Containing Costs in Minnesota's Health Care System

A Report to Governor Arne H. Carlson and the Minnesota Legislature

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Summary

Minnesota Health Care Commission

January 25, 1993

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Jasper Daube, Minnesota Medical Association Representative
Gayle Hallin, Provider Representative
Robert Kelly, Rural Physician Representative
Gretchen Musicant, Minnesota Nurses Association Representative
Douglas Robinson, Minnesota Hospital Association Representative

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Mary Miller, Insurance Federation of Minnesota Representative

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George Halvorson, Minnesota Council of HMO's Representative
Bert McKasy, Commissioner of Commerce
Mary Miller, Insurance Federation of Minnesota Representative
Richard Niemiec, Blue Cross Blue Shield of Minnesota Representative
Douglas Robinson, Minnesota Hospital Association Representative

* Chair

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Preface

The Minnesota Health Care Commission was established in the 1992 legislation known as "HealthRight." The Minnesota Legislature charged the Commission with the responsibility to develop a cost containment plan that will slow the rate of growth in health care spending by at least ten percent a year for the next five years. This report contains a summary of the Minnesota Health Care Commission's cost containment plan. The plan was developed by consensus and this report was approved by the Commission without a dissenting vote.

The plan that is summarized in this report is not a detailed blueprint but a strategy and a series of first steps toward achieving cost containment goals. Many details remain to be worked out. If the plan is approved by the Legislature and the Governor, the Commission will resume its progress toward resolving the implementation details. The plan will also require continuous refinement as Minnesota accumulates better information and gains more experience. The plan is not the final answer but the beginning of a continuous process of improving the efficiency and quality of our health care system.

Early in its proceedings, the Commission adopted a policy that it would foster a spirit of openness to community involvement and participation. In the process of developing this report, the Commission welcomed proposals from the greater community and developed a process for routing proposals to appropriate committees for consideration. The report contains numerous strategies and concepts that were suggested by persons and organizations other than Commission members. However, the publication of this report does not signal the end of opportunities for the greater community to participate. In the spirit of continuous improvement of the cost containment plan, the Commission welcomes comments and suggestions on this report, and will be holding a series of public hearings throughout the state. The Commission also encourages interested persons and organizations to submit written comments. The Commission will continue to improve its cost containment plan in response to comments and suggestions from the community.

Guiding Principles

Partnership.

The Commission is a partnership between government and the private sector and between the different stakeholders in the health care system. Since the stakeholders are partners, not antagonists or competitors, striving to achieve a common mission, Commission activities will be undertaken in an atmosphere of mutual respect and trust, open communication, and cooperation. The Commission will strive to make decisions by consensus.

Shared responsibility.

It may well be that the Commission's mission cannot be accomplished without some investment or sacrifice by all groups of stakeholders. The responsibility should be distributed equitably among stakeholders.

Incentives.

Incentives are preferred over mandates.

The role of government.

Private sector roles will be encouraged and facilitated and the role of government minimized. However, some level of governmental involvement is appropriate for the public good.

Balancing competition and regulation.

The ultimate goal of the health care system is to provide high quality health care at an affordable price. Competition can be an effective force for achieving this goal and has some distinct advantages over regulatory approaches. However, competition is not always the most effective strategy. Regulation is appropriate in those circumstances when an uncontrolled competitive environment is not in the best interest of consumers or when governmental involvement is necessary to preserve or promote competition. When pure competition is not in the best interest of consumers, collaboration will be encouraged but with an appropriate level of governmental supervision or regulation to ensure that the collaboration furthers the public good.

Flexibility.

The Commission's strategic plan will be designed to be easily adapted as conditions change and as new information and techniques become available.

Regional variation.

To a large degree, health care delivery is a local process and conditions vary significantly from one region of the state to another. Different tools and techniques may be appropriate for different regions.

Introduction

The Minnesota Health Care Commission.

The Minnesota Health Care Commission was created by the 1992 HealthRight Act. The Commission consists of 25 members representing health care providers, health plans, employers, unions, consumers and state agencies. Thirteen of the members are appointed by the Governor, two consumer representatives are appointed by the Legislature, and ten members are appointed by trade associations and other organizations.

Cost containment plan.

The 1992 HealthRight Act requires the Minnesota Health Care Commission to submit to the Legislature and the Governor a plan for slowing the growth in health care spending by at least ten percent a year for each of the next five years. During its first six months of existence, the Commission has devoted most of its time and effort responding to the statutory mandate to submit a cost containment plan to the Legislature and the Governor in January 1993. The Commission's statutory charge also includes broader issues relating to the access, quality, and affordability of health care in Minnesota. The Commission will turn to these broader issues during 1993 after the cost containment plan has been submitted and approved through legislation.

The cost containment plan was developed collaboratively by the stakeholders in the health care system through their representatives on the Commission and through openness to community involvement and participation. The plan includes both major, long-term structural change to the health care delivery and financing system and short-term targeted strategies.

The Commission took very seriously the statutory charge that the plan reduce the rate of growth in health care spending by at least ten percent a year for each of the next five years, and believes its plan moves as quickly as possible toward achieving this goal. The Commission estimates that Minnesotans will spend about $150 to $200 million less on health care in 1994 as a result of the cost containment plan. By the end of five years, the Commission estimates that Minnesotans will have saved a cumulative total of about $6.9 billion. These estimates will be further refined in the coming months as more data is collected.

The Commission is committed to closely monitoring and evaluating the

success of the plan in achieving cost containment goals. If at any time it appears that cost containment goals will not be realized, the Commission is committed to taking corrective action to keep Minnesota on target.

Minnesota's health care system: a tradition of excellence.

The Commission recognizes that Minnesota is a leading state in terms of the quality and efficiency of its health care system and the proportion of Minnesotans who have access to health coverage. The Commission is committed to ensuring that Minnesota continues to show leadership through continuous improvements in the health care system.

ERISA.

The Commission recognizes the relevance of the federal ERISA (Employee Retirement Income Security Act) law to Minnesota's health care reform efforts. ERISA limits the ability of states to regulate the health benefit plans of employers, particularly large employers and group purchasers that "self-insure" their health benefit plans (they cover the entire cost of health coverage for their employees or enrolled members rather than purchasing insurance to cover these costs). The cost containment plan is designed to be attractive to self-insured purchasers and promote voluntary participation, thereby reducing the significance of the ERISA issue. Even though the Commission and its committees spent a great deal of time analyzing and discussing ERISA issues, they are not discussed in this report. Various state laws have been challenged on the basis that the laws were preempted by ERISA. The State of Minnesota has already faced one lawsuit and more challenges are likely. Because of the risk that public statements from a state entity assessing the ERISA impact of a particular proposal might ultimately be offered as evidence in a future legal challenge to the proposal, ERISA issues are not analyzed or discussed further in this report.

Long-term care.

Long-term care costs are not presently included in the Commission's statutory charge. The Commission is aware of the substantial and growing expenditures associated with long-term care. Although long-term care is not a part of the overall cost containment plan, the Commission intends to monitor the costs and trends of long-term care along with other components of the system.

The definition of "price."

The word "price" is used throughout this report to mean the actual amount paid (after discounts or other adjustments) by the ultimate purchaser to buy health coverage and health care services. The word "price" is used in this manner to differentiate between health plans' costs of paying for health care services for insured individuals and the cost to the purchaser of buying coverage from a health plan.

The definition of "health plan."

The term "health plan" is used throughout this report to mean a company that sells health insurance or another form of health coverage. "Health plan" includes health insurance companies, health maintenance organizations (HMOs), nonprofit health service plans such as Blue Cross-Blue Shield, health carriers, and other organizations that are licensed by the state to offer health coverage.

Key Features

Under the cost containment plan, the Commissioner of Health will set an annual limit on the rate of growth in health care spending and will implement programs to achieve compliance with the limits. The plan includes health care reforms that will reduce costs and enhance quality through a more effective competitive marketplace. However, the entire health care system will be subject to overall limits and regulatory controls that will prevent excessive increases in costs. The major features of the plan are:

- **Integrated Service Networks.** The plan uses incentives to encourage the development of competing Integrated Service Networks (ISNs) that are accountable for the cost and quality of their services. ISNs will be responsible for providing the full array of health care services (from routine primary and preventive care to acute, inpatient hospital care) for a fixed price for the purchaser, thus creating incentives for the participating providers and health plans to become more efficient. The development of ISNs will also facilitate competition because the quality and price of the ISN "product" can be more easily compared than services provided in fragmented nonsystems of independent providers.

