Containing Costs in Minnesota's Health Care System

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

Minnesota Health Care Commission

May 1993

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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 each of the next five years. This report contains 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 Commission also held a series of public hearings throughout the state. 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. 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.

Addendum

The body of this report contains recommendations of the Minnesota Health Care Commission as of February 1993. Subsequent to the approval of its initial report, the Commission approved additional and supplementary recommendations which are described in materials in the Addendum at the end of this report.

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 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

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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 of the Cost Containment Plan

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 networ ;. 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.

Key Features

- **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. Practice parameters that are developed should recognize the need for intraprofessional and inter professional collaborations. 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.

CHAPTER ONE:

Cost Containment Plan

Introduction

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 described 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

Chapter One: Introduction

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 50-60 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 Commission and the Commissioner of Health, with the advice of the Data Collection Advisory Committee, 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 alone

are not sufficient to 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.

The 1992 HealthRight Act specified that limits on growth should become effective July 1, 1993, rather than January 1, 1994, as the Commission recommends. To address any excess spending that Minnesotans may experience due to the six-month delay in implementation, spending levels will be monitored and growth limits set in a manner that ensures that, by January 1, 1997, total health care spending in the state will be no greater than the target that would have been achieved had the growth limits been implemented July 1, 1993.

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 anytime the Commissioner departs from a recommendation of the Commission.

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.

Summary

A key feature of the cost containment plan is the development of Integrated Service Networks (ISNs) which will compete with each other to provide higher quality services at a lower price. ISNs will be responsible for providing the full continuum of health care services (from routine primary care to acute inpatient hospital services) for a fixed price, 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. The development of competing ISNs that are accountable for the price and quality of their services will be encouraged through incentives for providers, health plans, and purchasers.

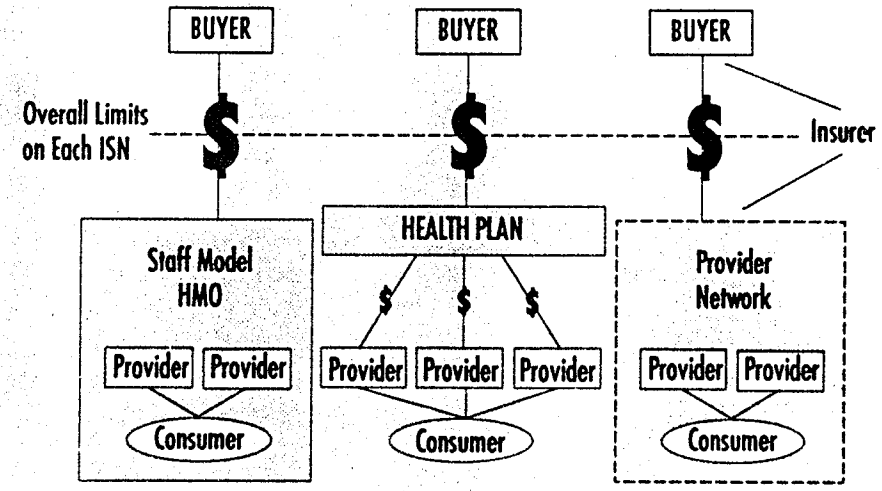
What is an ISN?

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. An ISN will provide all needed health care services to its enrollees for a fixed price. 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. Or a number of independent providers could form an ISN and collectively share the risk of providing needed services to individuals and groups that purchase coverage from the ISN. The risk could be borne entirely by the participating providers or the ISN could purchase reinsurance to protect it against high-cost cases or exceptional losses. These kinds of arrangements are not permitted under current law. ISNs will have flexibility in structure as long as they meet basic criteria of being responsible for a continuum of care and costs among a defined population. (See figure on next page for three examples of how an ISN might be structured.)

The ISN concept is not new. The underlying principles upon which the ISN concept is based have

Examples of
INTEGRATED SERVICE NETWORK MODELS



been shown to be effective both in urban and rural areas. A good example is the Itasca County Medical Assistance demonstration project. Under this project, the state Medical Assistance program contracts with Itasca County to provide all needed health care services to Medical Assistance recipients for a fixed payment amount. Participating providers share in the risk that the county will be able to provide the required services within the budgeted amount. Because of the greater efficiency that has resulted from this arrangement, providers who participate in this project receive substantially higher payment rates than the rates paid to nonparticipating providers under the conventional Medical Assistance fee schedule.

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. Employers, state programs, and other purchasers will be encouraged through incentives and other methods to purchase health care through ISNs. Providers will not be required by the state to participate in 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. Technical assistance and start-up grants will be provided to facilitate the formation of ISNs.

State and federal 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 implement a plan that is consistent with the Commission's cost containment plan and promotes the development of ISNs. In addition, a request for a waiver from the Health Care Financing Administration will be developed for the implementation of a statewide demonstration projection to enroll Medicare beneficiaries in 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 satisfy basic criteria. but will have flexibility to define their own structure. 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 on Growth Limits and Payment Systems). Growth limits must be reflected in prices charged to purchasers. 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 uniform, standard comprehensive benefit set will be established which every ISN must offer. The Minnesota Health Care Commission will develop guiding principles to be used in developing the benefit set. ISNs will have the option of offering additional benefit options. ISNs are expected to compete on the basis of price and quality of the standard benefit set and supplemental benefit options. An ISN could offer additional options such as additional covered services, different levels of copays, and a "swing-out" or " instant-choice" coverage plan. The services covered by all ISNs should include the most cost effective services and consumer incentives, with some type of competition among ISNs for additional 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. Financial accountability requirements will be designed to facilitate entry into the market of new ISNs.

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, group purchasers, 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 determine whether an ISN is retaining excessive profits or reserves or depleting necessary reserves. A standardized format and process for reporting, analyzing, and disseminating information will be developed collaboratively. This process should be undertaken as a public-private partnership, with the State of Minnesota acting as a facilitator to ensure that information is complete, uniform, and objective.

Provider participation

Participation by providers in ISNs is not mandatory. 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.

The financial relationship between the ISN organization and its participating providers will be defined by contract. ISNs may establish credentialing standards for provider participation. 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. During 1993, the Commission will consider a mechanism which will allow providers to work together to define their relationship with their ISN.

ISNs will be encouraged and empowered to make appropriate use of mid-level practitioners and allied and alternative providers. Steps must be taken to prevent these providers from being barred inappropriately, while at the same time allowing flexibility for ISNs to manage their own networks.

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

The development of ISNs throughout the state is an important component in achieving cost savings and achieving the target of slowing the growth in health care expenditures. In addition, ISNs can make significant contributions to the development and implementation of quality and outcome measures and practice parameters. The development of ISNs in the Twin Cities metropolitan area is likely to be readily achieved. It is anticipated that most, if not all managed care organizations currently operating primarily in the Twin Cities region will be able to qualify as an ISN in a rapid manner. Additional enrollment in the Twin Cities region in existing and newly created ISNs is likely to occur fairly rapidly.

The overall development of ISNs throughout the state will require a longer period of time. The longer timeframe will be needed primarily to develop ISNs in rural areas which have not traditionally been involved in managed care systems. The enrollment of consumers and the contracting with providers in rural areas will need to be accomplished with a great deal of care and sensitivity to the needs of rural communities. Technical assistance and start-up loans will be provided to facilitate the formation of alternative ISNs in rural areas, based on existing successful ISN models. As the first rural ISNs experience success, the development of ISNs in rural areas will accelerate.

The Commission is optimistic that ISNs will form in rural areas. One reason managed care plans have not generally developed in rural areas is the resistance of providers to participation in HMOs, particularly HMOs entering the region from other parts of the state. The Commission's cost containment plan will offer new options to rural providers, such as the opportunity to join with other rural providers in a community to form an ISN on their own. Under the Commission's cost containment plan, providers are expected to seek to join an ISN or form their own ISN because of the advantages of the ISN structure over the regulated, non-ISN system. However, even if the development of ISNs does not occur in some

regions, the region will still be protected from excessive growth in health care costs through the implementation of a regulated system for non-ISN health care services.

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.

Cost impact.

The Commission estimates that, even in the short term, implementation of ISNs will produce a significant reduction in costs, as compared with nonmanaged care insurance. In addition, other longer term strategies for slowing the growth of health expenditures will also be enhanced by the rapid implementation of ISNs, such as practice parameters, purchasing efficiencies and the cost-effective use of mid-level practitioners and other allied health professionals.

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

As directed under the 1992 HealthRight Act, the Commissioner of Health, with recommendations from the Minnesota Health Care Commission, will establish an annual limit on the rate of growth of total public and private spending on health care services for Minnesota residents. This limit will be set at a realistic, achievable level. However, the limit will ensure that the annual rate of growth of health expenditures is reduced by at least ten percent below the rate of growth that otherwise would occur.

Under the Commission's cost containment plan, this goal will be achieved through extensive system reform, implementation of targeted cost savings programs, and expenditure growth limits applied through payment systems. The limits on the growth of health expenditures will be enforced through two different payment systems, one which covers health care provided through the ISN system, and a second which covers health care provided outside of the system. Both of these systems will be held to limited growth rates for health care expenditures, and both will be subject to competition or comparisons based on cost and quality.

While two payment systems are discussed here in relation to the enforcement of spending limits, the Commission recognizes that a third major system exists for providing health care services: the public health system. The public health system plays a vital role in the health care system. Public health agencies perform important functions that cannot be expected to be provided by private organizations. The roles and functions of public health agencies, however, will necessarily be redefined in the context of a changing health care system. The role of public health is discussed in detail in a later section of this chapter.

Limits on ISN growth

ISNs will provide comprehensive health care services to a defined population within a defined budget. Each ISN will be subject to an overall ceiling on increases in aggregate revenues based on the statewide growth limit established by the Commissioner of Health. Fully operational ISNs will be accountable for remaining at or under the specified rate of increase for expenditures over the previous year, and this target will be reflected in the premium prices charged to buyers. Special trend limits will be used for new ISNs to reflect high initial expenses and trend fluctuations. Once an ISN is fully

operational, the ISN's overall budget, adjusted for population changes, will be subject to a maximum rate of increase over the prior year.

The Commission will consider means of developing the target budgets for ISNs in a manner that does not penalize ISNs that have worked to keep cost increases low in the past. The philosophy behind the ISN concept is one where efficiency is rewarded, and methods of considering past efficiency will be developed as the details of the ISN implementation are worked through.

ISNs will be expected to provide comprehensive care to their enrolled population within their budget. The ISN will be free to determine the specific means of managing to reach this goal. This approach avoids micromanagement inherent in rate regulation by allowing each ISN to structure itself in the most cost effective manner possible. Eventually, competition among ISNs on the basis of cost and quality will provide the incentive to keep costs low, and has the potential to eventually render overall limits on ISN's budgets unnecessary.

In order to administer this system effectively, reporting of precise and detailed data on revenues, expenditures, outcomes, costs, and patient demographics will be necessary. The Commission will work with the Data Collection Advisory Committee, and the Health Department to determine the most effective means of collecting, analyzing, and reporting this data.

Adjustments to growth limits for ISNs. The specific rate of increase for each ISN will be determined by adjusting the statewide growth target for changes in the population served by the ISN. These adjustments will compensate for changes in enrollment, changes in the relative risk of the covered populations, changes in statewide population demographics, changes in the Gross Domestic Product and other factors. Accurate and responsible methods of risk adjustment will be determined by the Commission over the course of the first year. The rates of increase will be set so that, in the aggregate, the overall rate of increase of each ISN is within the limit established by the Commissioner of Health.

ISNs will not be permitted to meet their spending targets by shifting greater portions of the expense to the consumer through increased copayments and deductibles. Reporting of information on plan design will be required so that co-payments and deductibles can be monitored.

Special populations and services. The direct incentives built into the risk adjustment system will encourage providers and ISNs to compete for populations with special needs, including patients at risk for costly illnesses, patients with additional social and medical needs, and public patients. The Commission will monitor the risk adjustment process with special attention to the effect on populations with special needs and the adjustment process will be revised as necessary to maintain incentives for providing care to all groups of Minnesotans. In addition, methods must be developed to incorporate the costs of graduate medical education and clinical research, both of which are important to the continued quality of Minnesota's health care delivery system.

The regulated all-payer system for non-ISN services

Providers and purchasers will not be mandated to participate in the ISN system. Rather, incentives will be created to encourage participation. Within this voluntary system, there will necessarily be care provided outside of ISNs, and the growth of expenditures in this non-ISN system must be limited as well. If ISNs are as successful as the Commission believes they will be, the non-ISN system should be a small portion of the overall health care system.

A regulated "all-payer" system will be developed and implemented to control prices and utilization of services not covered by an ISN. This "all-payer" system will provide a single, standardized payment scheme for all non-ISN payers. While the primary purpose of the all-payer system is to control the rate of increase in costs for services not covered by ISNs, the new system will also substantially reduce administrative costs for providers and payers by standardizing the hundreds of payment and utilization control systems currently used by payers.

Recognizing the complexities of attempting to control a diverse and non-integrated set of health care providers and payers, the means of implementing this system will be developed over the next year. A Request for Proposal (RFP) has been issued for consultant assistance in developing the specific details of the non-ISN system, utilizing the general principles and issues outlined by the Commission and the Payment Systems Committee.

General Principles of the non-ISN system. The non-ISN system will be designed and maintained in a manner that provides incentives for providers and others to enter or create an ISN. It is the Commission's goal that the ISN system will be successful enough that all or nearly all providers, payers, and patients will want to be affiliated with the system. It may be necessary to maintain a small regulated system even in the long term, to prevent mandating participation in an ISN and to also reach the goals for expenditure reduction.

Quality measures will be developed for the non-ISN care to monitor the impact of the regulatory system on quality of care. Wherever possible, competition among providers will be facilitated.

The non-ISN system will be designed to control costs. Overall expenditures on care that occur outside of an ISN will be limited in a manner that is consistent with the legislative mandates and the growth limits established by the Commissioner of Health.

Limits or fee schedules will apply to all providers with independent billing rights whenever they care for an individual not linked with an ISN. Insurers who do not choose to operate in an ISN structure will be required to reflect similar limits in their premium structure. These limits or schedules will be constructed with input from affected provider groups through regional and statewide representation in the decision-making process. The system will provide an opportunity to appeal.

The administrative costs associated with creating and maintaining the regulated system will be minimized. Participants will be required to report data on revenues, expenditures, utilization, and outcomes. The specific issues that will be addressed in the development of the all-payer system, through the consultant and discussions with the Commission and its Payment Systems Committee include:

Methods of controlling expenditures. In developing the payment system for the services provided outside of the ISN system, the Commission and consultant will evaluate a variety of methods for controlling fees. The methods considered will include the establishment of a fee schedule, adoption or adaptation of an existing fee schedule such as Medicare's RBRVS system, price freezes and other possible methods. The regulated, all-payer system does not necessarily mean lower provider payment rates. The system will be managed to ensure that the overall growth in spending in this sector does not exceed the growth limits established by the Commissioner of Health. The starting point for the non-ISN system will be current spending levels, plus reasonable increases for growth based on statewide limits. To the extent that providers serving non-ISN patients can become more efficient and avoid excessive increases in utilization, fees, and total spending, non-ISN provider fees need not be reduced and could in fact be increased.

Methods of controlling utilization. In order to control total expenditures, it will be necessary to control utilization as well. Options include application of standardized utilization review criteria, a take back of excess spending due to over-utilization, required use of practice parameters or guidelines, enforcement of provider conflict-of-interest restrictions, volume-based adjustments to fee schedules based on the Medicare fee update model, and other methods.

System oversight. The Commission will work with the consultant to examine the possible means of overseeing the non-ISN system. Alternatives such as centralized state oversight, regional administration or some combination will be examined with the goal to minimize administrative costs.

Data reporting requirements. Specific data on the cost and quality of care provided outside of the ISN system will be reported. The Commission will work with the Department of Health, the Cost Trends and Measurement Committee, and the Data Collection Advisory Committee in determining how this data will be collected.

Timetable. The RFP for consulting service to deliver the non-ISN system was issued in February of 1993. The consultant will work with the Payment Systems Committee over a several month period. By May 1993, the legislation is expected to be enacted to authorize development of an all-payer system for non-ISN services. If all of the details regarding the all-payer system are not specified in legislation, an expedited rulemaking process will be needed to allow the Commissioner of Health to resolve the remaining details and implement the system in January 1994.

Short-Term Strategies

Fraud and abuse. Experts estimated that fraud and abuse in health care represents about ten percent of total system costs. The Commission recommends expanding programs to combat health care fraud and improving laws to facilitate enforcement. Some short-term actions which can be taken include adoption of a model immunity reporting law, passage of an antifraud statute, and creation of a fraud unit with increased government enforcement. This is estimated to be one of the most significant cost savings strategies with at least a 10:1 savings ratio.

