes "too far." As a result, the system remains wasteful, unjust and inhumane. The proposals presented here are not a panacea. They are a beginning, though, and a first step toward transforming an ugly system which has become completely out-of-control.

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