- **Limits on growth.** The plan uses global limits to protect consumers from excessive growth in health care costs without micromanaging provider and health plan budgets. The Commissioner of Health will establish an annual limit on the rate of growth of all public and private health care spending for Minnesota residents that will ensure that the projected rate of growth will be reduced by at least ten percent a year for each of the next five years.

- **Payment systems.** The global limits on growth will be enforced by the Commissioner of Health through payment system reforms. The limits will be enforced differently for ISN and non-ISN health care services. Each ISN will be subject only to an overall limit on growth. Non-ISN services will be regulated through an all-payer system (in which multiple payers and health plans use a single payment system) that will ensure that overall growth in expenditures for non-ISN services does not exceed the growth limits established by the state.

- **A balance of competition and collaboration.** The plan uses incentives to prompt changes in the marketplace so that ISNs will begin competing with each other to provide better quality services at reduced

prices to purchasers and consumers. Competition will be facilitated by the collection and distribution of comparative data on the price and quality of each ISN. In circumstances where competition is likely to produce inefficiency or excess capacity, the plan facilitates managed collaboration of providers and networks. Competition and collaboration are balanced to produce the best possible environment for Minnesota consumers.

- **Purchasing reform.** Opportunities for small groups to join together through public and private pooling mechanisms will be enhanced and facilitated.

- **Technology.** The Health Planning Advisory Committee will evaluate selected technologies for safety, efficacy, health outcomes, and cost effectiveness. The technology assessment will be used by providers, health plans, employers and other purchasers, consumers, and ISNs to make decisions about coverage and appropriate use of technology. Because ISNs are accountable for controlling their costs and are subject to limits on growth, they bear the risk if they do not make appropriate, cost-effective decisions about technology. It is anticipated that regulatory controls will be necessary to control the diffusion and use of technology in the regulated system for non-ISN services.

- **Health care data systems.** Comprehensive, coordinated health care data systems will be established to collect, analyze, and disseminate data on quality, price, revenues and expenditures. Information on health care spending will be used to establish growth limits and evaluate the success of cost containment strategies. Comparative data on ISN prices and quality will be widely distributed to inform consumers and purchasers and encourage competition. Data on quality will also be used to evaluate and improve the quality of health care throughout the state. A resource center will be established through a collaborative public-private partnership to compile and disseminate information on health care costs and quality and provide related technical assistance to consumers, providers, employers, health plans, and other persons and organizations. The center will offer information and assistance relating to practice parameters, outcomes data and research, technology assessments, the prices and quality of ISNs, purchasing pools for small groups, consumer education, prevention strategies, and other initiatives.

- **Practice parameters.** Practice parameters will be developed and approved to provide guidance to providers regarding the most effective methods of care and treatment. Providers who adhere to approved practice parameters will be protected from malpractice liability.

- **Prevention.** Public and private prevention activities will be enhanced and expanded.

- **Consumer education.** Consumer education programs will be established to empower and encourage consumers to make informed, wise choices about buying and using health care services and to encourage and motivate consumers to adopt healthy lifestyles that will reduce health care costs.

- **Regional Coordinating Boards.** Regional Coordinating Boards will provide local input to the Commissioner of Health and the Commission regarding statewide cost containment programs and will serve as a local connection for statewide activities and a forum for local efforts to improve health care in each region.

- **Public commitments of health plans and providers to voluntarily reduce growth in costs.** Health plans and providers will be challenged to make a public commitment to reduce the rate of growth of their costs and prices by at least ten percent. Health plans and providers who make the public commitment will submit trend projections and data that will be used to monitor and evaluate their success in meeting the targets. The names of participating providers and plans will be published and general information on their success in fulfilling the commitment will be distributed to employers, purchasers and other interested groups.

- **Special projects with short-term cost savings.** In addition to the structural health care system reforms and major cost containment initiatives that will be implemented under the Commission's cost containment plan, a number of specific, targeted strategies that have the potential for short-term cost savings will be undertaken in areas such as reducing provider fraud, reducing health care advertising, improving immunization programs, reducing tobacco use and improving birth outcomes.

Cost Containment Plan

Overview of the cost containment plan

The Commission's cost containment plan includes both long-term major restructuring of the health care system and initiatives to achieve short-term cost containment goals. The plan combines many different strategies into a comprehensive package. Under the plan, **limits on growth** in health care spending will be established and enforced by the Commissioner of Health to ensure that the rate of growth is reduced by at least ten percent a year for each of the next five years. The plan encourages the formation of **Integrated Service Networks** which are integrated networks of providers and/or health plans that are fully accountable for providing the full continuum of health care services to their enrollees for a fixed dollar amount. Integrated Service Networks will compete on the basis of both cost and quality. **Competition** and **Collaboration** will be balanced to produce the best possible environment for health care consumers. **Technology** will be evaluated for effectiveness and value. **Practice parameters** will be developed and approved. **Prevention** and **public health** activities will be promoted and enhanced. **Consumer education** programs will be conducted. **Health care data** collection systems will be developed and implemented. **Short-term cost containment strategies** will be implemented. Health plans and providers will be challenged to make a **public commitment** to voluntarily reduce their own rates of growth.

Each component of the cost containment plan is summarized later in this report.

Limits on growth

The 1992 HealthRight Act requires the Commissioner of Health to establish an annual limit on the rate of growth of total public and private health care spending in Minnesota. The limit must reduce the current rate of growth by at least ten percent a year for each of the next five years. Under the legislation and the Commission's plan, health care costs may continue to grow, but at slower rates than those now being forecast.

To set the limit on growth, the Commissioner must first forecast the rate of growth that would occur without any cost containment initiatives. Then the Commissioner will set a growth limit that will ensure that the actual rate of growth will be at least ten percent less than the forecasted increases that

Minnesotans would otherwise experience. For example, if the Commissioner estimates that the amount Minnesotans spend on health care will increase by 10 percent from 1993 to 1994, the Commissioner must limit the actual rate of increase to 9 percent or less. This process is repeated each year for the next five years. Using the example of a 10 percent annual rate of increase, the annual rate of growth in costs would be reduced from 10 percent to 5.9 percent by 1998.

Based on preliminary estimates of total spending and assuming a hypothetical rate of increase of 10 percent a year, the implementation of the spending limits and the cost containment plan will mean Minnesotans will spend from $150 to $200 million less on health care in 1994 and by 1998 will have saved a cumulative total of $6.9 billion dollars. Estimates of total spending and growth rates will be refined in the coming months.

The 1992 HealthRight Act requires the Commissioner of Health to use 1991 as the base year for estimating total spending and rates of spending growth. Using 1991 as the base year helps to ensure that the base level of total health care spending is not artificially inflated by individual providers or health plans who increase their rates during 1992 and 1993 in order to anticipate or offset limits that will be established for 1994. Artificial inflation or padding of costs or prices will be monitored and addressed through adjustments to the base year spending totals or future spending limits or through other methods to be developed by the Commission in the coming months.

Data collection strategy

A data collection strategy was adopted by the Commission early in its deliberations to collect the best figures possible on 1991 health care spending to meet the January 1993 deadline for submitting a report to the Legislature. The strategy involves working directly with the major payer groups (health insurance companies, HMOs, Blue Cross-Blue Shield, large employers, and government programs) to determine the growth rate in health spending between 1990 and 1991. This strategy will capture spending on personal health care services for approximately 60-70 percent of covered individuals in the state.

More detailed information will be needed from both the provider and payer groups. As more data becomes available, the state will be able to more

closely monitor Minnesota health care spending and adherence to the spending limits. The Commission will collect data from providers beginning in July 1, 1993. This data will be used along with the data from payers to track total health expenditures in the State of Minnesota. The two levels of data will be used to document revenues and expenditures and to cross check the data provided by each method.

The data collection strategy is described in more detail in the section on Spending Data and Trend Projections.

1994: the first year of spending limits

The inadequacy of existing data on health care spending handicaps the short-term implementation of the cost containment plan. The Commissioner of Health and the Commission are implementing a comprehensive, statewide data collection initiative that will allow Minnesota to begin collecting detailed data on spending in January 1994. For the time period before this, the Commission must rely upon aggregate figures and estimates which cannot serve as the basis for enforcement or regulatory action against individual providers or health plans. For this reason, the Commission's plan contemplates that calendar year 1994 will be the first full year that is subject to a limit on the rate of spending growth.