State Negotiated Volume Discounts. For patients who are not enrolled in an ISN, savings can be achieved by negotiating discounts for pharmaceuticals, medical supplies, and equipment. Volume purchasing programs may also be beneficial to small providers and payers. The Commission recommends establishing a pooling program to enable small purchasers to join together and obtain the discounts that are available to large volume purchasers.

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.

Summary

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 that consists largely 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.

Why is competition important?

The Commission considers competition to be an effective force that can produce innovative and creative cost containment strategies without micromanaging health care decision making. Therefore, the Commission's plan facilitates competition between ISNs on the basis of both price and quality. Changes in the health care marketplace can be made that will increase the effectiveness of competition as a force to reduce costs and increase quality. However, the Commission does not consider competition to be an end in itself, but a means to an end. Some kinds of competition are undesirable. An example is when competition between providers to purchase expensive equipment results in excess capacity and increases cost and volume without improving access or quality. In these situations, regulated collaboration is appropriate.

The concept of "consumerism" guides decisions about the appropriate balancing of competition and regulation. The key factor in determining whether competition is appropriate is the impact on health care consumers. Competition that benefits consumers should be encouraged and that which has a negative impact on consumers should be discouraged. Similarly, competition should be supplemented by, or replaced by, other strategies if the alternative strategies will produce a greater benefit for consumers. Even in circumstances where competition has the potential for controlling costs, a number of years may be required before a mature competitive marketplace emerges. In the meantime, the continuing rise of health care costs will place health care out of reach of more and more consumers and employers. For this reason, the Commission will rely upon setting and enforcing global limits on growth through

regulation as well as competition. The Commission's plan thus represents a balancing of competition and regulation.

Why isn't competition working?

Although many experts feel that health sector competition in Minnesota has resulted in lower health care costs in comparison to other states, a major question has been why competition is not working more effectively to slow the growth of health care costs. One reason has been that the consumer has been split into users (individual consumers) and payers (employers and other group purchasers) acting independently of one another. Users are often detached from the cost impact of their decisions. Consumers do not have good information about price and quality. In addition, decision making is complex and often "delegated" to the physician or other provider. Moreover, tax laws partially insulate consumers and employers from the full cost of health care.

Another reason is that there has not been the strong consensus to contain health care costs within government, the health care industry, and in society at large. Although Minnesota and especially the Twin Cities have had a relatively high level of enrollment in managed care plans over the past 10-20 years, the development and expansion of ISNs are envisioned to cover a much greater proportion of Minnesotans. With the combination of stronger consensus and determination to control costs and greater numbers of Minnesotans in ISNs, competition has a much better chance to be effective in slowing the growth of 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

An undesirable side effect of competition in the current marketplace is that large purchasers use their purchasing power to obtain deep discounts in provider fees and health plan premiums. Providers and health plans often make up for the lost revenue by increasing their fees or premiums for small purchasers. This is known as cost shifting. Purchasing pools increase the ability of small employers to obtain an affordable price by increasing their clout in the health care marketplace. Purchasing pools also enable small employers to benefit from the advantages of a larger risk pool; the risk of high-cost cases is evened out by being spread across a large population. The newly created Private Employers Insurance Program (PEIP) provides an opportunity for employers to join a larger pool. (The PEIP program is described in more detail in the section on Health Insurance.) 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 competing ISNs are possible, and will be encouraged, even 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 encouraged or required to collaborate when competition is likely to produce excess capacity in the health care system and when collaboration is more efficient than competition. Competition can be an effective force for lowering costs and improving quality. However, competition is not always the best approach. In some cases, competition produces inefficiency and excess capacity which actually increases costs to consumers. The Commission's plan balances competition and collaboration to produce the best possible benefit for consumers. In circumstances where competition is likely to produce inefficiency or overcapacity, the Commission's plan facilitates managed collaboration between providers and networks.

Impact of collaboration.

When determining whether private sector collaboration should be condoned or facilitated, the impact on other providers, including private sector, community-based or large public teaching facilities, should be carefully considered to ensure that the arrangement is beneficial to the entire community.

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

Some kinds of private sector collaboration violate 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 collaborative 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. Antitrust laws and issues are discussed in more depth in Appendix B.

Antikickback (provider conflict of interest) issues

A strategy that features provider collaboration must also take into account the federal and state "antikickback" (provider conflict of interest) laws. These laws prohibit certain arrangements in which a provider receives a benefit for making a referral to another provider (an example is a physician who has an ownership interest in a medical laboratory and therefore profits every time the physician refers a patient to the laboratory). These collaborative arrangements are believed to cause overcharging and overutilization, particularly in systems in which provider compensation is based on fee-for-service. Provider conflict of interest restrictions are summarized in Appendix C.

Unlike the recognized state action exemption that may protect collaborative arrangements from federal antitrust liability, there is technically no equivalent protection that a state can apply to protect providers from federal antikickback liability. Therefore, the federal antikickback law may conceivably prevent certain arrangements that are beneficial to consumers. However, enforcement of the sweeping antikickback laws is largely a matter of prosecutorial discretion. By emphatically endorsing ISNs as the best method for containing cost and halting over-utilization, the Commission and the Legislature can make it highly unlikely that the antikickback law would be applied to bar the formation or operation of ISNs, even if the structure of some ISNs could otherwise be viewed as technically contrary to the antikickback laws. The Commission will study this issue further, to determine whether changes in state or federal law should be recommended to further facilitate the development of ISNs or promote other beneficial collaboration.

Outside of ISNs, much of the collaboration prohibited by the antikickback laws is undesirable. The Commission will monitor the Department of Health's current rulemaking process, which may result in stricter regulation of such collaboration.

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 & Major Expenditures

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, regulatory controls on services provided outside of an ISN, and the existing retrospective review process administered by the Commissioner of Health.

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 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 including collaborative requests for proposals to jointly contract for high-cost, low volume technologies;

(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.

Capital expenditures and other major expenditures

The 1992 HealthRight Act provides for notification of the Commissioner of Health of any major 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 Commissioner to aid in the retrospective review process.

Capital expenditures and other major expenditures are not outside of the limits on growth that will be established by the Commissioner of Health. An ISN's decisions about major expenditures will be controlled by the overall budget that applies to the ISN which will limit the amount of revenues that will be available to pay for the purchase or expenditure. Capital expenditures and other major expenditures will be regulated and controlled under the regulated, all-payer system for non-ISN services.

Exemption from Spending Limits for Research

Under the 1992 HealthRight Act, the Commission is charged to consider the advisability and feasibility of a number of options as part of its cost containment planning, including "criteria for exempting spending on research and experimentation on new technologies and medical practices when setting or enforcing spending limits" (Laws of Minnesota, Chapter 549, 1992 Legislative Session, Article 1, section 3, subd. 7, clause 4). The Commission reviewed HPAC recommendations on this issue, and approved that funding for health care research be exempt from spending limits under the MinnesotaCare Legislation as follows:

1. Any expense paid for by a federal research agency, foundation, academic organization, commercial firm for research and development, or private donation should be exempted from the spending limits imposed by MinnesotaCare Legislation.

2. Any clinical research expenses not paid for under paragraph #1, should be exempted from spending limits if:

   A. the participating patient is enrolled in an integrated service network (ISN) for her/his health care, and
   B. the study is conducted under the supervision of an institutional review board certified by the U.S. Department of Health and Human Services for a single or multiple project assurance from the office of protection for research risks (NIH), and
   C. the research protocol formally divides the protocol budget into those expenses for standard clinical care, and other expenses, and
   D. the integrated service network has negotiated with the entity conducting the research as to which incremental components of the clinical care expenses are exempt, and
   E. formal records of the numbers of research patients, their expenses, and the source of funds be kept for review by state agencies, public agencies, and the ISN, and
   F. the contribution of an ISN in supporting clinical research be recognized. The agreed upon incremental clinical care expenses are exempt from the cost limitations of the ISN in which the patient is enrolled, and
   G. the results of clinical research [meeting criteria A-F above and exempted from spending limits] be made available to the public.

The Commission also recommended that the financial impact of the clinical research exemption should be reported to the Commission annually.

Data on Quality & 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 system-wide health care quality. Data will be collected in a cost-effective manner that respects the financial and administrative burden of reporting requirements. Legal issues of data privacy will be given careful consideration by the Data Collection Advisory Committee.

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.

Chapter Five contains a broader discussion of issues of quality and outlines a strategy for improving quality data.

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 defines practice parameters as "a statement intended to guide the clinical decision making of health care providers and patients that is supported by the results of appropriately designed outcomes research studies, including those studies sponsored by the federal Agency for Health Care Policy and Research, or has been adopted for use by a national medical society." The Commission recommends that this definition be expanded to include not only practice parameters developed or approved by the federal Agency for Health Care Policy and Research and national medical societies, but also those developed or approved by other national or regional organizations and professional associations.

Practice parameters will be used by medical societies, professional organizations, ISNs and individual practitioners to assist in improving the quality of care while reducing health expenditures. Practice parameters must recognize the need for intraprofessional and interprofessional cooperation. Reduction in health expenditures will be achieved on several fronts. First, practice parameters will assist practitioners in determining which services or patterns of care are most effective, thereby eliminating some unnecessary or ineffective care. Second, the approval of statewide practice parameters as the accepted standard of care will reduce the amount of "defensive medicine" or care provided only for protection against possible legal action rather than for medical reasons. Third, the ability of providers to use practice parameters as an absolute defense in malpractice cases will reduce malpractice caseloads, and therefore awards and malpractice expense. Practice parameters will target health care expenditures more appropriately, thereby improving the overall quality of care delivered in the state.

Minnesota Department of Health Program

The 1992 HealthRight Act established a program in the Minnesota Department of Health to develop, adopt, revise, and disseminate practice parameters. Practice parameters must be supported by medical literature and appropriately controlled outcomes studies. These outcomes studies will assist in determining the cost effectiveness of various treatments and procedures. The Department of Health may also require peer review by the Minnesota Medical Association, the Minnesota Chiropractic Association, or the appropriate licensing board in the event that care patterns deviate from approved practice parameters. The process for approval of practice parameters will be designed in such a manner as to allow for update and revision as often as necessary so that the parameters remain current and relevant for providing high quality care.

The Commissioner of Health is advised in this process by the Practice Parameters Advisory Committee. This committee is charged with recommending a process for adoption of practice parameters by the state. Practice parameters which have been developed and approved by the Agency for Health Care Policy and Research, or by medical societies, or other national health care organizations may be considered for adoption, adaptation and dissemination in Minnesota. Practice parameters approved for use in Minnesota will be interdisciplinary in nature wherever appropriate, and input from appropriate provider groups will be sought in the approval process.

The Practice Parameters Advisory Committee will recommend approval of practice parameters for conditions which represent a high total cost (considering both per unit cost and frequency) and for conditions which result in a high number of malpractice claims. The large-scale outcomes databases established by the Minnesota Department of Health will be focused on the conditions which are the subject of practice parameters. Cooperation in establishment of inter- and intra-professional practice parameters will be encouraged by addressing antitrust issues.

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 change approved practice parameters to incorporate appropriate refinements and improvements as the developed.

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.

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.

Short-Term Strategies: Practice Parameters

The development of practice parameters will provide improved efficiency in the use of health care resources in the short term as well as into the future. The Commission recommends the following specific actions related to practice parameters for short-term cost savings:

The Practice Parameters Advisory Committee will select the 5-10 most costly conditions on the basis of per unit expenditure and frequency for the development of practice parameters. By focusing first on the most costly conditions, cost savings can be achieved early on. Specific estimates of cost savings will be developed as these conditions are identified. Small area analysis estimates that $1 million could be saved in 1994 alone through the dissemination of practice parameters.

The Practice Parameters Advisory Committee will also select the top five conditions which result in malpractice claims. By developing practice parameters on the conditions which most frequently result in malpractice claims, defensive medicine costs can be reduced and legal costs associated with these claims can be reduced as well.

The Practice Parameter Advisory Committee will review the National Institutes of Health practice parameter for prenatal care for possible trial implementation statewide. This practice parameter reallocates prenatal health care spending toward high-risk pregnancies by reducing prenatal care slightly for normal pregnancies. This shift of resources would be budget neutral, with costs savings achieved through improved birth outcomes for high-risk pregnancies.

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.

ISN administrative costs: 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.

Administrative inefficiency

Currently, each payer has different requirements providers must follow when submitting a bill. Payers may require different forms, specify the uses of forms differently, provide different definitions of data elements on the forms, require different attachments to be included with the forms, and have different procedures for submitting forms for payment. These variations result in increased provider expense associated with maintaining rules and requirements for a large number of payers, greater rate of error in submitting claims which results in delays and additional staff time in identifying and correcting errors, and unnecessary and extensive paperwork.

Administrative Uniformity Committee

In order to develop a consensus on specific methods of achieving reductions in administrative costs, the Commission recognized and endorsed the voluntary effort of the Administrative Uniformity Committee (AUC). The AUC is a broad-based group representing Minnesota health care public and private payers, hospitals, physicians, other providers, and state agencies. The purpose of the committee is to develop methods of achieving uniform claims and billing procedures and electronic data interchange, in order to reduce administrative costs and improve efficiency for providers and payers in the system. The committee was formed voluntarily in 1991, and in September of 1992 was requested by the Commission to develop specific recommendations for incorporation in the cost containment plan.

The Administrative Uniformity Committee has developed an initial set of forms and recommendations. These recommendations include uniform billing forms and procedures, standardized patient and provider identifiers, standardized patient identification cards, creating a centralized data base on health care personnel, 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.

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. Specifically, the UB82/92 (The Uniform Bill) and the HCFA 1500 form will be designated as the standard for use within the state. The UB82/92 will be used for hospital or institutional services, and the HCFA 1500 for professional services. The Administrative Uniformity Committee will continue to meet to provide detailed specifications on which form should be used under which circumstances, and will recommend to the Commission a common set of data definitions for the fields on each form. A preliminary report to the Commission will be completed in early 1993, and a final plan for implementation will be approved by the Commission by the end of 1993. Providers and payers, who are an integral part of the planning process for these changes, will begin to implement the concepts in 1994. Many of these concepts, however, are already being implemented in provider and payer settings.

Standardized patient and provider identifiers

Unique and standardized patient and provider identifiers will be developed in a manner that is consistent with national efforts in this area. In addition to simplifying the billing process for providers and payers, and facilitating electronic transmission of data between payer and provider, this will also facilitate the use of claims data for the purposes of monitoring expenditures and enforcing global growth limits, and will provide a link to outcomes data as well. The national Workgroup on Electronic Data Interchange (WEDI) is focusing on establishing nationally uniform identifiers by the end of 1993. Minnesota will adopt standardized identifiers that are consistent with WEDI recommendations, and will also participate at the national level to influence this effort.

Electronic Data Interchange

The Commission will support and facilitate rapid progress toward electronic methods of data interchange. The Minnesota health care community will actively support the efforts of the national WEDI and American National Standards Institute (ANSI) groups, and will provide input to the national workgroups proactively. The AUC will develop a plan to educate providers, payers and purchasers

regarding the benefits of electronic data interchange (EDI), and to outline the activities needed to expand use of EDI. The current demonstration project on electronic data interchange in Minnesota, being conducted at Blue Cross/ Blue Shield and Medica, will provide evidence of the benefits and cost savings. The AUC plan will be completed in early 1993. The Commission, working with the AUC, will develop a timetable for implementation of EDI in Minnesota which will include mandatory implementation for large businesses and incentives for smaller groups to participate. These tasks will be complete by the end of 1993.

Patient ID Cards

Patient health care ID cards will be standardized, by utilizing a consistent format, and consistent terminology. WEDI anticipates national standards for ID cards in early 1993. Minnesota will monitor WEDI efforts and will examine, through the AUC and the Commission, the feasibility of developing a model card for use in Minnesota.

Centralized Database for Licensed Health Care Personnel

Currently, databases on licensed health care personnel are fragmented and not centrally located. This makes the process of determining the status of providers difficult for payers, and makes it difficult to assess the supply of personnel overall and by region and specialty. The 1992 HealthRight Act directs the Commissioner of Health, through the Office of Rural Health, to develop and maintain a database on health care personnel, for the purpose of assisting in recruitment and retention of health personnel. This health care personnel database will include data on physicians, dentists, physician assistants, nurse practitioners, nurses, physical and occupational therapists, and respiratory care practitioners.

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.