Responsibility for implementing the plan

Most components of the cost containment plan will be implemented by the Commissioner of Health. As envisioned by the 1992 HealthRight Act, the Commission will provide extensive and detailed recommendations to the Commissioner and closely monitor implementation by the Commissioner. The 1992 HealthRight Act requires the Commissioner of Health to submit a report and explanation to the Legislature any time the Commissioner departs from a recommendation of the Commission.

Components

INTEGRATED SERVICE NETWORKS

Incentives will be used to encourage the development of competing Integrated Service Networks that are accountable for the price and quality of their services.

An ISN is an organization that is accountable for the costs and outcomes associated with delivering a full continuum of health care services to a defined population. ISNs will take many forms and may be sponsored or initiated by providers, health maintenance organizations, insurance companies, employers, or other organizations. ISNs are similar to health maintenance organizations (HMOs), except that there will be significantly more flexibility in terms of both the types of organizations that may form or participate in an ISN, and the structural and contractual relationships between providers, health plans, and other participants in a network. For example, an insurance company and a number of independent providers could form an ISN by agreeing to share the risk of providing coverage for a fixed cost to the purchaser. This kind of arrangement is not permitted under current law.

Individuals, employers, and other purchasers will buy health coverage from ISNs in the same manner they now purchase coverage from insurance companies, HMOs, and other health plans, except that the price of coverage will be more clearly identified, future increases will be lower and more predictable, and more information on price and quality will be available to facilitate comparisons between different ISNs when purchasing health coverage.

Incentives for the formation of ISNs.

Formation of ISNs will occur in response to incentives, not governmental mandates; *providers will not be required by the state to participate in ISNs*. Employers, state programs, and other purchasers will be encouraged through incentives and other methods to purchase health care through ISNs. Providers are expected to voluntarily join ISNs or form their own ISNs because of the opportunity to benefit financially from efficiencies that can be realized in an ISN and because ISNs offer greater flexibility and fewer regulatory controls than the non-ISN system. (Services that are not provided through an ISN will be subject to regulatory controls to contain costs. See the next section on Growth Limits and Payment Systems). ISNs are also expected to encourage providers to affiliate with them by offering benefits such as office and administrative support, a simplified payment schedule for patients, simplified reporting systems, and liability coverage.

State programs.

The State of Minnesota will facilitate the development of ISNs by moving toward purchasing coverage for persons enrolled in state programs from ISNs. The 1992 HealthRight Act required the Department of Human Services to develop a plan for providing coverage under state programs through managed care arrangements. The Commission will work with the Department of Human Services to ensure that this plan is consistent with the Commission's cost containment plan and promotes the development of ISNs.

Regulatory requirements.

Enabling legislation will be needed to authorize the formation of ISNs. All ISNs will operate on a level regulatory playing field, regardless of whether an ISN was formed by an HMO, an insurer, a provider, or a purchaser. Regulations will not be used to micromanage the administration of the networks. ISNs will be required to limit the rate of growth in their costs to the growth rate established by the Commissioner of Health (this is discussed in more detail in the next section of Growth Limits and Payment Systems). Growth limits must be reflected in prices charged to purchasers. ISNs will be required to satisfy basic criteria, but will have flexibility to define their own structure. ISNs will be required to demonstrate their ability to bear the financial risk of providing all needed services to its enrolled population. ISNs will be required to satisfy standards for quality and to submit data and information on health care revenues, prices, costs, and quality.

Covered services.

ISNs will be responsible for providing needed services within a defined benefit structure that includes a continuum of care and services. A basic benefit set will be defined by the Minnesota Health Care Commission during 1993. ISNs will have the option of offering additional benefit options; ISNs are expected to compete on the basis of price and quality of the basic benefit set and supplemental benefit options.

Financial accountability.

ISNs will be responsible for providing all necessary and appropriate services to the enrolled population for a predetermined or fixed payment

amount or capitated rate. ISNs could bear the financial risk themselves, share the risk with an insurance partner, or use other arrangements.

Quality and price information.

ISNs will be measured and compete on the basis of definable cost, patient satisfaction, and outcomes expectations. ISNs will be required to report data on quality, prices, costs, and utilization. Extensive information will be provided to consumers and providers about the quality and price of each ISN. The information will be provided in a form that facilitates direct comparisons between ISNs and is useful to consumers and purchasers in making decisions about ISNs. Financial reporting will allow the state of Minnesota and purchasers to ensure that an ISN is not retaining excessive profits or depleting necessary reserves. A standardized format and process for reporting, analyzing, and disseminating information will be developed collaboratively.

Provider participation.

Providers may choose not to participate in an ISN, may participate in more than one ISN, and may simultaneously serve both ISN enrollees and non-ISN patients. Most providers are likely to have both ISN and non-ISN business. ISNs may establish credentialing standards for provider participation. The financial relationship between the ISN organization and its participating providers will be defined by contract. ISNs and providers will have maximum flexibility to negotiate the provider credentialing and payment relationships. Payment methods may include fee-for-service, salaried staff, efficiency bonuses, capitation, or other arrangements. ISNs will be encouraged and empowered to make appropriate use of mid-level practitioners such as nurse practitioners and physician assistants.

High risk groups and individuals.

The goal of the ISN system is to provide access to ISN coverage for everyone. The principles of health insurance reform that are reflected in the 1992 HealthRight Act will be incorporated into the regulatory requirements for ISNs. The goal of the Commission is that ISNs may not deny enrollment on the basis of any specific underwriting criteria. At the same time, safeguards must be included to address serious adverse selection against ISNs. Costs of coverage will be spread across large populations to ensure that high risk groups and individuals have access to affordable coverage. Enrollment standards will ensure that high risk and special needs

populations will be included, and growth limits and payment systems will be designed to provide incentives for ISNs to enroll even the most challenging and costly groups and populations. The requirements for ISNs will be developed in concert with requirements for the non-ISN system to ensure that rating, underwriting, and guaranteed issuance requirements are consistent and equitable in both systems.

ISNs in rural areas.

ISNs are likely to begin to form in rural areas not currently served by managed care health plans because of the incentives for providers to join or form ISNs in order to avoid the regulatory controls on non-ISN services and to take advantage of the benefits and support services that ISNs will offer providers. The impact of rural ISNs is discussed in more detail in the section on Rural Health Issues.

Non-ISN services.

The formation of ISNs will be voluntary. In order to meet the global spending limits established by the Commissioner of Health, services provided outside of the ISN system will also be subject to expenditure controls. Uniform standards for provider payments and utilization in the non-ISN system will ensure that growth in spending in this sector remains within the growth limits. The non-ISN system is described in the next section on Growth Limits and Payment Systems.

GROWTH LIMITS AND PAYMENT SYSTEMS

While competition and other strategies have a potential for controlling costs over time, limits on growth will protect consumers from excessive cost increases. Growth limits will ensure that the rate of growth in health care spending is reduced by at least ten percent a year for each of the next five years.

Limits on growth.

The Commissioner of Health will establish an annual limit on the rate of growth of all health care spending in Minnesota, both public and private. The limit will be set at a realistic, achievable level. However, the limit must ensure that the rate of growth is reduced by at least ten percent below the rate of growth that otherwise would occur.

Enforcing the limits on growth.

The Commissioner of Health will enforce the growth limits through two methods:

(1) An overall limit on each Integrated Service Network (ISN); and
(2) An all-payer system for non-ISN services.

Each ISN will be subject to an overall ceiling on increases. The limits on growth must be reflected in the prices charged to consumers. The ISN limits will be adjusted to reflect changes in enrollment, risk and severity, and benefit design. Because ISNs are accountable for providing all care within a fixed amount that is subject to growth limits, the ISN must contain costs in order to remain fiscally viable.

Non-ISN services will be subject to a regulated system that will control both price and volume in order to achieve global spending targets. The combination of the ISN aggregate ceilings and the regulated system for services provided outside of ISNs will restrain growth in health care costs to the limit established by the Commissioner of Health.

Regulated system for non-ISN services.

A regulated all-payer system will be developed and implemented by the Commissioner of Health to establish a uniform payment system to be used to control prices and utilization of services not covered by an ISN. The all-payer system (in which multiple payers and health plans use a single payment system) will be designed to control costs to achieve the statutory limit on growth. The non-ISN system will be designed and maintained in a manner that provides incentives for providers to join or form ISNs. The process of designing the all-payer system and the ISN system will be coordinated to ensure that the two systems are consistent and complement each other, and to prevent adverse risk selection.

Quality measures will be developed for non-ISN care, to monitor the impact of the all-payer system on quality of care. Whenever possible, competition among providers for non-ISN patients will be encouraged and facilitated.

The Commission, with assistance from an independent consultant, will develop recommendations on the design of the all-payer system. The system will be designed with input from affected provider groups through regional and statewide participation in the decision-making process. The regulated system will include an appeals process. The Commissioner of Health will be responsible for making final decisions on the design of the system and for implementing and administering the system either directly or through contracts.

Timing of implementation of the ISN and non-ISN systems.

The ISN and non-ISN systems will be developed during calendar year 1993 for implementation January 1, 1994. The design of the ISN and non-ISN systems will be completed and publicized several months in advance of the actual date of implementation of the regulatory system for non-ISN services, to allow health plans and providers an opportunity to make decisions about whether to join or form an ISN before they become subject to the non-ISN regulations.

Both the ISN and non-ISN systems may be phased in over a transition period to reduce disruption and allow more time to develop some aspects of each system. Even though the systems may be phased in and some components delayed beyond January 1994, growth limits will be effective for calendar year 1994 and any excess growth that occurs as a result of implementation delays or transition periods will be recouped in subsequent years.

Mid-level practitioners.

The quality and efficiency of health care can be improved by greater use of mid-level practitioners such as nurse practitioners and physician assistants. The ISN and non-ISN systems will be designed to encourage and facilitate the use of mid-level practitioners and to eliminate inappropriate barriers to their participation.

Universal coverage.

The ultimate goal of the Commission is universal coverage of all Minnesotans. The fact that a percentage of the state's population continues to be uninsured inhibits the effectiveness of the cost containment plan. Many of those who do not have coverage are healthy individuals who could contribute financially to the cost of insuring others without adding significant additional costs to the system, thus reducing the costs of coverage for everyone else. At the same time, these individuals and families will eventually require treatment, the costs of which are likely to be shifted to those who are paying for coverage. In addition, uninsured persons often delay treatment until more costly services are required which results in a greater financial burden on the system than would occur if preventive care or early intervention had been provided. The Commission intends to devote a significant amount of time and discussion to the issue of universal coverage during 1993.

COMPETITION

Incentives will be used to produce changes in the marketplace so that Integrated Service Networks will compete with each other to provide better quality services at lower prices.

The Commission believes competition shows significant promise as a method of controlling costs and improving quality over time. However, different Commission members have different views on the likelihood that competition will ultimately make growth limits and regulatory controls unnecessary. If the health care system evolves to a system of competing ISNs, regulatory controls will be minimal. Competition will keep costs below the overall limits established by the Commissioner of Health and the non-ISN regulations will apply to a relatively small percentage of health care services. The Commission believes that in three to four years close to 90 percent of health care services will be provided through ISNs. However, if ISNs and competition do not all but eliminate the need for regulation, the limits on growth and the all-payer regulatory system for non-ISN services will ensure that consumers and purchasers are protected from excessive increases in health care costs.

Competition between ISNs.

Competition between ISNs will be promoted and facilitated. The formation and expansion of ISNs will itself facilitate competition because the health care "product" will be the entire package of services and the price will be clearly defined. The regulatory system for ISNs will be designed to stimulate competition by making it easy for new ISNs to enter the market.

Competition will be further stimulated by improving the availability of information on the price and quality of each ISN. Providers, health plans, employers, consumers, and other stakeholders will collaboratively develop and continuously improve a system of collecting and disseminating data on quality and price. This information will help consumers and purchasers compare the quality and price of services offered by different ISNs and non-ISN providers. This information will also help providers and health plans improve their quality and efficiency.

Major efforts will be undertaken to fully exploit the potential for competition between ISNs to produce significant improvements in quality and affordability of health care. A major focus of these efforts will be to give ISNs the tools and information they need to continuously improve their quality and efficiency, such as practice parameters, technology

assessments, and quality and outcome data (see the sections on Practice Parameters, Technology and Major Expenditures, and Data on Quality and Outcomes).

Purchasing pools.

Purchasing pools enable small employers to benefit from the advantages of a larger risk pool and increase their ability to obtain an affordable price by increasing their clout in the health care marketplace. The newly created Private Employers Insurance Program (PEIP) provides an opportunity for employers to join a larger pool. Other private purchasing pool initiatives will be encouraged and facilitated through statutory changes and other methods.

Governmental involvement.

The State of Minnesota will act, as necessary, to preserve competition by prohibiting monopolies and monopsonies (excessive market power of a single purchaser) and preventing unfair practices. The State of Minnesota has a role in ensuring that the process of collecting and disseminating data on quality and price is standardized, reliable, objective, and useful. The State of Minnesota will also act to protect individual consumers or specific populations who might otherwise be excluded or adversely affected in a competitive marketplace.

Rural competition.

Multiple ISNs are possible, and will be encouraged, in rural areas where provider monopolies may be unavoidable. Even if competing ISNs do not emerge in these areas, data on price and quality will facilitate comparisons to other regions and create pressure for improvements in affordability and quality.

COLLABORATION

In circumstances where competition is likely to produce inefficiency or overcapacity, the plan facilitates managed collaboration between providers and networks.

Providers will be required or encouraged to collaborate when competition is likely to produce excess capacity in the health care system and when collaboration is more efficient than competition.

Examples of collaboration.

Specific instances where collaboration is appropriate include:

(1) The development of uniform criteria, forms and procedures for the collection of data on outcomes, quality, prices and costs;

(2) The development of uniform billing forms and claims processing procedures;

(3) The criteria and process for evaluating new technology and disseminating information on its safety, effectiveness, and cost-effectiveness;

(4) Collaboration in the purchasing and use of costly diagnostic equipment and technology when competition is likely to produce excess capacity;

(5) Collaboration in the formation of ISNs;

(6) Collaboration in the development of practice guidelines;

(7) Collaboration in the development and implementation of uniform utilization review requirements; and

(8) Collaboration to reduce health care advertising costs.

Antitrust protection.

In many cases, private sector collaboration violates antitrust laws. For example, an agreement between competing hospitals to share a costly testing device such as an MRI, rather than each hospital purchasing one, is potentially prohibited under antitrust laws. Similarly, agreements between competing providers regarding which providers will offer which highly specialized procedures raise antitrust issues. However, in certain circumstances, these agreements may prevent excess capacity, improve quality and access, and reduce costs for consumers. The 1992 HealthRight Act established a process for the Commissioner of Health to sanction collabo-

rative agreements involving health plans or providers that will benefit consumers. By sanctioning the agreements and providing ongoing state supervision, the state can protect participating providers and health plans from antitrust liability. The Minnesota Department of Health is in the process of developing rules and procedures for the program. The Commission will work with the Commissioner of Health, the antitrust division of the Attorney General's office, and health care industry representatives to successfully implement this program.

Reporting and review of major expenditures.

The reporting and retrospective review process established in the 1992 HealthRight Act will allow the Commissioner of Health to monitor health care expenditures greater than $500,000 and encourage collaborative arrangements when appropriate. This process is described in more detail in the next section.

TECHNOLOGY AND MAJOR EXPENDITURES

The 1992 HealthRight Act defines technology fairly broadly to include not only medical equipment but also expensive drugs, transplants, and specialized procedures.

Evaluation of technology.

A limited number of technologies that have high initial and cumulative operating expense and are surrounded by complex social, ethical, or legal concerns will be designated for evaluation. The Health Planning Advisory Committee (HPAC) created by the 1992 HealthRight Act will be the entity primarily responsible for evaluating technologies, under the general direction of the Commission. The HPAC will develop standardized criteria and processes for assessments of technology undertaken by federal agencies, researchers, plans, providers, and others that relate to a particular technology. Expert assistance will be utilized when necessary to evaluate assessments and to provide input to the HPAC. The results of the evaluation will be made available to all interested persons and organizations.

Priorities for designating technologies for assessment.

The following criteria will be used to designate technologies for

Technology will be evaluated for safety, clinical effectiveness, health outcomes, and cost effectiveness. The results of the evaluation will be used by ISNs, providers, health plans, employers and other purchasers, and consumers in making decisions about purchasing, covering, using, and paying for technology.

Inappropriate major expenditures will be controlled through ISN incentives and limits, non-ISN system rules, and the existing retrospective review process administered by the Commissioner of Health.

evaluation:

(1) the level of controversy within the medical or scientific community; questionable or undetermined efficacy;
(2) cost implications;
(3) potential for rapid diffusion;
(4) impact on a substantial patient population;
(5) existence of alternative technologies;
(6) impact on patient safety and health outcome;
(7) public health importance;
(8) level of public and professional demand;
(9) social, ethical, and legal concerns; and
(10) rare diseases or conditions.