Regulated all-payer system

The regulated all-payer system will also reduce administrative costs. The all-payer system will be a standardized system of fees and utilization controls that will be used by all providers and all payers for

those services not covered by an ISN. Instead of the hundreds of different fee schedules, documentation requirements, and utilization controls used by payers now, a single, uniform system will be used. This will substantially reduce providers' and health plans' administrative costs and complexity.

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 Minnesota Department of Health is surveying state agencies to determine the level of current involvement in health care purchasing and management. An interagency group will begin meeting this summer to discuss management options. 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 & 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.

Introduction

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. Furthermore, episodes of care such as hospitalizations may be such infrequent events that many consumers will lack the experience that would otherwise help guide their decisions. Similarly, episodes of care related to emergencies, trauma, or diminished competency may not be under a patient's control. There is often relatively little information to guide patient decisions among alternative forms of health care, and patients typically rely on physicians as their agents in making health care decisions. Finally, consumers may be inhibited from obtaining timely cost-effective care because of financial and nonfinancial barriers to care, and may require assistance to overcome these barriers.

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. These changes should help make healthy choices easy choices, and the most cost-effective choices the most desirable choices.

Consumer education and 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.

Because ISNs will be fiscally responsible for the health care utilization of their enrolled populations, they will have natural incentives to provide the necessary information and assistance to consumers to help

them reduce their risk of illness and injury, and to use the health care system appropriately.

Consumers will also be empowered to make healthy choices and appropriate use of the health care system through a number of additional means. A resource center providing information and technical assistance will be established to provide consumers with information on the quality and costs of ISNs, health care, and health and wellness issues. The Commission has recommended that employers be aided in providing wellness and health promotion activities for their employees, and that promising health and wellness programs be expanded and offered through community-based settings. Collaborative arrangements between providers to furnish patients information on life style issues, health maintenance, and use of the health care system will be encouraged. The Commission recognizes the importance of cultural diversity and culturally sensitive, culturally competent care in making the health care system "user friendly" for all, including persons from communities of color and persons with special needs. It recommends that awareness of cultural diversity be incorporated in health care education and training programs, and that efforts be made to recruit and retain health care providers from communities of color. The Commission will continue to work with communities, providers, and ISNs in recommending ways to identify and rectify bias, or lack of knowledge, that limits opportunities for making healthy choices and effective use of the health care system.

One approach to motivating consumers to be more cost conscious is to establish financial incentives (e.g., point of service cost sharing with copayments or deductibles, cash and in-kind rewards). However, financial incentives must be used judiciously, as many specific consumer financial incentives are potentially unfair or harmful to consumers. To avoid the potential harm or inequity arising from these incentives the Commission recommends that they be directed at behavior which is shown to be voluntary and most likely to be under the direct control of individuals. Sufficient information, assistance, and lead time should be provided to consumers before incentives are implemented. Financial incentives should take into account the income of the consumer and other special needs. The effects of financial incentives on access and health should be monitored, and financial incentives which create barriers to appropriate use of health care services should be eliminated. The Commission will explore the issue of consumer financial incentives in more depth and will make recommendations to employers and other group purchasers on the appropriate use of financial incentives and other methods of motivating consumers to be more cost conscious.

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

Prevention refers to measures which reduce the incidence of disease, injury, disability, and premature death. The potential impact of prevention for improving health outcomes and contributing to health care cost containment is significant. According to a 1992 report, "preventable illness makes up approximately 70 percent of the illness burden and its associated costs." (The Health Project Consortium, *"Reduction in health care costs by reduction in demand"*, October, 1992.) Despite the importance of preventable illness and injury, national spending on prevention is estimated to be only 3% of total health care expenditures.

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. Tracking epidemiologic variables to identify outbreaks of disease or changes in disease patterns, for example, will often require statewide data that no single ISN would have. If environmental hazards are found which pose a threat to public health, ISNs would not have the regulatory authority to take action on the hazards. In some instances, it may be difficult to bring about the rapid cooperation and collaboration of private sector competitors to meet a health emergency, and the immediate deployment of public health system professionals may be necessary. Some prevention activities are more effective and efficient if provided collaboratively. Incentives will be developed to promote collaboration between the private and public sectors to meet public health goals. 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 Commissioner 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

Statewide or regional prevention strategies may be most cost-effective to address complicated behavioral and lifestyle changes through large scale, comprehensive, mutually reinforcing means involving the health care community, community groups, schools, mass media, consumers, non-profit agencies, merchants, and others. The 1992 HealthRight Act requires the Commissioner of Health, after obtaining the advice and recommendations of the Minnesota Health Care Commission, to "administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services." To the extent authorized by the Legislature and within the limits of available funding, statewide consumer education and wellness programs will be established through the statewide system of Community Health Services under the 49 Community Health Boards and other potential sources. These programs should be coordinated with and utilize additional community resources to adequately address the health education and wellness needs of low income persons and special needs populations.

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 defined 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 states 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. "Charting the Course: Minnesota Health Goals and Objectives for the Year 2000" provides a framework recommended for defining and measuring public health goals. "Charting the Course" goals include:

Disease and Injury related goals:

- Reduce the occurrence of diseases or conditions that are influenced by lifestyle choices and cultural norms;
- Reduce the incidence of vaccine preventable disease;
- Reduce the transmission of HIV infection and the incidence of sexually transmitted disease in Minnesota;
- Reduce the occurrence and severity of chronic disease;
- Reduce the incidence of mortality and morbidity resulting from injury.

Special population goals:

- Improve the health status of Minnesota's communities of color;
- Improve the health status of women of child-bearing age and their children;
- Improve the health status of Minnesota's elderly citizens.

System goals:

- Increase access to affordable, quality health care and health care coverage for all Minnesotans;
- Increase the effectiveness and efficiency of Minnesota's public health infrastructure.

An ISN should be evaluated on its case-mix adjusted performance in meeting public health objectives defined in "Charting the Course" for its population. The evaluations would be reported as part of the overall reporting of ISN performance to inform purchasers and consumers. Similarly, financial reimbursement and incentives should be structured to reflect performance in meeting public health goals. Adoption and practice of population-based approaches to health care in ISNs should be encouraged for its membership, including identifying populations at risk, identifying causes of risk, and developing and implementing strategies to address risks. Incentives will be developed to promote collaboration between the private and public sectors to meet public health goals. In all cases, efforts to be responsive to cultural diversity should be strengthened.

Health Insurance

One of the goals of the 1992 HealthRight Act is to increase access to health care coverage for the uninsured and to ensure continued access to health care for those who are currently covered. The MinnesotaCare program (the program for the uninsured) is just one of the vehicles by which access will be increased. This section outlines existing Minnesota initiatives to improve the health insurance system. The Commission generally supports these initiatives and intends to devote significant attention to health insurance issues in the future.

Small Group Reform

Historically, most Minnesota employers have made health care coverage available to their employees. According to a survey of Minnesota employers conducted by Anderson, Niebuhr, and Associates, Inc., most Minnesota employers who have 5 or more employees offer some health care coverage to their employees. However, the Andreson survey also found that as the size of the group becomes smaller, it is less likely that the employer will provide health care coverage. Only 33 percent of employers with 1 - 4 full-time employees provide health care coverage for their employees.

In light of this statistic, it is apparent that many small employers find it difficult to provide health care coverage to their employees. There are many reasons, but the Anderson survey found that most prominent is cost of coverage. According to the survey approximately two-thirds of those employers who do not offer health care coverage would like to do so, and are willing to pay a portion of the premium. Minnesota requires HMOs and insurance companies to provide coverage for more than 30 specific treatments and providers. Some of these mandated benefits may directly increase the cost of health care coverage.

To make it easier for small employers to offer health care coverage for their employees, the 1992 HealthRight Act devoted an entire article to small group insurance reform affecting employers with 2 - 29 employees. It includes many provisions which could have a significant impact on the small group market.

The benefit package is designed to include coverage for a limited number of services and providers. It is comprehensive in nature, but does not include all of the current mandated benefits. The benefit package emphasizes preventive and primary care and can utilize either copayments or deductibles.

In addition, any health carrier who is doing business in the small group market must make available to any small employer, either benefit package. In fact, any product offered by a carrier is subject to the guaranteed issue provisions to a small employer. This is known as guaranteed issuance. Many employers were discovering that health carriers would not cover their group if the group had some negative claims experience. And if the group was able to find a carrier to cover them, it was probably at great expense.

The small group benefit packages are also guaranteed renewable. This means that a small group

cannot be canceled because of poor claims experience. Should the group become ineligible because of an increase or decrease in the number of employees, or because of failure to pay premium, the group's coverage may not be renewed.

Underwriting restrictions were also created for the small group market. Health carriers may only use case characteristics and demographic composition of the small group and the health status of the employees as the bases for setting the rate. In addition, gender based rates will no longer be allowed, resulting in males and females being rated equally.

The issue of whether to require community rating was discussed at length during the 1992 legislative session. Community rating exists when an insurance company or health plan charges all individuals the same premium, regardless of their age, sex, health status, occupation, etc. The trend in the current market is toward risk rating, under which the premium reflects the relative risk of the person or group seeking coverage. The trend toward risk rating makes it increasingly difficult for high-risk persons and groups to obtain affordable coverage.

The small group insurance reforms in the 1992 HealthRight Act represent a compromise between pure community rating and unrestricted risk rating. Under the 1992 Act, rate bands will be imposed on the small group market. Health carriers must offer premium rates to small employers that are no more than 25% above or below the index or "community" rates charged to small employers for the same or similar coverage. The variations must be based on health status, claims experience, industry of the employer and duration of coverage. An additional age-based variation of $\pm$ 50% of the index rate may be charged to the small employer. Premium variations based on geographic regions may also be charged to the small employer. However, a health carrier may request approval from either the Commissioner of Health or the Commissioner of Commerce for no more than three geographic regions and separate index rates. These rate bands will help to stabilize premiums in the small group market. In addition, the Department of Commerce will study the impact of community rating the small group market.

While all of these provisions make health care coverage more accessible to the small employers, they also place a burden on health carriers. To alleviate some of the reservations health carriers may have about the small group market, a reinsurance association has been created to spread the risk throughout the industry. Participation in the association is mandatory for those carriers doing business in the small group market unless the carrier elects not to participate and the Commissioner of Commerce approves the application for non-participation. Health carriers may transfer up to 90% of the risk above the threshold of $5,000. For cases where eligible charges exceed $50,000, a carrier may transfer 100% of the risk.

Some speculation occurred before and after the passage of the 1992 HealthRight Act that these reforms will not increase, but decrease the number of small employers who offer health care coverage to their employees. A survey will be conducted through a grant from the Robert Wood Johnson

Foundation to the Minnesota Department of Health to evaluate the impact these reforms have on the small group market. Further, the Department of Commerce is responsible for conducting a study on the impact of the rate bands, and the effect that moving toward community rating will have on this market. The law specifically states that the study should address how achieving community rating by 1997 will affect the small group market.

Under current law, the Departments of Health and Commerce have regulatory authority for compliance with the small group reform provisions. The Department of Health will monitor and review the HMOs' compliance with these new provisions and the Department of Commerce will monitor and review the insurance companies' compliance with the small group provisions. While these statutes are new, the departments have had similar regulatory authority for traditional types of health plans in the past.

Individual Insurance Reform

Similar insurance reforms were made to the individual insurance market in the 1992 HealthRight Act. While approximately 9 percent of Minnesota's population purchases individual health care coverage, the effect of skyrocketing health care costs is significant to this population as well. (Who Are the Uninsured in Minnesota? A Report to the Minnesota Health Care Access Commission, Nicole Lurie, M.D., M.S.P.H., Michael Finch, Ph.D., Bryan Dowd, Ph.D., October, 1990)

All individual accident and sickness policies must be guaranteed renewable at a premium rate that does not take into account claims experience or any change in health status of the individual covered. There are conditions, such as failure to pay premium, which do not apply to the guaranteed renewability.

Rate bands have also been imposed on the individual market. The rate bands are similar to those imposed on the small group market $\pm$ 25 percent of the index rate for such factors as benefit design, duration of coverage, claims experience and industry, and $\pm$ 50 percent of the index rate for age. Also, individual policies may not be rated based on sex. A similar evaluation of the effects of the rate bands and the other insurance reforms on the individual market will also be conducted by the Robert Wood Johnson Foundation.

In an effort to address a person's ability to make life decisions, the 1992 HealthRight Law included a provision to prohibit a health care plan from applying a pre-existing condition limitation or exclusion of greater than 12 months. The individual must have maintained continuous coverage, similar to the provision in the small group reform and any unexpired limitation or exclusion may apply. Further, a health care plan must offer individual coverage to any individual previously covered by an insured group plan as long as the individual has maintained continuous coverage. Any unexpired pre-existing condition limitation or exclusion may be applied.

Private Employers Insurance Program

The 1992 HealthRight Act addressed the issue of purchasing pools by creating the Private Employers Insurance Program (PEIP). Currently, the Department of Employee Relations administers the Public Employees Insurance Plan. This program allows public employers to pool their employees and leverage greater purchasing power when buying health care coverage. The Private Employers Insurance Program allows private employers of any size to pool their employees and resource for the purpose of purchasing health care coverage. The Public Employees Insurance Plan has been in existence since 1989. The Private Employers Insurance Program goes into effect on July 1, 1993.

The benefits available through this pooling mechanism will be similar to those available through the state employees insurance program. Acceptance into the pool will be guaranteed, and the pool will use the same rate bands as those imposed on the small group market.

Purchasing pools are becoming more and more popular with employer coalitions. However, some state laws make it difficult for employers to create such pools. It will be necessary for the Commission to consider any statutory revisions needed to increase the use of purchasing pools.

Health Professional Education

The Commission recognizes the important role health professional education plays in the health care system and the significant potential the health professional education system possesses for contributing to cost containment efforts. In particular, health professional education programs must undergo changes in order to produce more primary care graduates and graduates who will practice in rural areas. Significant initiatives in this area were enacted in the 1992 HealthRight Act. The Commission supports these initiatives and will continue to monitor their implementation. These initiatives are described below.

1992 legislative mandates

Dollars have been appropriated to the University of Minnesota in the 1992 HealthRight Act for primary care physician education. The Board of Regents, having accepted the appropriation, must work to increase the number of graduates of residency programs of the medical school who practice primary care by 20 percent over an eight-year period. The initiatives must be designed to encourage newly graduated primary care physicians to establish practices in areas of rural Minnesota that are medically underserved.

The law requires the Board of Regents to seek grants from private foundations and other non-state sources for the medical school initiatives outlined in the statute. The medical school submitted a proposal to the Robert Wood Johnson Foundation to "increase the number of graduates of residency training programs of the University who actually practice primary care in family practice from 51 to 73 per year, in Pediatrics from 12 to 15 per year, and general medicine from 14 to 18 per year." This would represent an increase in the number of generalists trained by 32 percent. The goal in the medical school was to increase the number of students selecting residencies in family practice from 23 percent to 30 percent, medicine from 20 percent to 26 percent, and pediatrics from 9 percent to 11 percent of the classes by the year 2000. The competition for these grant funds was very keen, however, and the University did not receive an award.

Criteria for Selection of Medical Students. Another initiative included in the law is to study the demographic characteristics of students that are associated with a primary care career choice and modify the selection process for medical students based on the results of the study.

Medical School Curriculum Design. In the 1992 HealthRight Act, the medical school is requested to ensure that its curriculum provides students with early exposure to primary care physicians and primary care practice and that it supports premedical school educational initiatives that provide students with greater exposure to primary care physicians and practices.

Clinical Experiences in Primary Care. The medical school, in consultation with the medical school faculty in Duluth, is requested to develop a program to provide students with clinical experiences in primary care settings in internal medicine and pediatrics. The program must provide training experiences in medical clinics in rural Minnesota, and community clinics and HMOs in the Twin Cities.

Primary Care and Rural Rotations. The medical school is requested to increase the opportunities for general medicine, pediatrics, and family practice residents to serve rotations in primary care settings, including community clinics, HMOs, and rural practices.

Rural Residency Program in Family Practice. The medical school is requested to establish a rural residency training program in family practice with the initial year of training in a metropolitan-based hospital and family practice clinic. The second and third years of the residency program are to be based in rural communities by using local clinics and community hospitals and specialty rotations in nearby regional medical centers.

Continuing Medical Education. The medical school will develop continuing medical education programs for primary care physicians that are comprehensive, community-based, and accessible to primary care physicians in all areas of the state.