Evaluation criteria.

The criteria for evaluating technology recommended in a report of the Medical Alley task force released in the fall of 1992, including safety, clinical effectiveness, health outcomes, and cost effectiveness, will serve as a starting point but will be further refined by the HPAC.

Use and Impact of Technology Evaluations.

The principal function of technology evaluation is to supply providers, health plans, consumers, and purchasers with information about the value, cost-effectiveness, and appropriate use of new technology to guide decisions about use and coverage. The evaluation process and its outcome will not, in themselves, eliminate or bar new technology. Findings will be used by:

(1) the Commissioner of Health under the existing process of retrospective review of major expenditures;

(2) ISNs in making coverage, contracting, and reimbursement decisions;

(3) government programs and regulators of the non-ISN system, in making coverage, contracting, and reimbursement decisions;

(4) the Commissioner of Health and other organizations in the development of practice parameters;

(5) providers in making decisions about adding or replacing technology and the appropriate use of technology;

(6) consumers in making decisions about treatment; and

(7) medical device manufacturers in developing and bringing to the market new technologies.

In addition to facilitating appropriate decisions about coverage and use of technology through better information for providers, health plans, purchasers, and consumers, the Commission intends that technology evaluation and collaborative decisions about coverage and use will become the community standard for the use of technology, thereby providing better guidance to providers and plans that will lead to reduced malpractice liability.

Referral centers.

The Commission recommends the use of the term "referral centers" rather than the term "centers of excellence" which is used in the 1992 HealthRight Act. Referral centers are providers or facilities that meet minimum standards established by the HPAC for the safe, effective, and efficient delivery of services for specific clinical conditions. Criteria for designation as a referral center may include minimum standards for personnel, facilities, patient volume, patient health outcomes, patient health outcome management, data reporting, research, education, patient and family involvement, access, community cost effectiveness, and financial support. The HPAC will develop criteria for referral centers but will not designate specific referral centers. The implications of satisfying criteria for designation as a referral center will depend upon the relevant delivery model and source of coverage.

Major expenditures.

The 1992 HealthRight Act provides for notification of the Commissioner of Health of any capital expenditure establishing a health care service, new specialized service, or other major spending commitment in excess of $500,000 after April 1, 1992. In general, the Commissioner does not have any prior approval or denial authority over the reported expenditures. However, if the Commissioner determines that a reported expenditure was inappropriate under criteria specified in the law, the Commissioner may require the entity that made the expenditure to submit future

major expenditure proposals to the Commissioner for prior approval. The reporting and retrospective review process allows the Commissioner to monitor major expenditures and encourage collaborative arrangements when appropriate. The HPAC will provide information on the results of its technology evaluations to the Commission and the Commissioner to aid in the retrospective review process.

DATA ON QUALITY AND OUTCOMES

The Commission and the Commissioner of Health will work collaboratively with providers, health plans, unions, employers, consumers, and other organizations to develop, implement, and continuously improve a coordinated system of collecting and disseminating information on health care quality and outcomes.

Importance of data on quality and outcomes.

The Commission believes health care cost containment can be accomplished without compromising health quality, and may in fact even improve the quality of care provided to Minnesotans. Although individual plans and providers collect data on the quality of care in their system, little information has been available to compare the quality of care delivered by individual providers, groups of providers or plans. The development of an effective system of collecting and disseminating data on quality and outcomes is an essential component of a health care reform strategy. Such a strategy will allow the monitoring of the impact of cost containment initiatives on health care quality. Data on quality and outcomes is also essential to the success of competition as a cost containment strategy; data on price is of limited value without data on quality to facilitate an assessment of the relative value of services and providers.

Strategy.

The 1992 HealthRight Act created a significant health care data initiative within the Department of Health to collect and analyze data on health care quality. A Data Collection Advisory Committee was established in 1992 to advise the Commissioner of Health. The Commission will work collaboratively with the Commissioner of Health, the Data Collection Advisory Committee, and affected stakeholder groups to promote the use of standard measures of health care quality for use by providers, health plans, employers and other purchasers, and consumers. The Commission and the Commissioner of Health will work collaboratively to collect and disseminate comparative data on the quality of services provided by providers, health plans, and ISNs in order to facilitate competition and continuously improve systemwide health care quality. Data will be

collected in a cost-effective manner that respects the financial and administrative burden of reporting requirements.

Regional use of data.

Data on quality and outcomes will also facilitate regional comparisons of prices and quality in negotiations between health plans and consumers and group purchasers in rural areas where provider competition is impractical. In the development of data systems, the Commission and the Commissioner of Health will work collaboratively to reduce or eliminate geographical differences in access to and utilization of health care quality data such as outcomes research and clinical practice parameters.

PRACTICE PARAMETERS

Practice parameters will be developed and approved by the Commissioner of Health, in consultation with the Commission. Providers who adhere to approved practice parameters will be protected from malpractice liability.

Development and approval of practice parameters.

The 1992 HealthRight Act established a program in the Minnesota Department of Health to develop, adopt, revise and disseminate practice parameters. The Commissioner of Health is advised in this process by the Practice Parameters Advisory Committee. The law requires that practice parameters must be supported by medical literature and appropriately controlled studies. The process for approving and revising practice parameters must be rigorous and allow opportunities for public scrutiny and input.

The practice parameters initiative in the Minnesota Department of Health represents one process for collecting or developing practice parameters. Practice parameters will also be developed by ISNs, health plans, providers, and other public and private organizations in Minnesota as well as in other states and countries.

Practice parameters will be continuously improved as new information on treatment, outcomes, and technology becomes available. A process will be established to permit swift and efficient changes to approved practice parameters to incorporate appropriate refinements and improvements as they are developed.

Dissemination of practice parameters.

Information about practice parameters will be made available to providers, health plans, consumers, and employers and other purchasers to improve the efficiency and quality of health care services.

Malpractice protection.

In addition to identifying, developing, endorsing and disseminating practice parameters, the law authorizes the Commissioner of Health to approve practice parameters for purposes of providing malpractice protection. The 1992 HealthRight Act provides that, in a malpractice action, adherence to an approved practice parameter is an absolute defense against an allegation that a provider did not comply with accepted standards of practice in the community. Evidence of a departure from a practice parameter is admissible only on the issue of whether the provider is entitled to the absolute defense.

Role of practice parameters in the ISN system.

The ongoing development and refinement of practice parameters will help ISNs and providers improve quality and become more efficient. Financial incentives and competition on the basis of quality and efficiency will motivate ISNs to make appropriate use of practice parameters without the need for governmental mandates. ISNs will be expected to maintain and provide data on prices, costs, quality and outcomes of care. This data, and information on each ISN's own work in developing practice parameters and efficient methods of providing health care, will assist with the ongoing evaluation and development of practice parameters. It will help identify conditions where variation in practice patterns, either within or across ISNs, suggest the need for development of practice parameters. Competitive pressures will encourage ISNs to facilitate the dissemination of information on practice parameters and outcomes within their own provider network as a means of improving efficiency and effectiveness of care.

Role of practice parameters in the all-payer system for non-ISN services.

Practice parameters will be made available to all providers in the state, including providers who have no ISN business. As the details of the all-payer system for non-ISN services are defined, other uses of practice parameters in the regulated system will be considered.

ADMINISTRATIVE COSTS

Administrative costs will be reduced through uniform billing forms and procedures and other collaborative initiatives, through competition and incentives for health plan and provider efficiency, through public commitments to reduce costs, and through collecting and analyzing data on administrative costs.

Uniform billing forms and procedures.

The Commission recommends the adoption of uniform billing forms and procedures to be used by all health plans and other major purchasers. A public-private work group, the Administrative Uniformity Committee, has developed an initial set of forms and recommendations. These recommendations include uniform billing forms and procedures, standardized patient identification cards, creating a centralized data base on health care personnel, standardized patient and provider identifiers, and ongoing evaluation of additional administrative areas where standardization is possible. The Commission has adopted the committee's recommendations and will work collaboratively with health plans and purchasers to facilitate the adoption of the uniform forms and procedures and to continuously improve them.

Electronic Data Interchange.

The Commission will support and facilitate rapid progress toward using electronic methods of data interchange. The Commission will continue to work with existing state and federal task forces to develop a plan for implementation.

ISNs, competition and growth limits.

The Commission believes competition and the financial incentives produced by limits on health care increases will create significant pressure to reduce administrative costs. The administrative costs of ISNs are expected to be significantly lower than in other health insurance arrangements where incentives for efficiency are weaker. Administrative costs will be further reduced as competition forces ISNs to lower their prices without reducing quality or services. ISNs will also be encouraged to use "total quality management" and "continuous quality improvement" techniques to reduce administrative costs through enhanced efficiency.

Public commitments to reduce costs.

The Commission has challenged health plans and providers to make public commitments to reduce their costs and to provide data that will allow consumers, purchasers, and others to evaluate their success in fulfilling the

commitment. This initiative shows significant promise as a method of creating pressure on plans and providers to reduce administrative costs. It will also provide additional data to help the Commission identify instances where administrative costs may be excessive and develop and refine strategies for reducing excessive costs. The public commitment program is described in more detail in the section on Targeted Strategies.

Minimum requirements for benefits paid by insurance carriers.

The insurance reform initiatives in the 1992 HealthRight Act included new "minimum loss ratios" for the small group and individual insurance markets. "Minimum loss ratio" is the legal term used in state laws which specify the minimum percentage of insurance revenue received by an insurance company that must be paid out in health care claims. It is the percentage of the health insurance premiums collected that are actually paid out to enrollees or providers for health care services. For the small group market, in 1993 insurers will be required to pay out in claims and benefits not less than 75% of premiums collected. The percentage paid out must not be less than 80% by 1998. For the individual market, ratios must be no less than 65% by 1993, and at least 70% by 1998. These statutory minimum payout ratios will provide an incentive for insurance carriers to streamline their administrative processes, and thereby reduce their administrative costs. The Commission will monitor the implementation and impact of these changes.

Administrative costs in state-administered programs.

The 1992 HealthRight Act directed the Commissioner of Health to develop a plan for consolidating and coordinating the health care programs administered by state agencies and local governments in order to improve the efficiency and quality of health care delivery. The state has issued a Request for Proposals to develop recommendations in this area. A preliminary report will be completed by April 1, 1993, and a final report will be completed on May 1, 1993. The Commission supports this initiative and will continue to monitor its progress.

Data on administrative costs.

The Health Care Analysis Unit in the Minnesota Department of Health is required to study the administrative costs incurred by providers and health plans for the submission of information to the federal government,

insurers, and other third parties. The Commission intends to work collaboratively to collect and analyze data on administrative costs in order to monitor the impact of the cost containment plan on these costs and to identify additional areas where administrative costs can be reduced.

CONSUMER EDUCATION AND INCENTIVES

Consumer education and incentives will empower and motivate consumers to make appropriate choices about buying and using health care services and to adopt healthy lifestyles that will reduce health care costs.

Consumer education.

Consumers often do not have the information and incentives that would increase their knowledge and empower them to use the health care system more effectively and efficiently. Many consumers covered by insurance rarely face or recognize the full costs of care because most of the costs are paid by a third party. In addition, because of the current tax treatment of employer-provided health coverage as a nontaxed fringe benefit, employers have an incentive to provide first-dollar coverage (with limited copayments and deductibles), which further disguises the cost of insurance and insulates consumers from the true cost of health care. The Commission will work collaboratively with providers, health plans, employers, unions, consumers, the Commissioner of Health, and other organizations to develop effective, coordinated consumer education programs. Consumers need information and assistance to make healthy choices about lifestyles and behaviors which reduce the prevalence of illness and injury. Consumers also need information to make good choices about health care and to use the health care system appropriately and effectively.

Consumer incentives.

Payers, employers and other group purchasers are encouraged to consider methods of educating consumers on the cost impact of their decisions and empowering and motivating them to make choices that will ultimately reduce the costs of health care for themselves and others. Consumer incentives should be consistent with the role of the consumer as one of many collaborators in decisions on health and health care spending.

PREVENTION

Enhanced public and private prevention activities will contribute to achieving cost containment goals by reducing the incidence of disease, injury, disability, and premature death.

Prevention.

Competition and ISN financial incentives will lead to new and expanded prevention activities when they are cost-effective or increase quality. Some prevention activities that serve the public good and benefit the consumer cannot be undertaken by the private sector and will require governmental action. Some prevention activities are more effective and efficient if provided collaboratively. The Commission will work collaboratively with stakeholder groups to design and implement coordinated public and private prevention activities.

Disseminating prevention information and technical assistance.

A number of community-based and corporate education, safety, and wellness programs have demonstrated improved health outcomes and cost savings. Models with potential will be identified and researched for possible replication or expansion. The resource center described in the section on Information and Technical Assistance will serve as a central source of information and technical assistance regarding prevention and wellness programs as well as other aspects of the health care system.

Incentives for worksite prevention programs.

To the extent authorized by the Legislature and within the limits of available funding, the Commission will provide financial incentives such as start-up grants and tax credits to encourage employers to implement worksite wellness and prevention programs.

Special prevention projects.

Special prevention initiatives that have the potential for producing short-term cost savings are described later in the section on Targeted Strategies.

PUBLIC HEALTH

Public health agencies play a vital role in the Minnesota health care system. The roles and functions of public health agencies must be redefined in the context of a changing health care system.

Public health principles.

Public health is what we as a society do collectively to ensure the conditions in which people can be healthy. All health care providers and organizations have a responsibility and opportunity to make important contributions to the public health. In Minnesota, the public health system is anchored in the state's Community Health Services system, a partnership between the Minnesota Department of Health and the 49 local Community Health Boards around the state. Public health agencies perform vital functions that cannot be provided efficiently or effectively by private organizations, but that should be coordinated with private sector activities.

Defining the role of public health agencies.

The Community Health Services (CHS) system is a unique statewide coordinated health care system. The CHS system will continue to contribute to the effectiveness of the health care system through community-based control of communicable diseases, development and enforcement of community health policies, community-wide assessment of population health, coordinating and linking health and community services for high risk populations, and acting as a public resource for information. Community Health Boards will act as resources for the Regional Coordinating Boards.

The Commission will undertake an ongoing effort to evaluate and improve the current role and effectiveness of public health agencies and define their role in a changing health care system. The appropriate role of publicly provided functions and services in a competitive environment will be clarified. Public health agencies will continue to play an important role in Minnesota's health care system, including both traditional public health roles and new roles as resources and contractors to assist ISNs, employers, and other organizations with the implementation of wellness and prevention programs and other activities to improve health care quality and reduce costs.

Private sector contributions.

All constituencies in a system of mature competition will be held accountable for the extent to which they meet general public health goals and specific health goals for its enrolled membership.

TARGETED STRATEGIES

In addition to health care system structural reforms and global cost containment strategies, special projects and public commitments by health plans and providers to meet cost containment targets through voluntary actions will enhance Minnesota's ability to control health care costs.

Major structural reforms in the health care system and global cost containment strategies will be implemented on an aggressive timetable which will ensure that cost containment goals are met beginning with calendar year 1994. The Commission has also developed special projects and targeted strategies that will supplement and enhance the global cost containment strategy.

The two categories of targeted strategies are:

(1) public commitments of providers and plans to voluntarily take action to reduce the growth in their costs and prices by at least ten percent below the rate of growth that would otherwise occur; and

(2) special projects with the potential for short-term cost savings.

Public commitments by health plans and providers to voluntarily meet cost containment targets.

The Commission's cost containment plan establishes and enforces limits on growth as swiftly as can be prudently accomplished. While the plan will produce some immediate and short-term results, the full impact of the Commission's cost containment plan will not be realized for several years. The Commission will be able to begin evaluating compliance with the overall growth limits retrospectively in 1995 for the year 1994. However, in some circumstances action to address excess spending may not occur until late 1995 or early 1996. While the excess spending will eventually be recovered or offset, the Commission searched for additional methods of preventing excessive short-term growth to reduce the risk that future corrective measures will be needed. The Commission considered a number of options for rapid, short-term governmental intervention to control price increases, including limits on premium increases and other approaches. However, the Commission concluded that these approaches were either not enforceable in the short-term due to the inadequacies of current data systems, or were likely to produce undesirable consequences such as incentives for health plans to deny or discontinue coverage for high-risk groups. The problems with short-term regulatory intervention led the Commission to challenge health care providers and health plans to make

public commitments to take voluntary action to reduce the rate of growth in health care costs. The public commitment does not replace other available strategies, but adds an additional layer to other strategies that will be implemented as quickly as possible.