Loan Forgiveness Programs

The 1992 HealthRight Act also provides for loan forgiveness programs for health care students who agree to practice in rural areas. The physician loan forgiveness program will repay one year of medical school tuition, up to $10,000, for each year of practice in a rural area after graduation. The physician can qualify for no more than four years of loan repayment. Medical students can also earn loan repayment money by replacing a rural physician for up to four weeks during any year. This will allow rural physicians time away from their practice for vacation and continuing education.

The midlevel practitioner loan forgiveness program will permit nurse practitioners, nurse-midwives, nurse anesthetists, advanced clinical nurse specialists, or physician assistants to qualify for school loan repayment in exchange for an agreement to practice at least two of their first four years of practice in a rural setting.

University of Minnesota/Minnesota Department of Health Partnership

The mandates set forth in the 1992 HealthRight Act pertaining to the University are an integral part of health care reform in Minnesota. As the University of Minnesota moves forward in meeting its goals, it is working in partnership with the Minnesota Department of Health.

Cost impact of a shortage of primary care providers

The Commission recognizes that the relationship between costs and availability of primary care providers is particularly significant in rural areas. The rural health system functions with primary care providers at the hub. There is a declining percentage of primary care physicians generally, and rural communities have had difficulty recruiting new physicians. As rural primary care physicians reach retirement, communities will have difficulty replacing them unless action is taken to improve the availability of rural primary care providers. If access to primary care is insufficient, medical care costs are likely to increase through higher use of more costly emergency room visits, delays in receiving needed care resulting in higher overall costs to treat advanced conditions, and the use of more costly specialists to provide routine primary care. The Commission believes many of the initiatives enacted in the 1992 HealthRight Act and proposed in the cost containment plan will improve the availability of rural primary care providers. The Commission will monitor the impact of these changes and study additional approaches to addressing this problem.

Medical Malpractice

The Minnesota Health Care Commission recognizes that medical malpractice costs and defensive medicine contribute to rising health care costs. The development and approval of practice parameters, which will provide some protection from malpractice liability for providers who follow them, is an important step toward malpractice reform. The Commission supports the initiatives that were enacted in the 1992 HealthRight Act and will monitor their impact on costs. (See Appendix A for a summary of HealthRight initiatives.) The Commission intends to devote significant attention to the issue of malpractice and may make further recommendations in the future. (See Practice Parameters section for additional discussion on medical malpractice.)

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:**

   a. **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

   b. **Conduct statewide consumer health education and wellness programs**

   c. **Improve immunization programs**

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

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

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

   c. **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**

Chapter One: Targeted Strategies

The Commission has identified a number of opportunities to invest in people, and to help create the necessary supportive environment, to improve the health of the state's population and generate near term health care cost containment. These investments include services, information, education, support, and other assistance to aid consumers in using the health care system most effectively and efficiently, and to help consumers minimize their need for health care by promoting prevention and health maintenance. Some of the investments are targeted broadly, for example with proposed funding for community and worksite-based wellness programs, while others are targeted to children, low income persons, and others especially at risk for significant private and public costs of unmet health care needs. The Commission proposes that these investments be funded from revenues collected from increases in the excise tax on tobacco and alcohol products. These products are major contributors to poor health outcomes, and have been contributors to health care cost escalation. Price increases on these products, and the corresponding decrease in the use and abuse of these products, will also contribute to improved health and reduced health care costs.

As part of a comprehensive approach to dealing with health issues that affect all Minnesotans, the Commission proposes protections and safety requirements that should be taken at the state level. The proposals include mandatory helmet use and increased enforcement and penalties for nonuse of seatbelts. These proposals are not meant as punitive measures targeted toward any group or groups, but will affect all users of motor vehicles, snowmobiles, motorcycles, All Terrain Vehicles, and bicycles -- virtually all Minnesotans -- to address high rates of tragic injuries and fatalities that often can be prevented with appropriate safety equipment. The human and financial costs of vehicle related accident injuries are borne by all Minnesotans, and should be addressed to ensure that all state residents are protected.

Together, these investments and strategies have been identified to help meet health care cost containment goals in the near term. At the same time, they also provide services and assistance to a wide variety of Minnesotans, including many of those especially in need, and protections to improve the health and welfare of all state residents. These steps are not viewed as ends in themselves, but as the start of an ongoing process of identifying and strengthening investments, support, and protection for consumers that it integral to the health care reform efforts of the Commission.

Details on targeted strategies

Improve Birth Outcomes -- Increase subsidized family planning services to prevent unintended pregnancy. Ambivalence about unintended pregnancy has been found to be an important psychological barrier to seeking prenatal care, and results in some pregnant women not receiving timely, appropriate prenatal care needed for good birth outcomes. The Commission proposes that funding be increased to meet unmet needs for subsidized planning services to women of childbearing age with incomes at less than 200% of the federal poverty level and their partners (an estimated 104,000 eligible women), as one means to help reduce unintended pregnancies. Recognizing that reproductive health care services entail sensitive issues associated with confidentiality and availability, the Commission

encourages that multiple providers be part of cost containment and service delivery endeavors. While the potential short-term cost savings of this strategy are difficult to predict, a study by Forrest and Singh reported that each dollar invested in publicly subsidized family planning for its study population returned an estimated savings in medical care expenditures of $3.21 over a two-year period. The Commission will continue to evaluate the potential short-term cost savings from programs to reduce unintended pregnancies.

Improve Birth Outcomes -- Reduce smoking among pregnant women. Smoking during pregnancy has been demonstrated to have significant adverse effects on birth outcomes. While smoking cessation may be a complex, difficult behavior change for many, research has shown that an estimated 12 percent of women who smoke will quit during pregnancy if simply offered low-cost, tested cessation methods of physician advice and instructional materials. Studies have shown that each dollar invested in the smoking cessation program is estimated to save $19-$38 attributable to improved birth outcomes among mothers who quit smoking. The Commission recommends that funding and education be available to enable pregnant women who smoke and are most likely to quit smoking with minimal intervention to do so. At the same time, the Commission will continue to evaluate other interventions to aid other groups of pregnant women who smoke to quit.

Improve Birth Outcomes -- Review potential prenatal care practice parameter. The Commission will continue to explore the potential for a National Institutes of Health sponsored community trial of statewide implementation of practice parameters for prenatal care in association with the Practice Parameters Advisory Committee, professional associations, state government, public health, consumer groups, and other organizations. The trial would assess the impact of a program of identifying high-risk pregnant women, and budget neutral reallocations of prenatal care spending to provide additional services to high-risk pregnant women. With overall participation of 50,000 - 75,000 women and potential statewide reduction in poor birth outcomes requiring expensive prenatal care, cost savings may be significant.

Improve Birth Outcomes -- Explore repeal of laws requiring reporting of pregnant, cocaine using women. Women who are using cocaine and pregnant may be inhibited from seeking timely prenatal care because of current requirements to report pregnant women with cocaine use The Commission will continue to explore repeal of current cocaine abuse reporting requirements by providers of women seeking pregnancy testing and prenatal care to facilitate early and continuous prenatal care by potentially high-risk pregnant women who may be most in need of such care and counseling. Potential cost savings of this strategy are not known at this time.

Improve Birth Outcomes -- Provide culturally sensitive, culturally competent care. Women of color, low-income women, and others with special needs may face nonfinancial barriers to prenatal care in the form of bias, and unfamiliar or intimidating providers or surroundings. The Commission recommends that awareness of cultural diversity be incorporated in health professional education and

training programs, and that efforts be made to recruit and retain medical providers from communities of color. It will work with providers and health plans in the community to recommend ways to identify and rectify bias and intimidating or unaccommodating providers and treatment locations.

Improve Birth Outcomes -- Explore incentives for low-income women to use early and continuous prenatal care. Low-income women may face a number of obstacles to early and prenatal care even if prenatal services themselves are available at no charge. Lack of transportation, childcare options, flexibility or paid leave time at worksites, and other factors may pose significant additional costs to individuals in attempting to use prenatal care. The Commission will continue to explore the use of a variety of cash or inkind incentives to overcome barriers to prenatal care, and to encourage early, continuous, prenatal care among low-income women.

Improve Birth Outcomes -- Enhance use of nurse practitioners and nurse midwives when it improves coordinated, cost-effective, continuous prenatal care. Women seeking or in prenatal care may desire midlevel health care practitioners, particularly certified nurse midwives and nurse practitioners, to play key roles as primary care providers during pregnancy and delivery. In some cases, midlevel practitioners are unavailable, or are difficult to access. The Commission will continue to explore opportunities and methods to encourage use of nurse practitioners and nurse midwives, and to eliminate barriers to use of midlevel practitioners when it improves coordinated, cost-effective, early, continuous prenatal care. A number of studies cite evidence of underutilization of mid-level practitioners, and have estimated potential cost savings from increased utilization of mid-level practitioners. To the extent that access to midlevel practitioners improved early and effective prenatal care and leads to improved birth outcomes, additional savings might be anticipated from the improved birth outcomes.

Improve Birth Outcomes -- Chlamydia Screening. Chlamydia trachomatis is the most common sexually transmitted bacterial pathogen in Minnesota. Chlamydia infection is associated with increased risk of infertility, ectopic pregnancy, intrauterine growth retardation, preterm delivery, and neonatal infection which can result in conjunctivitis or pneumonia. The Commission recommends funding for achieving the Center for Disease Control screening guidelines for all sexually active adolescent women, and all those under 25 with one or more partner in past three months or inconsistent use of barrier contraception. A number of clinics would be needed to provide and monitor at least 40,000 screening tests annually. One study has estimated that screening was cost-effective when prevalence of the disease was greater than 2 percent; a recent state survey of 7,000 women among 26 clinics reported a 5.8 percent prevalence rate. In Colorado, savings from universal screening were estimated to be over $700,000 annually; in California, savings were estimated to be over $6 million dollars.

Improve Birth Outcomes -- Improve Nutrition of Women, Infants, and Children. Poor nutrition status during pregnancy is associated with adverse effects on birth outcome. Studies have shown that nutrition screening of pregnant women and assessment and intervention for pregnant women at nutritional risk can reduce the incidence of low birthweight in babies by approximately 50 percent. The

Commission recommends increased funding for nutrition and nutritional education programs through expansion of the Women, Infant, and Children (WIC) program. The Minnesota WIC program participated in a 1991 national study which demonstrated that for each $1 spent on WIC benefits in pregnancy, $4.21 was subsequently saved in lower Medicaid costs, due to fewer preterm births.

Reduce the incidence of vaccine preventable disease -- Improve adherence to immunization standards, fund immunization efforts. Although reductions of 90 percent or more in the reported incidence of immunizable disease have been documented in the U.S., these diseases can still be quite dangerous in unimmunized populations. Reduction in incidence of a disease may be temporary if immunization is not continually emphasized. Data suggest that immunization rates among Minnesota's preschoolers can vary widely. The Commission recommends steps to improve immunization rates among children and preschoolers, including promoting greater provider adherence to "Standards for Pediatric Immunization Practices" and funding of outreach, tracking, provider education and follow-up to implement the state Immunization Action Plan. Savings estimates for this strategy range considerably, and savings on investment ratios of 2:1 to 14:1 have been documented.

Establish statewide consumer health education and wellness programs through Community Health Boards and other organizations. The state's population experiences high rates of preventable disease, disability, and injury. The Commission recommends funding and coordinating statewide media campaigns and communitywide prevention campaigns to influence cultural norms leading to behavior and lifestyle changes. These programs could be administered through the statewide system of community health services under the 49 Community Health Boards. These programs should be coordinated with and utilize additional community resources to adequately address the health education and wellness needs of low-income persons and special needs populations. Many communitywide wellness programs have reported high rates of return on their health investments. In addition, media campaigns and community prevention campaigns can help other prevention activities to have greater impact, and bring about greater savings.

Establish statewide consumer health education and wellness programs -- information clearinghouse on wellness. Employers and worksites are potentially well suited to promote wellness and prevention programs. Employers have a self-interest in a healthy, productive workforce, and often offer natural economies of scale and central locations for worksite based prevention and wellness programs. What is often needed however, is information and technical assistance to initiate worksite based health programs. The Commission recommends development of a statewide information clearinghouse and technical resource on successful models of worksite based health and wellness programs to disseminate to employers. Models might include examples of national "Koop Award" winners and other programs which have demonstrated cost effective improvements in health status and health care cost containment/ cost savings.

Establish statewide consumer health education and wellness programs -- Establish incentives to aid employers in implementing worksite prevention and wellness programs. The Commission recommends that incentives be established to aid employers in implementing worksite wellness and prevention programs which have been demonstrated to have potential in improving health and limiting growth of health care expense. The programs might include, for example, education and inter. entions to address safety, self-care, exercise, smoking cessation, and nutritional issues. Incentives that might be considered may include possible state start-up grants programs (e.g., as currently underway in the "Michigan Health Initiative") or possible tax credits to employers implementing worksite wellness and health promotion programs. Potential cost savings can be expected to vary by type of incentive and program implemented.

Establish statewide consumer health education and wellness programs -- Evaluate successful wellness programs for possible replication in schools, community centers, etc.. The Commission will continue to explore promising wellness and health promotion programs for possible expansion or replication through the school system, community centers, etc.

Description of programs to discourage high-risk activities

Reduce injury from motor vehicle crashes -- Make seatbelt nonuse a primary offense. Unrestrained and inadequately protected users of motor vehicles can suffer severe, costly injuries in crashes. The medical care costs of traumatic brain injuries (TBI) in Minnesota over the five year perion 1984-1988 have been estimated to be over $1 billion dollars (average: over $200 million per year during this period); motor vehicle crashes account for approximately 30 percent of all TBI. The Commission recommends making nonuse of seatbelts a primary offense, for which nonusers could be stopped and required to pay a fine. Revenues from fines beyond the costs of enforcement could be dedicated to additional preventive health activities. It has been estimated that if restraints had been used by the 10,030 Minnesota crash victims in 1991 who did not use them, an estimated 181 lives and 742 severe injuries could have been prevented. The fiscal impact of these saved lives and reductions in severe injuries varies depending on the assumptions and cost accounting methods used, and merits further consideration.

Reduce injury from other crashes -- Require mandatory helmet use. Health care costs of traumatic brain injury resulting from motorcycle and other crashes among those without proper helmet protection have been shown in a number of studies to be higher than for those properly wearing helmets. Studies have also shown that a disproportionate number of those injured in motorcycle accidents have no health insurance, or are covered by public sources, and result in direct health care expenditures to the state. The Commission recommends mandatory use of appropriate headgear meeting safety criteria for anyone operating or riding motorcycles, bicycles, mopeds, snowmobiles, and all-terrain vehicles. Anyone not in compliance would receive a fine. Revenues from the fine in excess of the costs of enforcement should be dedicated to fund additional preventive health activities. An estimated 450-500 motorcyclists in Minnesota sustain traumatic brain injuries as a result of motorcycle accidents each year.

Based on experience with Louisiana's mandatory helmet law, hospital and long-term disability costs for these 450-500 motorcycle injuries might be significantly reduced with enactment of a universal helmet law. If the severity of injury among the 450-500 motorcycle accident traumatic brain injuries were reduced by the same level as in Louisiana, for example, the potential long-term disability cost savings would be approximately $31,000,000 or more. The more immediate impact on health care costs have not been determined at this time.

Reduce tobacco use and associated adverse health effects--Increase the excise tax on cigarettes. Tobacco use is ranked as the single most significant cause of preventable morbidity and mortality. In Minnesota, health care costs attributable to tobacco related illnesses were estimated to be nearly $355 million in 1990. The Commission recommends an increase in the excise tax on cigarettes to bring about a 5 percent reduction in overall consumption. (It has been estimated that every increase in the total price of cigarettes of 10 percent will lead to an overall reduction in total consumption by approximately 4.5 percent.) Achieving the targeted 5 pecent reduction requires increasing the current state tax $.23 from $.48/pack (25.4 percent of wholesale price) to $.71/pack (37.5 percent) of wholesale price. It is important to note, however, that the impact of price increases is greater on young people than adults and that price influences the decision to initiate smoking more than it influences the quantity of cigarettes smoked. The immediate savings of lowered cigarette consumption are difficult to quantify. Given the large expense associated with tobacco however, even relatively small immediate effects of an increased excise tax are likely to produce measurable and important savings. In addition, after accounting for reduced consumption because of the higher tax, every penny increase in the tax is estimated to generate an additional $2.8 million dollars in excise and sales tax revenue that are recommended to be dedicated at least in part to fund the preventive health activities identified in this report. (The total estimated fiscal year 1994 total excise and sales tax revenue impact of a $.23/pack increase in the state cigarette tax described above is $65.3 million in additional revenue.)

Reduce tobacco use and associated adverse health effects -- Restrict advertising of tobacco products. Advertising restrictions on tobacco products should be developed as statewide policy to the extent possible, given first amendment rights to free speech. Restricted advertising of tobacco products can be coupled with an increase in the price of cigarettes from an increase in the excise tax to reinforce community norms against tobacco use, and bring about greater reductions in smoking and potential savings.

Reduce tobacco use and associated adverse health effects -- Institute additional statewide restrictions on access to tobacco products. Institute statewide restrictions on self service merchandizing of tobacco products. Restrictions on the availability of tobacco products including cigarettes can be coupled with an increase in the price of cigarettes from an increase in the excise tax to reinforce community norms against tobacco use, and bring about greater reductions in smoking and potential savings.

Increase the level of exercise and personal fitness, explore exercise prescriptions. The American Heart Association has labelled physical inactivity or lack of exercise, as a fourth risk factor for coronary heart disease (along with cigarette smoke, high blood pressure and high cholesterol levels). Coronary artery disease is now the major cause of death, and a major cause of disability and health care costs. The Commission has had considerable discussion of the need to reduce sedentary lifestyles and increase the level of personal fitness and exercise. It will continue to explore methods to promote exercise and fitness as part of corporate wellness programs, community-based health promotion, and ISN prevention strategies. It further recommends that the Practice Parameters Advisory Committee evaluate "exercise prescriptions" as part of practice parameters and benefit design. The potential cost savings of this intervention are being developed by the Commission.

Reduce use and abuse of alcohol and adverse health effects -- Increase the excise tax on alcohol to bring about a 5 percent reduction in overall consumption. Direct health care costs of alcohol in Minnesota are estimated to be over $200 million. The Commission's Consumer Incentives, Prevention and Public Health Committee approached the alcohol use/abuse issue from a primary prevention perspective by asking the question: What can we do to bring about a positive change, over a period of time, in the existing cultural norm concerning the use of alcohol? From that point of view, using excise taxes to accomplish an overall reduction in consumption of 5 percent in each of the three types of alcoholic beverage (beer, wine and distilled spirits) was an attractive approach because the impact would be apparent among the larger group of Minnesotans who represent occasional or moderate consumers of alcohol, but for whom the potential for experiencing alcohol related problems always exists (e.g., drinking and driving). If the amount of state excise tax was based solely on alcohol content regardless of the type of alcoholic beverage, beer (which is taxed at only 8 cents per six pack now) would continue to be taxed at relatively low levels. Because the demand for beer is less responsive to changes in price than is true for wine or distilled spirits, it is necessary to increase the current tax on beer by a greater percentage than that required for wine or distilled spirits in order to accomplish the desired 5 percent decrease in consumption. This is of concern because beer may serve as the "entry level" alcoholic beverage for many adolescents, an important target group for any primary prevention effort. This approach results in a more significant increase in the excise tax for beer and would make it less affordable for adolescents who, because they have less disposable income than adults, are more responsive to changes in price.

The Commission recommends an increase in the excise tax on alcoholic beverages to bring about at least a 5 percent reduction in consumption. To maintain the reduction over time, it is recommended that the method of taxation be changed from an amount per unit/volume to ad valorem tax. Because the impact of price increases vary with the type of alcoholic beverage, this recommendation would increase the state excise tax on beer to at least 22.8 percent of the wholesale price (increase from $.08 per six pack to $.38 per six pack); on wine to 13.6 percent of the wholesale price (from $.12/liter to $.39/liter); and on distilled spirits to 27 percent of the wholesale price (from the current level of $1.33/liter to $1.97/liter). The Commission recommends dedicating at least some revenues of the increased taxes to fund other health

promotion and prevention activities. It is estimated that the impact on state sales and excise taxes for fiscal year 1994 of the increased excise taxes would total over $80 million dollars. The immediate savings of lowered alcohol consumption are difficult to quantify. Given the large expense associated with alcohol however, even relatively small immediate effects of an increased excise tax are likely to produce measurable and important savings.

Summary

It is important to note the limitations of evaluating prevention, and health promotion interventions described above almost exclusively on their potential for recouping measurable, short-term health care cost savings. Prevention and health promotion are often simply additional means, like secondary and tertiary medical care, for achieving desired health outcomes. Like other forms of medical care, expenditures are often incurred for prevention and health promotion for which it is unreasonable to expect to recoup cost savings as a result of these activities. The Commission has proposed that at least some of the revenues of proposed increases in excise taxes on tobacco and alcohol products be dedicated to funding the targeted strategies and health investments described above. Evaluations of these investments should also measure whether the health outcomes obtained through these means justify their cost, rather than whether they produce net economic savings alone.

In addition, as with many other health care interventions, data on the relative costs and potential savings of these proposed interventions are often limited. Time and resources for conducting research and analysis to estimate costs and potential savings have also been limited. Many of the interventions with positive cost savings reported in the literature may be limited to specific targeted groups, and subject to diminishing marginal returns when applied more broadly. Many benefits of prevention and health promotion strategies are also likely to accrue over much longer timeframes than considered in the proposals above, and may also be important for equity, as well as efficiency reasons. Equity and longer term paybacks were not considered to as great a degree however, as short-term measurable cost impacts.

It should also be noted that cost savings were estimated for distinct interventions which may affect many common groups or populations. As a result, the cost savings achievable by implementing all of the interventions below may be less than the sum of the individual proposals listed. In addition, public health problems often have many causes, and require integrating numerous mutually reinforcing strategies to change community norms that influence behavior and lifestyles. However, the targeted approach focusing on individual strategies has been used to facilitate cost and savings estimates, and to aid in selecting particular strategies that might be of most immediate value in achieving cost containment in combination with health enhancement.

Information & 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 employees 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 referral 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 referral relating to health care.

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

Health care reform will work most effectively with strong regional involvement, commitment and implementation. Therefore, the Commission's cost containment plan calls for the continuation of the regional boards with the duties specified in the law as well as general expectations of activities which will assure effective implementation of the cost containment plan. The Commission and the Minnesota Department of Health have and will continue to work closely with the regional boards as they develop their workplans, timelines, and strategies on how best to fulfill their responsibilities.

Activities of Regional Coordinating Boards

Each Regional Coordinating Board's mission will vary somewhat because of regional differences and time needed to assess regional circumstances. General expectations regarding Regional Coordinating Board activities are:

(1) To develop a strategy to assist in the implementation of the cost containment plan by June 30, 1993;

(2) To initiate voluntary, regional efforts which promote better understanding by providers, payers, employers and consumers about each group's responsibilities under MinnesotaCare;

(3) To advise the Commissioner of Health as outlined in the law, with special emphasis on regional needs regarding access and health planning; and

(4) To seek advice, when appropriate, from private and public entities such as the Rural Health Advisory Committee, Health Planning Advisory Committee, and the Community Health Boards.

Future Directions for the regional boards

By June, 1993, a detailed workplan, assessing regional needs and strength and identifying implementation priorities, will be available from each Regional Coordinating Board. After each workplan is developed, each Regional Coordinating Board will seek local public input, make refinements and then begin implementation by July 1, 1993. Each workplan will include a statement of short and long-term goals for the region each board serves.

In its assessment of the region, each regional board is expected to address the following:

(1) Establishment of Integrated Service Networks, and related consumer and provider education;

(2) Monitoring and/or promoting spending growth limits, and related consumer, employer, and provider education;

(3) Regional comparisons of outcome data, including price, quality, and related consumer, employer and provider education;

(4) Prevention improvement, including needs assessment, private sector contributions and special projects recommended to increase awareness;

(5) Public health in the region, including needs assessment, the role of public health agencies and private sector contributions; and

(6) Issues of access to services, including provider availability, barriers to appropriate use of mid-level providers and issues of financial resources and transportation/mobility.

Each Regional Coordinating Board will define its role in coordinating ISN and non-ISN activities in the area. Over a longer period of time, the Regional Coordinating Boards will be expected to offer advice on regional data collection and disbursement, use of technology in the region and other components of the cost containment plan as well as other health care delivery service issues.

Community health boards

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

Impact on Rural Areas

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 database 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 are described in more detail in Chapter Three. These programs will significantly enhance the quality and accessibility of health care in rural areas. These programs are described in more detail in Chapter Four. 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 Health Planning Advisory Committee 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 a step in a continuous process of improving the Minnesota health care system.

A major theme underlying the cost containment reforms of the Commission is continuous quality improvement, also known as total quality management. The Commission believes the cost containment plan is an important first step toward achieving the cost containment goals expressed in the 1992 HealthRight Act. It is envisioned that the initial recommendations to slow the growth in health expenditures will be revised and improved upon in future years. An ongoing process is foreseen of implementing reforms, carefully evaluating the impact of the reforms, and then revising and recommending improvements.

The Commission intends to identify and define more precisely Minnesotan's expectations of the health care system and to continuously evaluate the success of the system in meeting those expectations.

The principles of continuous quality improvement are being widely adopted by health care providers and health plans. Without specific techniques of quality improvement, there are significant concerns that cost containment activities will compromise the quality of medical care in Minnesota. Therefore, the Commission intends to promote the principles of continuous improvement philosophy among health care providers to achieve higher levels of quality while containing costs.

A specific strategy for promoting continuous quality improvement is for the Commission to identify projects in which a public-private partnership could focus a continuous improvement activity and identify resulting cost-savings. In addition, educational activities and technical expertise in continuous improvement activities could be developed through this public-private partnership, so that duplicative resource expenditures could be avoided.

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 the 1993 legislative session 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 or emergency rulemaking procedures will be needed if spending limits are to be in place by January 1994.

Timetable

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

April 1993

- The phase-in of uniform billing forms will begin
- 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, quality, and utilizations 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.

CHAPTER TWO:

Spending Data & Trend Projections

Spending Data & Trend Projections

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

Legislative requirements

Cost containment plan. The Commission is required to submit to the Legislature and the Governor a plan for slowing the rate of growth in health care spending for the State of Minnesota. The goal of the plan must be to reduce the growth rate of health care spending, adjusted for population changes, so that the growth rate declines by at least ten percent per year for each of five years beginning in 1993. The Commission is required to use the rate of spending growth for 1991 as the base year for developing its plan. (Laws of Minnesota 1992, Chapter 549, Article 1, Section 3, Subdivision 7(a))

Limits on growth. The 1992 HealthRight Act requires the Commissioner of Health, in consultation with the Commission, to set an annual limit on the rate of growth of public and private spending on health care services for Minnesota residents. The Act specifies that the limit must be achievable through good faith, cooperative efforts of health care consumers, purchasers, and providers, but it also requires that the limit must slow the current rate of growth by at least ten percent per year. (Laws of Minnesota, 1992, Chapter 549, Article 1, Section 3, Subdivision 1).

Data collection. For purposes of setting growth limits, the Commission will make recommendations to the Commissioner regarding data needs and data collection strategy to fully implement the cost containment objectives. The Commissioner is authorized to collect data from all Minnesota health care providers on patient revenues and to collect data on health care spending from all group purchasers of health care. All health care providers and group purchasers doing business in the State are required to provide the data requested at the times and in the form specified by the Commissioner. (Laws of Minnesota, 1992, Chapter 549, Article I, Section 3, Subdivision 2).

Goals and objectives for establishing spending and growth trends

The Commission's Cost Trends and Measurement Committee developed the data collection strategy and will advise the Commissioner of Health on its implementation. The Committee set forth a list of data objectives that must be accomplished in order to effectively establish and enforce growth limits on health care spending. These objectives include the following:

(1) The Commission must be able to quantify and monitor Minnesota health care expenditures on an ongoing and consistent basis and must also acquire information on Minnesota health care expenditures for the 1990-1991 baseline period.
(2) The Commission must be able to determine and monitor the trends and growth rates of health care spending by type of payer (public versus private) on an ongoing and consistent basis.
(3) The data collected on health care spending must be at a level of detail that will make it possible

for the Commission and the Commissioner of Health to project spending growth, recommend limits on growth, monitor actual trends, and enforce compliance with the growth limits.

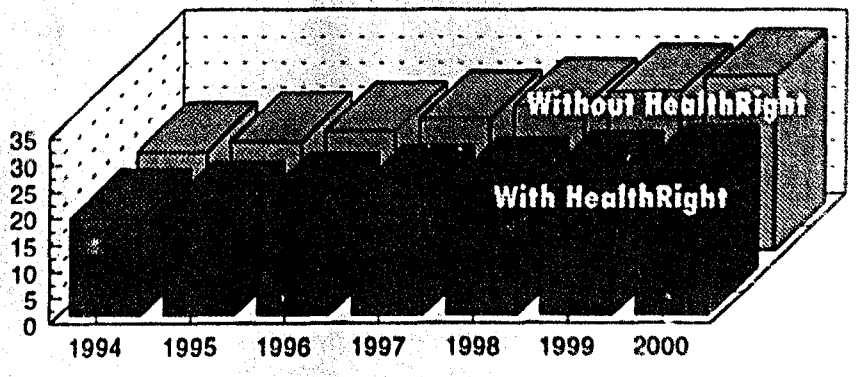
State estimates of health care spending and growth rates

Existing estimates of health care spending in the State of Minnesota are primarily based on national sources of data extrapolated to state level spending based on current population estimates and other state-level adjustments. There are two widely used sources of state-level estimates on health care spending: the national health expenditure (NHE) accounts published by the Health Care Financing Administration (HCFA) (Levit 1985) and estimates developed by Lewin/ICF for Families USA (Families USA 1990).

HCFA. The Health Care Financing Administration publishes annual estimates of national health expenditures and actuarial projections of expenditures by type of service and by source of funds (Sonnefeld et al, 1991). Estimates are made of state-level expenditures only periodically. The latest state-level information available was based on 1982 data (Levit 1985) with an update expected sometime early in 1993. Using the NHE accounts, HCFA estimated 1990 national health care spending at $666.2 billion or 12.2 percent of the Gross Domestic Product (Levit et al, 1991). The average annual growth rate in national health expenditures between 1985 and 1990 is estimated at 9.5 percent (U.S. Congressional Budget Office, 1992).

Lewin/ICF. Lewin/ICF, a national health consulting firm, developed a model to estimate state health care spending for 1991 (Families USA, 1990). The estimates are again based on national data and extrapolated to state level data based on the distribution of the state's population and other factors. The Lewin estimates have been used as the targeted health spending amount for the State of Minnesota by the Legislature and the Commission. The Lewin/ICF estimate for health care spending in the State of Minnesota is $14 billion for 1991. The current rate of growth in health care spending is ten percent per year based on an actuarial estimate by Deloitte and Touche for the Minnesota Legislature. An illustration of Minnesota health care spending from 1991 - 2000 with and without the growth limits established under the 1992 HealthRight Act is presented in Figure 1.

Figure 1: Minnesota Health Care Spending 1991-2000



Baseline spending based on study by Lewin/ICF December 1991, Health Spending: The Gross Threat to the Family Budget
Spending growth without HealthRight is 10% annually based upon actuarial estimate from Deloitte and Touche
Spending growth for HealthRight based on goal in bill to reduce the growth in spending by 10% each year
Source: Minnesota House Appropriations Committee, 1992

Tables 1A and 1B show in greater detail the projected rate of growth and anticipated savings given the enforcement of the limits on the growth in health care spending. It should be noted that the $14 billion estimated for 1991 health expenditures in the State of Minnesota is based on the best data available at this time. In addition, the ten percent growth rate used to project health spending into the future is hypothetical and intended to illustrate the effect of the growth limits into the future. It is likely that future growth rates will be different than ten percent.

University of Minnesota. A third source of information is the work done by the University of Minnesota, Division of Health Services Research and Policy, to provide an overview of health care expenditures in Minnesota from 1981 through 1985. The report compiles numerous sources of data to establish the aggregate cost and trends of health care expenditures by service category and by payer. The University estimated the average annual percent increase in total per capita expenditures during 1981-1985 at 8.6 percent. (University of Minnesota, 1987)

Table 1A: Current Health Care Spending Projections* (in billions)

1991	$14.0
1992	$15.4
1993	$16.9
1994	$18.6
1995	$20.5
1996	$22.5
1997	$24.8
1998	$27.3

Based on a hypothetical estimate of 10% growth rate per year

* Lewin/ICF Inc. 1990

Table 1B: Example of Reducing the Rate of Growth by 10% for the Next Five Years

Year	10% of Growth Rate	Growth Limit	Cumulative Savings (in billions)
1993-94	10% x 10% = 1.0%	9.0%	.2
1994-95	10% x 9% = .9%	8.1%	.7
1995-96	10% x 8.1% = .8%	7.3%	1.8
1996-97	10% x 7.3% = .7%	6.6%	3.8
1997-98	10% x 6.6% = .7%	5.9%	6.9

Based on a hypothetical estimate of 10% growth rate per year.