The public commitment. The Commission has challenged health plans and providers to make a public commitment to reduce the rate of growth of their costs and prices by at least ten percent below the rate of growth that they would otherwise expect to experience, as evidenced by documentation of existing trend projections. Names of plans and providers who make the voluntary commitment will be published. Providers and plans that make the public commitment will submit their existing internal trend projections and data that will be used to monitor and evaluate their success in meeting the targets. Internal projections and other data will be analyzed by Health Department staff in consultation with actuarial consultants to ensure that trend projections and data evaluating growth reductions are accurate and reliable.

Each plan and provider making the public commitment is free to choose its own strategy for reducing growth in costs. Plans and providers making the public commitment must agree not to achieve reductions by shifting costs to consumers or other participants and must agree to pass on the reductions to purchasers and consumers.

It is anticipated that, while the public commitments are voluntary, there will be significant pressure for providers and health plans to participate. Employers and other purchasers are expected to consider information about public commitments when making purchasing decisions. Provider and health plan representatives on the Commission also recognize that groups failing to make a public commitment and successfully control costs through voluntary action are likely to encounter significant, mandatory regulatory controls in the future.

Antitrust issues. The Commission believes the public commitment program is a desirable public policy that will be of significant benefit to consumers and purchasers. The Commission has asked Commission members and trade associations representing health plans and providers to take a position in support of the public commitment program, encourage their constituencies and members to make the commitment, and provide technical assistance to them to facilitate their participation. However, to avoid potential antitrust liability, associations and groups of providers or

plans must acknowledge the right of each individual provider or health plan to choose whether to participate and must not attempt to coerce participation. Participating providers and plans are also free to choose their own strategy for reducing their costs. Commission members and organizations must use caution in the manner in which they relate to individual providers and health plans in the implementation of this program. The Commission recognizes that, as a result, their response may appear tempered or restrained. This should not necessarily be interpreted as reluctance to support the public policy of public commitments to reduce the growth in costs.

Special projects for short-term savings.

In addition to the structural health care system reforms and major cost containment programs that will be implemented under the Commission's cost containment plan, a number of specific, targeted initiatives that have the potential for short-term cost savings will be undertaken. Many of these projects are expected to begin producing savings even before 1994, the first full year of limits on spending growth.

The Commission recommends the funding and implementation of the following special cost containment projects:

1. **Programs and legislative changes to reduce provider fraud**
2. **Reduce advertising costs by authorizing collaborative agreements that are protected from antitrust challenge**
3. **Improve the ability of small groups to purchase health coverage through public or private purchasing pools**
4. **State negotiated volume discounts on drugs and equipment**
5. **Programs to empower consumers and enhance access to cost-effective preventive care:**
   - **Improve birth outcomes** through a variety of tactics, including preventing unintended pregnancy, reducing smoking among pregnant women, providing culturally sensitive, culturally competent care, and improved nutrition programs
   - **Conduct statewide consumer health education and wellness programs**

- **Improve immunization programs**

6. **Programs to discourage high-risk activities.**

   - **Reduce injuries from motor vehicle and recreational vehicle accidents** by making seat belt use a primary offense and requiring helmet use for recreational vehicles

   - **Reduce tobacco use** by increasing the cigarette tax, restricting tobacco advertising, and adding additional restrictions on access to tobacco products

   - **Reduce alcohol use and abuse** by increasing the alcohol excise tax

7. **Develop or approve high priority practice parameters that have the potential for the greatest impact on cost and quality**

INFORMATION AND TECHNICAL ASSISTANCE

A resource center will be developed to act as a clearinghouse for information on health care costs and quality and provide technical assistance for consumers, providers, health plans, and employers and other purchasers.

The Commission's cost containment plan relies significantly upon the effective collection and dissemination of a variety of data and information on health care costs and quality. Information on ISN costs and quality must be available to facilitate competition. Providers and health plans will benefit from access to effective practice parameters and other methods of increasing efficiency and quality. Employers need information and assistance to purchase quality health care for their employers and to implement worksite wellness and prevention programs and other cost containment activities. Consumers need information that will empower them to be more effective purchasers and users of health care. The 1992 HealthRight Act and various components of the Commission's cost containment plan create mechanisms for collecting and disseminating data and information relating to health care.

A resource center will be established through a collaborative public-private partnership. The resource center will offer information and assistance relating to practice parameters, outcomes data and research, technology assessments, the costs and quality of ISNs, purchasing pools for

small groups, consumer education and wellness programs, and other initiatives. The resource center would not have any authority of its own to require reports but would act as a repository and point of dissemination for information and resources collected through other state initiatives or submitted voluntarily by health plans, providers, employers, and others. The primary purpose of the resource center is to create a single, user-friendly source of information and assistance relating to health care.

Further details on the resource center will be developed in the coming months.

REGIONAL COORDINATING BOARDS

Regional Coordinating Boards provide an opportunity for regional input to the state Commission and the Commissioner of Health and facilitate local collaborative efforts to improve access, quality, and affordability.

Regional Coordinating Boards.

The Commissioner of Health, in consultation with the Commission, designated six regions in the state for purposes of implementing the cost containment plan and other initiatives in the 1992 HealthRight Act. Each region is represented by a board of 17 members who advise the Commissioner of Health and the Commission on issues of quality, accessibility, and affordability of health care.

Statutory duties of the regional boards.

Under the 1992 HealthRight Act, Regional Coordinating Boards are authorized to:

(1) Recommend that the Commissioner of Health sanction voluntary agreements between providers in the region to provide protection from antitrust challenge;

(2) Make recommendations to the Commissioner of Health on major capital expenditures and the introduction of expensive new technologies and medical practices;

(3) Undertake voluntary activities to educate consumers, providers, and purchasers or promote voluntary, cooperative community projects to improve access, quality, or affordability; and

(4) Make recommendations to the Commissioner of Health regarding ways of improving access, quality and affordability in the region and throughout the state.

Continuation of the regional boards.

Regional coordination and input are vital to the success of the Commission's cost containment plan. The plan calls for the continuation of the regional boards beyond the scheduled expiration date of June 30, 1993, with the duties specified in law. The Commission and the Minnesota Department of Health will work closely with the regional boards in the continued refinement and implementation of the cost containment plan. The Commissioner of Health will request additional staff resources to serve the regional boards.

Community health boards.

Community Health Boards will act as resources to the Regional Coordinating Boards.

SPENDING DATA AND TREND PROJECTIONS

Methods of collecting data on health care spending and projecting growth trends will be established and continuously improved.

Data on health care spending.

Estimates of total spending for years before 1994 will be based on data voluntarily provided by health plans, major self-insured employers, state and federal medical programs, and hospitals, and other available data on spending. The provider and health plan data, and data available from other sources, will be used to estimate total health care spending for 1993. In early 1993, providers and health plans will be given notice that beginning July 1, 1993, they will be required to maintain and report certain information about revenues and costs. Data for the last six months of 1993 will be collected in early 1994. The data will include information on revenues, administrative costs, reserves, and operating margins, in addition to health plan and provider expenditures and costs.

The Commissioner of Health and the Commissioner of Revenue will work together to coordinate the collection of reports and data through tax returns and other reports on expenditures. Data will be collected in a cost-

effective manner that respects the financial and administrative burden of reporting requirements.

Growth trends.

In the spring of 1993, the Commission will use the growth rate established for 1990 to 1991, and additional information on 1992 spending, to estimate the growth in spending from 1993 to 1994 that is likely to occur without a statewide cost containment strategy. The estimates of total spending and growth for 1993 to 1994 will be based on data on health expenditures submitted by the payer groups for 1990, 1991 and 1992; national and public sector data on health care spending and trend estimates; and other state estimates of health care spending trends for similarly situated states when appropriate. The Commission will use this information to make recommendations to the Commissioner of Health regarding a realistic limit on the 1993-1994 growth rate. The Commissioner will then establish and enforce the limit. Growth estimates and limits on increases may be retroactively adjusted if national data and other information demonstrates that the original projection was inaccurate.

Year-to-year variations.

Target rates of increase will be established in a manner that recognizes the year-to-year peaks and valleys, and long-term trend fluctuations that exist in the health care system.

Costs of research.