In summary, the current estimates of state-level spending on health care services are either outdated or based on national-level data. The Lewin estimate of $14 billion that has been used by the Legislature and the Commission is only an estimate and based on data that is removed from actual state experience. The Lewin estimates will continue to be used until the Commission develops its own state estimate based on more accurate state-specific data on health care spending.

Chapter Two: Spending Data & Trend Projections

Although the HCFA information on health care expenditures provides consistent estimates of national health care spending over time, the data is not at the detail needed to effectively implement and enforce spending limits at the state level. In addition, much of the work done in estimating state-level spending is developed by manually pulling together a diverse set of information from various data sources and this time-consuming compilation of disparate data sources must be reenacted every year to keep the numbers up to date.

In order to estimate and monitor health care spending in the State of Minnesota for the purposes of establishing spending limits more precise state-level data is needed. A primary objective of the Commission is to collect uniform and consistent state-level data in a routine and efficient manner on an ongoing basis.

Existing state data sources

The state has several data sources that, while not all-inclusive, will be helpful in establishing the process for data collection for other payers and providers. In general, the state has access to reliable aggregate data on hospitals and HMOs and detailed information on the Medicaid program. However, there are no additional routine data collection activities to collect information from other payer groups, provider groups, or other state and local health care programs. Most notably, there is no data currently collected on physician-level spending. The two databases currently maintained by the Minnesota Department of Health are described below:

Health Care Cost Information System (HCCIS): This system provides information compiled by the Minnesota Department of Health on the financial condition and operating experience of hospitals in Minnesota. Information contained within the system includes income, expenses, charges, receivables, capital, staff levels, and utilization. The system is used to provide information for policy making concerning health care cost containment and access to health care. The system is updated as hospitals submit information at the end of their fiscal years.

HMO Annual Reports: This system provides information on the operating procedures, financial status, enrollment, and utilization of HMOs as well as complaints against them. The system's information on operating procedures are updated as HMOs amend their articles of incorporation, bylaws, enrollee contracts, provider contracts, geographic service area, and operating procedures. Complaints received are kept in a nonpublic file. Annual reports from HMOs provide standard aggregate information about financial status, enrollment, and utilization of services by HMO enrollees.

Initial assumptions: health care expenditure data

There are several basic assumptions that underlie the Commission's plan to collect data from both payers and providers for the purposes of quantifying and monitoring health care expenditures over time.

These assumptions include the following:

- Determination of spending targets and Integrated Service Network (ISN) accountability will require the collection of statewide, regional and comparative data to determine baseline expenditures and revenue infomration to set statewide expenditure goals and specific expenditure goals for ISNs and other health care providers.
- Health care revenue and spending data will be routinely collected from both payers and providers of health care services. The data collected and the data collection process will be reviewed on an ongoing basis.
- Data will be collected annually based on consistent guidelines and data definitions.
- The data set will include as a base, expenditures and revenues for health care services contained in the set of basic benefits generally included in health coverage programs.
- The expenditure database will be limited in the initial years but will evolve as additional sources of data are developed and submitted on either a voluntary basis or through legislative requirements.
- Data definitions and data collection techniques will be refined over time to assure the collection of uniform and accurate data on health care spending and to assess the balance between the need for accurate data and the costs associated with collecting the data.
- Random or cyclical events may distort the estimates of the growth rate of health care spending. Target rates of increase and implementation of spending limits 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.

Overview of data strategy

The 1992 HealthRight Act requires that the rate of spending growth for 1991 be used as the base year for developing the cost containment plan. The Commission has recommended using a two stage strategy for data collection that includes: (1) a short-term initiative that provides immediate information on a significant proportion of, but not all, health care spending, that will be used to establish a growth trend for 1991; and (2) a more comprehensive data collection plan that will provide more detailed data that can be used to monitor spending and growth patterns over time. Each of these strategies is described below.

The framework for defining the elements to include in health care spending is based on the framework used by HCFA National Health Expenditure accounts to estimate national expenditures. The framework includes three basic components of total health expenditures. (Levit et al, 1991)

1. Personal health care services and supplies. Includes expenditures resulting from the provision of services for direct patient care, program administration and the net cost of private insurance and government public health activities.

2. Research and education. Research expenditures includes expenditures for biomedical research and research on the delivery of health care. Education expenditures include formal federal, state and local subsidies to finance medical education.

3. Construction and capital expenditures. Includes all expenditures associated with construction expansion of medical facilities.

The ultimate goal will be to capture and monitor all health expenditures included in the basic framework. However, the data collection strategy will focus on personal health expenditures first and will be expanded to include the other categories as time and resources permit.

Long-term care

Expenditures for long-term care are not presently included in the Commission's cost containment charge. The Commission is concerned about the substantial and growing expenditures associated with long-term care. Baseline data on Medicaid and other expenditures for long-term care services are available and will be collected and monitored. Although long-term care is not a part of the overall cost containment plan, it is the intent of the Commission to monitor the costs and trends of long-term care along with other components of the system.

Short-term strategy

The short-term data collection strategy was developed to collect the best figures possible on 1991 health care spending to meet the January 15, 1993, deadline for submitting the report to the Legislature. The process involved working directly with the major payer groups to determine 1991 baseline data. Payer groups were chosen for the initial information because of the availability of accurate data, the short timeframe needed to collect the data, and their ability to calculate growth trends.

The Commission requested total revenue by source and aggregate claims paid by general spending categories. The general spending categories included hospital services, physician services, drugs, services of other health professionals, mental health and chemical dependency services, dental services, and administrative expenses.

The list of the major payers and an outline of the strategy used for collecting aggregate spending data is presented below:

HMO PROVIDERS: Aggregate spending data provided in the annual audited financial statements submitted to the Minnesota Department of Health. Additional information was requested from the three largest plans to determine the aggregate amount of their self-insured business.

BLUE CROSS/BLUE SHIELD: Aggregate information on spending for all business provided in the state, including the self-insured business conducted.

SELF-INSURED PLANS: Survey data from the Business Health Care Action Group companies which includes fourteen large employers in the metropolitan area in addition to the self-insured data provided by BCBS, Group Health, and Medica.

COMMERCIAL INSURERS: Survey data from the top companies that do business in the State of Minnesota representing approximately 50 percent of the commercial business in the State of Minnesota.

PUBLIC PAYERS: Existing Medicare and Medicaid (the primary public payers in the state) data on health care expenditures, supplemented with Medicare information from BCBS and Travelers (Minnesota's Medicare carriers). Other public payers and programs include Workers' Compensation, the Minnesota Comprehensive Health Association, and the Public Employees Insurance Program.

It is estimated that the data generated by this strategy will capture approximately 60 percent of all personal health care expenditures. **Figure 2** provides an overview of the distribution of the Minnesota population covered by different payer categories and an estimate of the uninsured for 1991. The Commission will have complete information on the population covered by HMOs, BCBS, Medicaid and other public programs and a smaller proportion of the commercial and self-insured business. The Commission will continue to refine definitions of expenditure categories and colle : payer-level data on an ongoing basis with the anticipation that the ISNs will be required to submit similar information as a requirement of certification.

Figure 2: Distribution of Population by Coverage Category State of Minnesota, 1991

Sources: 1991 HCFA Medicare Estimated Benefit Payments; 1991 HMO Operations Report, MDH; 1991 Medical Assistance Report, DHS; 1991 Preliminary Health Expenditure Data

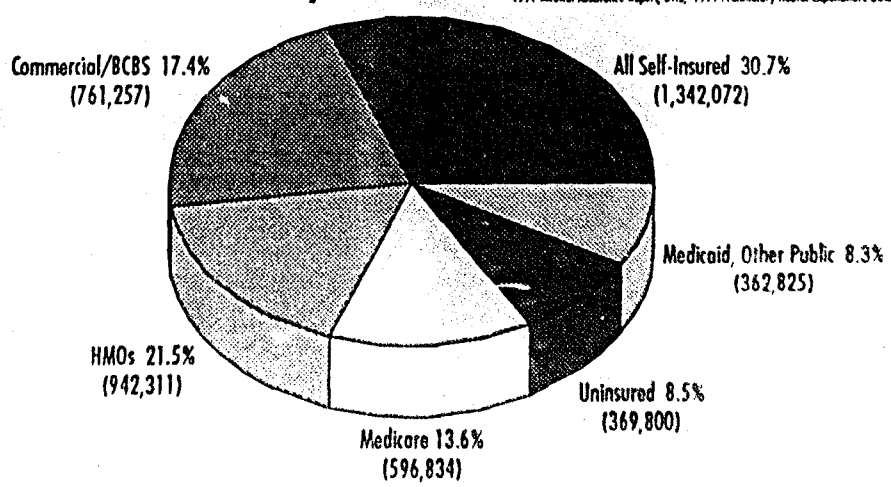


Table 2 provides a summary of 1991 personal health expenditures for the State of Minnesota. We have attempted to quantify federal, state and local programs in addition to private sector payments. The table includes actual data received to date plus an estimate of out-of-pocket expenditures (based on national patterns of out-of-pocket spending). For the commercial carriers and self-insured plans actual data received to date is presented along with an estimate of the percentage of total expenditures each amount represents by payer category. The figures do not include expenditures for research, education, construction costs, donations and other philanthropy including uncompensated charity care and bad debt. Long-term care (LTC) expenditures are listed as a separate category and include both public and private out-of-pocket expenditures.

Based on the expenditure data submitted and state estimates of covered individuals by type of payer, an estimate of total health care expenditures for 1991 was calculated. For 1991, personal health care expenditures for the State of Minnesota was $8,727,686,444. Adding LTC expenditures increased the estimate of total health care expenditures to $10,545,424,440.

Table 3 provides a break out of the public programs that were included in estimates of total health care expenditures. As stated previously, attempts were made to track all public programs, but there were several pieces of data that were not readily available or in a form suitable for reporting purposes. It is anticipated that the level of data required to document and track health care expenditures will be submitted by state and local health programs on an annual basis in a uniform format.

Table 2: Estimate of Personal Health Care Expenditures by Payer Category for the State of Minnesota, 1991

PAYER CATEGORY	$$
PUBLIC: FEDERAL *	
Medicare	1,451,000,000
Medicaid	406,704,756
Other Federal Programs	596,813,883
TOTAL: FEDERAL	2,454,518,639
PUBLIC: STATE *	
Medicaid	310,922,344
General Assistance Medical Care	119,982,016
Other State Programs	349,715,515
TOTAL: STATE	780,619,875
PUBLIC: LOCAL (COUNTY, CITY) *	
Medical Assistance	42,838,308
General Assistance Medical Care	9,357,693
Other Local Programs	80,995,754
TOTAL: LOCAL	133,191,755
PRIVATE: *	
HMOs	1,311,737,870
Commercial/BCBS (1)	[illegible]
Self-Insured (2)	494,864,975
Out-of-Pocket (3)	164,499,415
Workers' Compensation - Medical	259,000,000
Auto Insurance - Medical **	208,000,000
TOTAL: PRIVATE (1,2,3)***	3,109,386,263
TOTAL PERSONAL HEALTH CARE EXPENDITURES* **	**6,477,716,532**
LONG-TERM CARE	
State Payments	963,401,138
Out-of-Pocket/Private	854,336,858
TOTAL: LONG-TERM CARE	1,817,737,996
TOTAL	**8,295,454,528**
INDEPENDENT ESTIMATE OF ACTUAL TOTAL	**10,545,424,440**

* Exluding Long-Term Care ** Estimate from Minnesota Health Care Access Report, January 1991
*** Based on actual data submitted as of April 1993
(1) Represents 59% of commercial coverage and 100% of BCBS coverage
(2) Represents 34% of self-insured coverage (3) Represents 13% of Out-of-Pocket coverage

Table 3: Estimate of Public Health Care Expenditures for the State of Minnesota, 1991*

PAYER CATEGORY	$$
PUBLIC: STATE * **	
Medicaid	310,922,344
General Assistance Medical Care	119,982,016
Children's Health Plan	4,472,722
MCHA	86,718,765
U of M Hospital	16,014,519
State Employee Group Insurance Plan	117,016,602
State-paid Workers' Compensation	10,750,000
Correction System Health Program	10,105,475
Higher Education Student Health Programs	**
Head Start	6,500,000
Chemical Dependency Treatment Fund	29,012,000
Crime Victims Reparation Fund	753,432
Public Health Activities	68,372,000
TOTAL: STATE	780,619,375

PAYER CATEGORY	$$
PUBLIC: FEDERAL * **	
Medicare	1,451,000,000
Medicaid	406,704,756
Other Medical Assistance (Refugees)	1,184,954
VA Programs	249,994,381
Indian Health Services	27,000,000
CHAMPUS	17,022,000
Federal Workers' Compensation	**
US Public Health Services	202,700,000
Center for Disease Control	**
Federal Correction System - Health Program	15,664,648
Federal Block Grants	65,325,000
Head Start	17,600,000
Crime Victims Reparations Fund	322,900
TOTAL: FEDERAL	2,454,518,639

PUBLIC: LOCAL (COUNTY, CITY) ***	
Local Health Departments	**
Medical Assistance	42,838,308
General Assistance Medical Care	9,357,693
Hospital Subsidies	24,162,286
Local Government Workers' Compensation	32,250,000
School-based Clinics	1,307,120
Chemical Dependency Treatment Fund	20,600,348
Public Employer Insurance Plan	2,676,000
TOTAL: LOCAL	133,191,755

TOTAL PUBLIC HEALTH CARE SPENDING*	3,368,330,269

* Based on Actual Data Submitted as of April 1993
** Full Information is Not Available *** Excluding Long-Term Care

Estimates of health care spending

Estimates of total spending for years before 1994 will be based on the 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 heath 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 expenditures. 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. (see Table 4 for a more detailed time frame):

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. For the immediate future, the

Table 4: Proposed Timeline
Estimation/Projection of Growth Trends

Spring '93	➢	**Set trend estimate of health care spending for '93-94** Based on: • '90 - '91 - '92 payer level data and growth trends • Nat'l public/private sector data on health care spending • Other state trends (for similarly situated states) and multi-state spending data
	➢	**Set prospective target rate of increase from '93 - '94** Based on reducing the estimated rate of increase by 10 percent
July '93 - Dec '93	➢	**Collect/submit detailed payer & provider data** Due Spring 1994
Spring '94	➢	**Estimate actual total health expenditures for 1993** Based on actual data provided (July '93 - Dec '93)
	➢	**Set prospective target rate of increase from '94 - '95** Based on: • 1993 data submitted • Nat'l public/private sector data on health care spending • Other state trends (for similarly situated states) and multi-state spending data
Jan '94 - Dec '94	➢	**Collect/submit detailed payer and provider-level data** Due Spring 1995
Spring '95	➢	**Estimate actual total health expenditures for 1994** Based on actual data provided (Jan '94 - Dec '94)
	➢	**Calculate change in total expenditures from '93 - '94**
	➢	**Compare actual to estimate of '93 - '94 trend** Make appropriate adjustments to trend

Health Department will collect the six month data in 1993 to serve as a pilot test for full-scale data collection effort in 1994.

Comprehensive data collection strategy

The aggregate payer data on health care spending collected under the short-term strategy clearly will not capture all health care expenditures of interest. The data does not represent all payers and does not include all forms for health care expenditures. The key components that need to be addressed in a more comprehensive assessment of the trends and growth of health care costs include monitoring the following:

- Out-of-pocket expenditures
- Charity care and bad debt
- Technology
- Research and education
- Construction and capital expense

It is the intent of the Commission to outline a detailed strategy to capture and monitor these elements of health care spending. This will be part of the ongoing workplan of the Commission in 1993. In the interim, the Commission will be collecting provider-level and additional payer-level data beginning July 1, 1993. This data will be used to track total health expenditures in the State of Minnesota. Attention will be given to the data collection and aggregation process to avoid any double counting. The two levels of data will be used to document revenues and expenditures and to cross check the data provided through each method.

More detailed information will be needed for both the provider and payer groups including but not limited to the identification of Minnesota and non-Minnesota residents and the county of residence to be able to establish regional spending and growth targets as well. The cost of data collection will be assumed by providers as cost of doing business. The state effort for data collection and compilation will require an additional appropriation.

There have also been some initial discussions about the need for more detailed information from payers in the form of actual claims paid and patient-level data. This option would require increased information system capabilities including electronic interchange of data. These discussions are preliminary at this stage, but this level of data would facilitate the detailed documentation of health expenditures.

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.

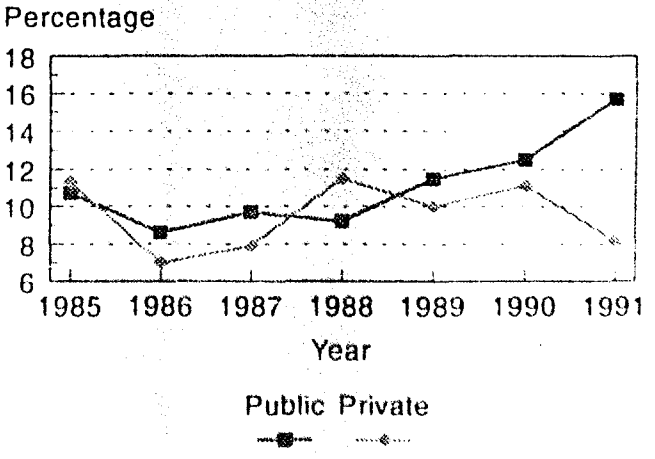
Year-to-year variations

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.

Information on national health care cost and growth trends shows a wide variation in the average annual trends. This is true whether looking at the trends for private insurance or public programs and whether looking at trends in actual expenditures or prices. Figures 3 and 4 illustrate the variation in the trend in both health care expenditures and prices. Figure 3 shows the annual trend in national personal health care expenditures as measured by the HCFA's national health expenditure accounts. (Levit et al 1991) This trend includes both public and private spending. Figure 4 shows the trend in the medical component of the Consumer Price Index for the Minneapolis/St. Paul metropolitan area compared to all other U.S. urban areas. It should be noted that the Consumer Price Index is a price index and does not adjust for changes in utilization. Both indices show a range of variation in annual trend from 4-20 percent change per year.

Figure 3: Annual Percent Growth in National Health Care Expenditures - Personal Care 1985-1991

Source: Health Care Financing Administration, Office of the Actuary; Data from the Office of National Health Statistics

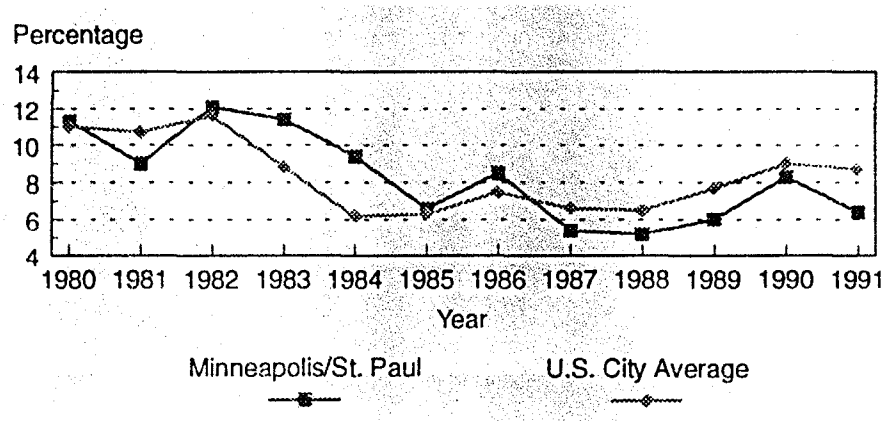


The major concern raised by the Cost Trends and Measurement Committee was whether a two or three year trend line to set limits on the growth in health care expenditures would be more feasible given the variability of the cycles in health care expenditures and prices. A key question is how to meet the goals of cost containment

and demonstrate that those goals have been met in a way that recognizes and accounts for the year to year fluctuations that are endemic to the industry. Monitoring of annual expenditures and targets are required with appropriate adjustments to account for utilization effects with the possibility of using of a two to three year trend line or some type of average annual trend over time to set and enforce limits.

Figure 4: Consumer Price Index - Medical Care Component Minneapolis/St. Paul and the U.S. City Average

Source: U.S. Department of Labor, Bureau of Labor Statistics, 1992



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.

DETERMINATION OF ACCOUNTABILITY FOR CONTAINING COSTS

Overall strategy

A key component of the cost containment plan is to be able to set and enforce spending limits and enforce compliance with those limits for both the Integrated Service Networks and those in the regulated system. Several components have been outlined to help define the methods for ensuring the accountability of Integrated Service Networks. The following components address issues related to the measurement and data collection needs to assure accountability.

- Measurement of Minnesota health care expenditures should include traditional components of actuarial trends including but not limited to the following:
    - Administrative costs
    - Actual payments to providers
    - Utilization of services
    - Intensity of services
    - Mix of services
    - Risk selection
    - Technology factors
    - Cost shifts
- Comparative data will also be collected to track Minnesota trends against other benchmark indicators. Such indicators include but are not limited to the following:
    - Medical component of the Consumer Price Index (CPI)
    - Medical care component of the Gross Domestic Product (GDP)
    - Specialized data maintained by research organizations (University of Minnesota, Lewin-ICH)
    - Other national data (HCFA actuary)
    - Data from private actuarial firms
- The projections of the annual growth in health care expenditures will be based on Minnesota health care expenditure database and comparable databases and trend projections.
- The trend projections will recognize both a public and private sector trend estimate in the health care market.

- The projections of trend in health care spending will be analyzed in subsequent time periods and appropriate adjustments will be made between actual and forecasted expenditures. Such adjustments will be based on the following:

    - **Expenditures controlled by Minnesota public policy decisions:** e.g. technology controls, controls on capital expenditures, benefit requirements, standards of care, etc.
    - **Expenditures not within the control of Minnesota policy (or provider) decision makers**: e.g., cost shifts from the federal government or organizations exempt under ERISA from Minnesota regulations, population shifts and aging; extreme economic conditions; epidemics; change in Medicare reimbursement policies, etc.

    - **Multi-state and national projections on health care spending.**

- Efforts to establish and project the trends in health care spending in the State of Minnesota should be coordinated with efforts to document and monitor the savings attributable to the recommended initiatives:

    - ISN specific accountability goals
    - Regulation of the non-ISN service delivery system
    - Population health goals such as improved birth outcomes, reduced traumatic brain injury, reduced tobacco use, etc..

Summary

The data and information required to document and monitor health care spending for the purposes of establishing and enforcing limits are currently unavailable. The work of the Commission in this area has been to determine the level of data that exists, the level of data that is needed, and the feasibility of collecting this data in a timely and useful format, and to develop a strategy to achieve the data objectives in a cost-efficient manner. The data will not be available in the required format for several years. It is the intent of the Commission to continue to refine its data collection plan to be able to establish and enforce limits on the growth in health care spending as set forth by the 1992 HealthRight Act.

NOTES:

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CHAPTER THREE:

Rural Health Care

Rural Health Care

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 database 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.

The rural health issues that are most directly related to the Commission's cost containment plan are discussed in Chapter One in the section entitled "Impact on Rural Areas."

Health services personnel database

During the past year the Office of Rural Health has been reviewing the need for and the sources of health services personnel data. These data are currently needed to aid in the designation and updates of Health Professional Shortage Areas (primary medical care HPSAs and dental HPSAs) and medically underserved areas/populations (MUAs/MUPs). The Primary Care Cooperative Agreement, which is described in detail later in this chapter, also requires these data for a county-based primary care plan. Future plans include using these data within physician recruitment and retention efforts in keeping with the mandate from the 1992 HealthRight Act, Chapter 549, Article 5, section 9(5) that the Office of Rural Health maintain a database on health care personnel. Additionally, other programs within the Minnesota Department of Health and other agencies and associations need data on health services personnel.

Data will be collected on the following health care professions (listed in the order of priority of need for data): physicians (MDs and DOs), dentists, physician assistants, nurse practitioners, nurses, physical and occupational therapists, and laboratory technicians. Forms for collecting data from the physicians, physician assistants, physical therapists, and respiratory care therapists have been designed. The Office of Rural Health began meeting with the respective boards to create the data forms for the other professions early in the first quarter of 1993.

Revised physician license renewal forms were sent out with mailings beginning in April. It will take one full year for the information to be collected from physicians because renewals are based on the physicians' birth dates. The newly revised forms for the other professionals will be sent according to the Board of Medical Practice renewal schedule.

The following have been identified as the minimum required data elements relating to physicians: license number, physician name, birth date, practice address including additional addresses if the physician practices at more than one site, practice status (e.g. number of hours related to seeing patients at each location), primary, secondary and tertiary specialty, professional activity status (e.g., hospital or office-based direct patient care or other, such as teaching or retired), obstetrics and pediatrics practice status, and status as an ambulance service medical director. The State Board of Medical Practice currently collects the first three data items.

The data elements required for the other health care professions, including physicians assistants, physical therapists and respiratory care practitioners have also been identified. These data items are similar to the physician data items, with allowances for profession specific differences.

The Office of Rural Health has researched the various sources of physician data including the Area Resource File (ARF) from the American Medical Association (AMA), member data collected by the Minnesota Medical Association (MMA), data collected by the Department of Human Services (DHS), data currently collected through the licensing process, managed care plan provider lists and data currently collected for the Primary Care Cooperative Agreement.

Licensing board data, Medicaid provider data, and Department of Human Services survey responses, plus the data collected for the Primary Care Cooperative Agreement, will help the Office of Rural Health meet some of its short-term goals. However, these data do not fulfill requirements totally, nor is the method a reliable, predictable ongoing process.

The Office of Rural Health, as directed by the Legislature, will create and maintain health personnel data at the state level. The effort will be ongoing and will not rely on a federal program or other agency. Collecting the data in cooperation with the boards through the licensing/registration process is similar to efforts in other states. The Office will continue the process begun with the Board of Medical Practice to revise renewal forms for dentists, nurses and occupational therapists.

Primary Care Cooperative Agreement

The Primary Care Cooperative Agreement (PCCA) program consists of a joint agreement between the U.S. Department of Health and Human Services, the Minnesota Department of Health, and the Minnesota Primary Care Association (an association of five federally funded community health centers and one migrant health center). The overall purpose of the PCCA is to improve the delivery of comprehensive primary care services in areas that lack adequate numbers of health professionals or have populations lacking access to primary care services because of financial, cultural, language or other barriers.

Requirements for the 1993 Primary Care Plan include collecting county-based data in several areas including perinatal indicators, disease and death rates, population, poverty status and other sociodemographic indicators. These data are being used to identify target populations in each county. These data will also be used to provide technical assistance to underserved areas in applying for federal HPSA and MUA/MUP designations.

Under contract with the Minnesota Department of Health through the PCCA, the Minnesota Primary Care Association is conducting informational workshops regarding the Federally Qualified Health Center Program and Rural Health certification. The workshops will address eligibility requirements and steps necessary to qualify for these programs, which allow primary care providers in underserved areas to obtain cost-based Medicare and Medicaid reimbursement.

In cooperation with Primary Care Association staff, the Office of Rural Health has completed work on the data and narrative requirements of the 1993 PCCA plan and has written the 1994 plan. In February, 1993 the Office of Rural Health filled the vacant staff position to coordinate the PCCA. This will enable Office of Rural Health to become more involved in other activities of the plan and include other programs such as Community Health Services and Maternal and Child Health.

Clearinghouse

The Office of Rural Health has begun planning for the establishment of a clearinghouse for collecting and disseminating information on rural health care issues, research findings relating to rural health care and innovative approaches to the delivery of health care in rural areas. This is one of the activities required by the Federal Office of Rural Health Policy Grant and by the 1992 HealthRight Act. The goal of the Office is to become established as a timely and responsive resource for rural health information.

This will most likely be accomplished by developing a system that balances information stored on-site with information that can be obtained through electronic means from other sources. For example, through the Minnesota Department of Health library, the Office of Rural Health has access to the databases of Dialog, BRS, Medlars, and Data Times. The Office can obtain materials from medical,

university and state agency libraries in Minnesota and neighboring states, and from libraries across the nation through the interlibrary loan program.

The Office can also use as a resource the Rural Information Center Health Service (RICHS) administered by the National Agricultural Library, USDA, Offices of Rural Health in other states, Rural Health Research Centers and other researchers at the University of Minnesota.

The clearinghouse will be available for information inquiries by the end of the first quarter of 1993.

Research projects

The Office of Rural Health has completed two studies for the Legislature, as mandated by the 1992 HealthRight Act: Obstetrical (OB) Care Access Study and Midlevel Practitioner Reimbursement Study. Office of Rural Health contracted with the University of Minnesota, Institute for Health Services Research, to conduct the studies.

Obstetrical (OB) Care Access Study. The purpose of this study was to examine the number of physicians discontinuing OB care in recent years, the effects of high malpractice costs and low government reimbursement and to identify areas of the state where OB access is most affected. The Commissioner is directed to recommend ways to reduce liability costs and encourage physicians to continue to provide OB services. Rural family physicians who are not doing OB are being surveyed to determine the reasons they do not provide OB services. Secondary data sources, such as birth data, hospital data, and physician/population data will be used to identify areas of state where OB access is a problem. The study also reviewed the literature for information on policy options and actions taken by other states to address OB access problems, and develop recommendations regarding the availability of OB services.

Mid-level Practitioner Reimbursement Study. The purpose of this study is to evaluate the impact of current reimbursement provisions for midlevel practitioners (MLPs) on their use in rural practice settings. MLPs include nurse practitioners, certified nurse midwives, physician assistants, and certified registered nurse anesthetists. The study examines reimbursement from state and federal programs, and private sector health plans. As directed under the 1992 HealthRight Act, the Commissioner will report findings and recommendations based on this study to the Legislature. The study (1) reviewed literature to identify reimbursement problems and states' approaches to encourage use of MLPs in rural areas; (2) reviewed Medicare, Minnesota Medicaid, and health insurance plan payment policies; (3) conducted interviews with MLPs, physicians, clinic administrators, and insurers; and (4) developed policy recommendations regarding the reimbursement of MLPs.

Federal Office of Rural Health Policy Grant

In addition to state funding and responsibilities for the Office of Rural Health, and federal cooperative agreement funding and responsibilities, the Office also has a grant through the federal Office of Rural Health Policy. The federal grant is a three year grant program. Minnesota is in the second year of funding, and has requested to carry over funds from the first year, which were not expended because the Office of Rural Health was not yet established.

The purpose of the grant program is to improve health care in rural areas by making grants to states to support the operation of state offices of rural health. To receive the grant, Office of Rural Health agreed to carry out the following three objectives:

(1) **Coordinate rural health activities in the state.** In order to achieve this objective Office of Rural Health is involved in several activities:

- Reviewing and coordinating rural health activities to avoid duplication of activities (this is also required of Office of Rural Health by the 1992 HealthRight Act);
- Developing a public-private partnership with the Center for Rural Health to consolidate recruitment and retention efforts for rural providers;
- Working with primary care specialty groups to promote primary care specialties to residents;
- Attending meetings around the state to discuss Office of Rural Health and rural health activities, or rural health activities; and
- Publishing a quarterly newsletter to disseminate information relating to rural health.

(2) **Establish and maintain a rural health information clearinghouse.** The clearinghouse and the data collected are discussed earlier in this chapter.

(3) **Provide technical assistance on state and federal rural health programs to public and private non-profit entities.** The Office of Rural Health is providing technical assistance on federal programs for designating shortage areas for primary medical care, including the Health Professional Shortage Area (HPSA) and Medically Underserved Area (MUA) programs. The Office is also providing technical assistance on the Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) programs, which are federal programs for providing clinics with cost-based reimbursement for Medicare and Medicaid, and the National Health Services Corps, which provides loan repayment for physicians and other health professionals.

Through the federally funded Primary Care Cooperative Agreement, the Office of Rural Health is assisting potential applicants for federal Community Health Center funding, and is contracting with the Minnesota Primary Care Association to conduct workshops on RHC and FQHC qualification and reimbursement. The Office of Rural Health plans to expand its capability to provide technical assistance when vacant staff positions are filled.

The Office of Rural Health has also applied for a grant from the Robert Wood Johnson Foundation. If granted, the funds will be used to expand and accelerate the combined efforts of Office of Rural Health and the Center for Rural Health to recruit and retain health care providers in medically underserved areas of Minnesota.

Rural Community Health Centers

The 1992 HealthRight Act requires the Office of Rural Health to create a program for state Community Health Centers. The program will provide rural communities and community organizations with technical assistance, capital grants for start-up costs, and short-term assistance with operating costs. The technical assistance component must provide assistance in:

- review of practice management
- market analysis
- practice feasibility analysis
- medical records analysis
- scheduling and patient flow analysis

The program must: include a local match requirement for state dollars received; require local communities to operate and own their community's health care program (through nonprofit boards comprised of local residents); encourage the use of mid-level practitioners; and incorporate a quality assurance strategy that provides regular evaluation of clinical performance and peer review comparison for rural practices. An advisory panel will be established.