The Commission and the Health Planning Advisory Committee devoted a significant amount of time to discussing how the costs of research should be counted when measuring total spending on health care and how spending limits affect research. Spending limits should be applied in a way that does not discourage research. At the same time, providers and health plans should not be able to circumvent or negate spending limits by characterizing health care services as research. The challenge facing the Commission is how to delineate research from patient care in a way that encourages appropriate research without creating loopholes that could decrease the effectiveness of spending limits. In the coming months the Commission will complete the process of defining the types of research that will be exempt from spending limits and will make recommendations to the Legislature and the Governor. The Commission will monitor the implementation of the exemption and make future recommendations as needed.

Border area data and implementation issues.

The legislation calls for controlling spending for Minnesota residents. Data on health care spending will be collected for Minnesota residents only. Data on costs for services provided by out-of-state providers for Minnesota residents will be collected from health plans. The Commission also intends to work with the border area providers to collect data on spending for Minnesota residents. The Commission recognizes the importance of border providers for certain geographic areas and will continue to refine the strategy for monitoring costs and implementing cost containment strategies in border communities.

RURAL HEALTH ISSUES

The cost containment plan is designed to be effective in every region of the state and strategies will be tailored to the special needs and conditions in rural areas.

The Commission recognizes the significant issues and concerns affecting rural Minnesota. Major rural health initiatives were enacted by the 1992 HealthRight Act. These include programs to increase the number of medical school graduates who practice primary care in rural areas, loan forgiveness programs for rural practitioners, financial assistance and transition grants for rural hospitals, programs to establish rural community health clinics which will make greater use of mid-level practitioners, a health services personnel data base for rural Minnesota, the creation of an Office of Rural Health to promote improvements in the rural health care system, and other initiatives. These programs will significantly enhance the quality and accessibility of health care in rural areas. The Commission will work closely with the Office of Rural Health and the Rural Health Advisory Committee to see that the programs are successfully implemented and to monitor their effectiveness.

The first responsibility assigned to the Commission by the 1992 HealthRight Act was the development of a cost containment plan. Geographic access, provider recruitment and retention, physician and provider support, and other issues that relate only indirectly to the cost containment plan are of significant importance to rural areas and have come up repeatedly during Commission discussions. The Commission intends to devote a significant amount of time to these and other rural health issues in 1993 after the cost containment plan has been submitted to the Legislature and the Governor. Some of the specific issues to be addressed include

the role of medical schools in increasing the number of primary care graduates who practice in rural areas, the use of mid-level practitioners such as nurse practitioners and physician assistants, and strategies for recruiting, supporting, and retaining rural providers.

Rural ISNs and competition.

The Commission will promote and facilitate competition between ISNs even in rural areas of the state where only one provider system exists. Just as multiple health insurance plans are available now, ISNs will compete in terms of the coverage they offer, their costs and efficiency, and the extent to which their contractual relationships with local providers are more efficient or offer better quality or service. Improved data on quality and costs will also promote comparative competition between regions. Employers and consumers will compare the quality and cost of health care services in their region to that of other regions and negotiate with providers and health plans for improvements when indicated.

Rural health care cost containment.

Limits and controls on provider services that are not offered within an ISN will control costs even when competition between ISNs does not occur. Evaluations of technology by the HPAC will include recommendations on appropriate use of technology, training required of health care personnel using the technology, and the minimum patient base that can support the technology. This information will be invaluable to rural regions, providers, and health plans, in assessing whether to acquire new technology. Practice parameters and data on quality and outcomes will help rural providers identify the most effective and efficient methods of practice.

CONTINUOUS IMPROVEMENT

The cost containment plan is one step in a continuous process of improving the Minnesota health care system.

The Commission believes the cost containment plan is an important first step toward achieving the cost containment goals expressed in the 1992 HealthRight Act. The plan will require ongoing refinements and improvements as we learn more, improve our data on quality and cost, and monitor the impact of changes as they occur. After fulfilling its immediate responsibility to submit a cost containment plan, the Commission intends

to address issues of access and quality more broadly. The Commission intends to identify and define more precisely Minnesotans' expectations of the health care system and to continuously evaluate the success of the system in meeting those expectations.

IMPLEMENTING THE PLAN

The plan will be implemented through legislation and other activities according to an aggressive timetable.

Legislation and rulemaking.

The Commission will seek legislation during the 1993 session to implement the cost containment plan. The Commission will continue to work on implementation details through February 1993 so that the legislation is as specific and detailed as possible. However, rulemaking by the Commissioner of Health will also be required to develop and implement requirements for ISNs and the all-payer system for non-ISN services. The Commission will work closely with the Commissioner in the development of rules.

Expedited rulemaking procedures will be needed if spending limits are to be in place by January 1994. To implement the plan according to this schedule, rules must be promulgated over a six month period following the enactment of legislation. Permanent rulemaking often takes 18 months or longer. For each six months of delay in the implementation of the cost containment plan, Minnesotans will pay an estimated $80 to $100 million more in health care costs. The Commission will propose expedited rulemaking procedures which will allow rapid implementation of the plan while still providing adequate notice and opportunities for input and participation through the Commission and through other methods.

Timetable.

The cost containment plan will be implemented according to the following timetable:

January 1993

Public commitments from providers and health plans to voluntarily reduce their rate of growth will be requested

The phase-in of uniform billing forms will begin

March 1993

Limits on 1993-1994 growth will be established by the Commissioner of Health

July 1993

Providers and health plans will be required to maintain and report data on costs, revenues, and prices

Implementation of short-term cost containment strategies will begin

Statewide consumer education programs will be implemented

A resource center will be established to provide information and assistance on health care quality and cost issues

Data collection for the large-scale quality data base will have begun

October 1993

Rules governing ISNs and the all-payer system for non-ISN services will be finalized and published, and the procedures for granting ISN status will be implemented

The process of defining the basic set of benefits and services that must be provided by an ISN will be completed

January 1994

The first year under spending limits begins

The all-payer system for non-ISN services will be implemented

July 1994

Comparative data on the prices and quality of ISNs will be published

January - July 1995

Evaluation of the actual 1993-1994 growth in total spending will be completed; action will be taken to address excess 1993-1994 spending growth, if necessary

Legislation.

The following legislation will be needed to implement the Commission's cost containment plan:

(1) Legislation authorizing the Commissioner of Health to adopt expedited rules governing Integrated Service Networks. The legislation will establish a level regulatory playing field for ISNs, impose limits on growth in costs to purchasers, identify rating and underwriting requirements, establish quality improvement standards, require reporting of prices and outcomes, and other requirements (See the section on Integrated Service Networks that appears earlier in this report);

(2) Legislation authorizing the Commissioner of Health to adopt expedited rules to establish an all-payer system for all non-ISN services. The legislation will establish requirements for prices and utilization that will ensure that the growth in the costs of non-ISN services does not exceed the limits established by the Commissioner of Health (See the section on Growth Limits and Payments Systems that appears earlier in this report);

(3) Legislation authorizing the Commissioner of Health, in collaboration with the Commissioner of Revenue, to adopt expedited rules governing the collection of data on prices, costs and revenues from health plans and providers;

(4) Legislation improving and expediting the process for state approval of collaborative arrangements to provide protection from antitrust liability;

(5) Legislation improving the ability of small groups to join purchasing pools to increase their ability to purchase affordable health coverage for their members;

(6) Legislation authorizing the creation of a resource center to provide information and assistance on health care quality and cost issues;

(7) Legislation repealing the sunset on Regional Coordinating Boards;

(8) Legislation implementing or authorizing short-term strategies;

(9) Legislation protecting members of the Health Planning Advisory Committee from liability when acting in good faith and within the scope of their responsibility;

(10) Legislation providing funding to implement the cost containment plan; and

(11) Other legislation to implement components of the plan.

Federal legislation and waivers.

Changes in federal laws and regulations will be requested that will facilitate the implementation of the cost containment plan.

Conclusion

The Commission's cost containment plan is an important step in a continuous process of improving the Minnesota health care system. A great deal of work lies ahead, including adding more detail to the plan, the drafting and enactment of legislation, state agency rulemaking, implementation of the various components of the plan, and ongoing monitoring, evaluation, and refinement of the plan's initiatives. These activities will be undertaken collaboratively in an open process that maximizes opportunities for input from all interested persons and organizations.

While the focus of this report is on cost containment, the Commission soon will be expanding its activities to encompass broader issues such as health care quality, access to health care services, rural health care, and long-term care. Because of the commitment and enthusiasm that has been shown by Commission members and because of the success of the Commission in achieving a consensus on significant, comprehensive health care reform, the Commission is highly optimistic about the future of Minnesota's excellent health care system. The coming years will bring continuous improvements and enhancements in the quality, accessibility and affordability of health care in Minnesota.