Medical Education

The Commission recognizes the important role medical education plays in the health care system and the significant potential the medical education system possesses for contributing to cost containment efforts. In particular, medical education programs must undergo changes in order to produce more primary care graduates and graduates who will practice in rural areas. Significant initiatives in this area were enacted in the 1992 HealthRight Act. The Commission supports these initiatives and will continue to monitor their implementation.

Dollars have been appropriated to the University of Minnesota in the 1992 HealthRight Act for primary care physician education. The medical school must increase the number of graduates of residency programs of the medical school who practice primary care by 20 percent over an eight-year period.

The medical school is requested to develop several programs which would directly impact the availability of primary care physicians in rural areas. Those programs include: clinical experience, including rural clinics, for students in internal medicine and pediatrics; increased opportunities for rotations in rural clinics for general medicine, pediatrics, and family practice residents; a rural residency training program in family practice; and community-based continuing medical education programs for primary care physicians.

Loan forgiveness programs

The 1992 HealthRight Act also provides for loan forgiveness programs for health care students who agree to practice in rural areas. The physician loan forgiveness program will repay one year of medical school tuition, up to $10,000, for each year of practice in a rural area after graduation. The physician can qualify for no more than four years of loan repayment. Medical students can also earn loan repayment money by replacing a rural physician for up to four weeks during any year. This will allow rural physicians time away from their practice for vacation or continuing education.

The mid-level practitioner loan forgiveness program will permit nurse practitioners, nurse-midwives, nurse anesthetists, advanced clinical nurse specialists, or physician assistants to qualify for school loan repayment in exchange for an agreement to practice at least two of their first four years of practice in a rural setting.

CHAPTER FOUR:

Access

Access

Introduction

The three broad areas the Minnesota Health Care Commission is charged to address are affordability, quality and access. The first area, **affordability**, is addressed specifically in the Commission's cost containment plan and other sections of this report. The issue of **quality** is discussed at length in Chapter Five. This chapter is devoted to the third subject area, accessibility or **access**. Of course, it is difficult to cleanly separate these three areas. Making health care more affordable will clearly improve access. However, financial access does not assure that all Minnesotans can or will utilize appropriate health care services.

Defining access

Access in the most general sense is the ability to obtain needed health care services. There are three major barriers affecting access that will be discussed in this chapter. The barriers include:

(1) Financial barriers
(2) Access to providers
(3) Ethnic and cultural barriers

FINANCIAL BARRIERS

The increasing number of persons who cannot afford health coverage is directly related to escalating health care costs. Successful cost containment will place health coverage within the reach of more Minnesotans and prevent further increases in the number of uninsured persons and families. Not only will cost containment make health care more affordable generally, it will also enable the state to continue to provide and expand health care programs for low-income and uninsured persons.

The cost of health care coverage is one of the most prominent reasons for being uninsured or underinsured, yet Minnesota has one of the lowest rates of uninsured persons in the nation. A report to the Health Care Access Commission in October of 1990, identified that at any given time, 6.5 percent of all Minnesota residents are uninsured (279,925 persons). Also, 8.6 percent of the population was uninsured at least one month out of the last year (370,363). These findings were the result of a telephone survey consisting of randomly selected individuals residing in randomly selected households. A total of 10,310 interviews were completed.

The 1991 Behavioral Risk Survey conducted by the Minnesota Department of Health finds that 9.3 percent of all adults surveyed did not have a health care plan. (Persons under age 18 were not asked to respond to the survey.) This is the finding of an annual telephone survey consisting of interviews with

3,500 individuals. (While the survey focuses on self-reported health status information, the survey does ask numerous questions on access to health care coverage.)

Minnesota's low rate of uninsured persons is due in part to some of the existing state health care programs. These include such programs as Medical Assistance and General Assistance Medical Care which are designed for low-income persons, and the Minnesota Comprehensive Health Association for persons denied health coverage because of their health condition or history.

Existing state programs

Medical Assistance (MA) is Minnesota's name for the federal medical program authorized under Title XIX of the Social Security Act. It is a health care coverage program for pregnant women, families with children, aged, blind, and disabled persons whose financial situation is such that the families are not able to pay for necessary health care. County human services agencies determine eligibility for MA based on varying income and asset limitations set by the Legislature.

The program is optional for states, with the fiscal responsibility shared between the federal and state governments. Minnesota receives approximately 54 cents from the federal government for every dollar spent on MA. Under current eligibility rules for MA and for MinnesotaCare, families often have members enrolled in both programs.

The average number of persons served by the Medical Assistance program each month has grown from 278,261 in state fiscal year 1988 to the 402,623 projected for state fiscal year 1993. The greatest rate of growth in the number of persons served has been in the coverage of families and children who do not receive any public assistance grants. This group has more than doubled since 1988 when 30,277 children and their families were served to 85,828 in fiscal year 1993. The number expected to be served in fiscal year 1995 rises to 104,080. The increase in medical coverage for this group of families is attributed to a series of eligibility changes designed to be more inclusive of low-income families and children by expanding the income standards and eliminating the asset tests for families not receiving cash assistance. These changes were part of a deliberate effort at the state and local level to break the tie between access to medical programs and the traditional welfare grant system.

General Assistance Medical Care (GAMC) is a program similar to MA; GAMC, however, is funded solely by the state. Recipients of GAMC are typically either General Assistance recipients or low-income individuals who do not meet the categorical requirements of MA. These are adults from ages 21 to 65 who are not disabled and are not caring for children in a family where one parent is absent, incapacitated or unemployed. County human service agencies determine GAMC eligibility based on income and asset limitations set by the Legislature. In addition, the Legislature determines the scope of covered GAMC services and the reimbursement rates for those services. A plan which discusses issues regarding this state program for adults and MinnesotaCare is due in January 1994.

The Minnesota Comprehensive Health Association (MCHA) is the country's oldest and largest high risk insurance pool. It is funded through a combination of premiums paid by enrollees and assessments paid by insurance companies and HMOs. Enrollment into MCHA is rather liberal in that any person who has been denied coverage or whose coverage becomes financially prohibitive due to a prior medical condition or whose group plan has been terminated for such reasons as bankruptcy are eligible to enroll. All enrollees are responsible for paying their own premium.

Children's Health Plan

Uninsured children of low-income families have been targeted for inclusion in a state financed program, the Children's Health Plan (CHP). CHP was established by the Legislature in 1987 and implemented in July 1988. It represents the earliest state plan of its kind to ensure broad availability of preventive and primary care services to children. The CHP provides coverage for over 28,000 uninsured children who are not otherwise eligible for Medicaid.

There are two key eligibility criteria -- age and income. Eligibility was initially limited to children up to age eight but was then expanded to children up to age 18. Eligibility is also limited to those children in families with incomes at 185 percent or less of federal poverty guidelines. Services covered include outpatient physician services, dental care, vision care, eyeglasses, emergency room care, outpatient surgery, laboratory and x-ray services, immunizations, home care services and prescription drugs. The plan does not cover inpatient hospital care.

Families are required to pay $25 per child per year, up to a maximum of $125 per family. There are no copayments or deductibles for services provided.

MinnesotaCare Program

Increasing access to the uninsured was a fundamental goal of the 1992 HealthRight Act. The MinnesotaCare Program, (an expansion of CHP) targets low-income working Minnesotans who find the cost of health care coverage prohibitive or whose employer does not provide health care coverage. The MinnesotaCare program provides coverage for primary and preventive services, and beginning in July, 1993, it will cover inpatient services up to $10,000 for those not spending down to medical assistance.

Initially, the ineligible siblings and parents of children enrolled in the CHP with incomes up to 185 percent of the federal poverty guidelines were eligible to enroll in the MinnesotaCare Program. In January 1993 children and their parents whose family income is not more than 275 percent of federal poverty guidelines started to enroll. Finally, in July 1994, families without dependent children and individuals whose income does not exceed 275 percent of federal poverty guidelines will be eligible to enroll.

The premium for this program is split between the state and the enrollees based on an income-based sliding scale. As an enrollee's income increases, their contribution to the cost of coverage increases. There was considerable discussion during the legislative session about the cost of the coverage to the enrollees and the fact that the premium contributions may be cost prohibitive. Through a grant from the Robert Wood Johnson Foundation to the Minnesota Department of Health, an evaluation of the effectiveness of the MinnesotaCare Program will be conducted. Specifically, the evaluation will identify who is enrolling into the program and who is not and why. It will also try to identify the correlation between the MinnesotaCare program and the insurance reforms and how those reforms affect the targeted population for the program.

Projected enrollment into the MinnesotaCare program is estimated at 170,000 by 1997. To date nearly 36,000 individuals are covered. The Commissioner of the Department of Human Services is authorized to evaluate the enrollment process and the benefit package to ensure that the cost of the program for both the families enrolling and the state remains within the projected estimates.

Publicity regarding the Children's Health Plan and subsequently, the MinnesotaCare program, has found uninsured or underinsured people who were eligible for federal funding of their health care through the Medical Assistance program. The Department of Human Services estimates that 3,000 of the families and children in fiscal year 1993 and approximately 10,000 of the total eligible in fiscal year 1995 will be eligible for Medical Assistance simply because of the effect of MinnesotaCare outreach.

Insurance reform

There were numerous insurance reform provisions enacted in the 1992 HealthRight Act that were designed to increase access to health care coverage. Those reforms focused on the small group and individual insurance markets.

Small Group Reform

The small group reforms are intended to increase the number of employers with 2-29 employees who offer health care coverage to their employees. An employer survey conducted for the Minnesota Health Care Access Commission found that most Minnesota employers who have 5 or more employees offer health insurance. Ninety percent of the employers with 30 - 49 employees offer coverage, while only 33 percent of the employers with 1 - 4 full-time employees offer health insurance. These results were based on a survey of 1,125 employers in Minnesota.

The same survey found that the high cost of health insurance is the primary reason why employers do not offer health care benefits. There is a direct relationship between mandated benefits and the cost of coverage. Minnesota statutes contain more than 30 mandates for coverage of certain treatments and providers.

In an effort to address the cost of coverage, two benefit packages were designed that do not include all of Minnesota's mandated benefits, but still emphasize primary and preventive care. Hopefully, these minimum benefits packages will cost less than coverage currently available, making coverage more accessible to the small employer.

A number of other provisions will have an impact on the small employer market. The guaranteed issuance provision will allow employers who have had difficulty in obtaining health care coverage greater access with less restrictive coverage. The guaranteed renewability provision will ensure that those employers who do purchase health care coverage will be able to maintain that coverage without fear of termination.

Current underwriting restrictions used by health care plans will be revised so that men and women are underwritten similarly and that plans underwrite on a person's health care status and not on family medical history.

Rate bands will be imposed on both the small group market and the individual market. This will help to stabilize premiums and provide for less discrepancy between similarly comprised and covered groups and individuals. This should have a positive impact on affordability of health care coverage for employers and individuals.

Individual Market Reform

The individual market reforms will increase the number of individuals who have continued access to health care coverage. Specifically, the portability of coverage provision requires that health plans offer individual coverage without underwriting to a person previously covered under a group plan who has not had a lapse in coverage for more than 30 days. This will result in fewer restrictions of coverage placed on individuals who, for example, decide to seek different employment or make other life decisions. Pre-existing conditions limitations and exclusions will be limited and underwriting restrictions will be prohibited so long as coverage is continuous.

Rate bands similar to those in the small employer market will be imposed on the individual market. In addition, a loss ratio of 65 percent will be required so as to direct more of the premium dollar toward health care services rather than administrative services.

Purchasing Pools

The availability of purchasing pools will also impact the number of employers who offer health care coverage for their employees. Currently, the Department of Employee Relations administers the Public Employees Insurance Plan (PEIP). To date, PEIP has more than 5,000 individuals covered. Leveraging

greater purchasing power through purchasing pools is only one advantage. Decreasing administrative costs is also accomplished through purchasing pools. The creation of the Private Employers Insurance Program is one option available to private sector employers who want to take advantage of purchasing pools. This program will be available to private employers beginning in July 1993.

Tax deductions

Many Minnesotans currently purchase their own health care coverage. For example, in an analysis conducted by John E. Kralewski, PhD, et al (*A Descriptive Analysis of Health Insurance Coverage Among Farm Families in Minnesota)*, "Almost seven percent (6.6 percent) of the farm families included in our study had no health insurance." Further, "A high proportion (69.5 percent) of the families that lacked insurance noted costs as the major factor influencing their decision."

In an effort to encourage those families and similarly situated self-employed individuals and families to continue to purchase health care coverage, the state tax laws were amended, beginning in tax year 1994, to allow a 100 percent deduction for the cost of health care coverage. This new tax law will not only affect the farming community, but it will also have a positive impact on the remaining self-employed population.

PROVIDER AVAILABILITY

Supply of providers

Another variable affecting access is the availability of providers. Over the last two decades, physician supply relative to the U.S. population has greatly increased. From 1963-1988 the physician supply more than doubled while U.S. population increased by only 31 percent. Despite the overall increase, however, rural areas have fewer than one-half as many physicians providing patient care as urban areas. In the least populated counties (those with fewer than 10,000 residents) there are only 48 physicians for 100,000 people -- about one physician for every 2,000 residents. An inadequate supply of primary care physicians and midlevel practitioners is a barrier to the availability of health care services in rural areas and certain urban areas, and medical costs may be increased because of this in the following ways:

More costly emergency room visits. Without a nearby primary care physician, Minnesotans are more likely to visit emergency rooms when they have a medical problem. Previous research has demonstrated that people without a regular source of medical care are more likely to use emergency rooms. Emergency rooms are a vastly more expensive location of care than physicians' offices.

More costly delays in receiving needed care. When health care is not accessible, more Minnesotans

delay seeking needed health care. The conditions which are not diagnosed or treated at an early stage become complicated and expensive to treat. Where primary care physicians are not available to provide preventive care, people may not see a physician until they develop conditions which could have been prevented. This can contribute to both an increase in the overall cost of health care and a decrease in the quality of the patient's health.

More costly health care. Primary care providers provide the most cost effective treatment of primary health care problems. If primary care providers are not available to coordinate patient care, rural Minnesotans with insurance will seek more expensive care from non-primary care specialists. When appropriate, care is essential and cost effective from specialists other than primary care. If such specialists are used to provide routine primary care, however, treatment costs are significantly higher.

Provider willingness to serve patients: reimbursement

Another financial barrier is the limitation or exclusion of any appropriate health service because of reimbursement issues. There are basically two types of financial barriers:

1) Provider refusals to accept patients because they are uninsured or their coverage is through a government program such as Medicare or Medical Assistance; and
2) Financial barriers that happen when revenues do not cover costs or generate a reasonable income to allow the retention and/or recruitment of health care providers to a problem area. This may result in a reduction or elimination of the services of that provider.

Factors which may contribute to provider financial barriers include high percentages of Medicaid and Medicare reimbursed patients (reimbursement rates are historically low), high percentages of charity care, expensive technology, low utilization, competition for similar services in low population service areas, and high personnel and administrative costs. In areas where there is a rapidly rising percentage of Medicare, Medicaid and MinnesotaCare eligibles, providers may not have enough patients compensated at market rates to recover the losses suffered by seeing Medicare, Medicaid and MinnesotaCare enrollees. Some providers refuse to take any more patients who are Medicare, MinnesotaCare or Medicaid eligible because their practices need the reimbursement from private payers to remain viable.

The 1992 HealthRight Act recognized the broad effects of this type of cost shifting from the public to the private sector and provided for increased reimbursement for physicians and other primary care providers in the Medical Assistance program. At the national level the Medicare program is readjusting fees to enhance reimbursement for office visits and decreasing the fees for procedural type care such as surgery. In combination with the new statewide payment structure under Medicare, the reimbursement system under these public programs is fairer than it was before Minnesota's initiative in health reform.

Chapter Four: Access

GEOGRAPHIC ACCESS

Geographic access may be defined as an absence of the appropriate health care services within a reasonable travel distance. The services may include facilities, medical personnel or technology. Different types of health care services have different standards for geographic availability. A widely used standard for the travel time is 30 minutes to "primary care services". Another commonly used standard for geographic access is not more than 60 minutes to most "specialty care."

Primary care needs

There are at least five different guidelines as to how many primary care providers are needed to take care of 100,000 population and they range from 28.6 for the Health Professional Shortage areas to 74.5 for the Graduate Medical Education National Advisory Committee to 91.9 for the Bureau of Health Professions to 44.5 and 59.6 for HMOs. The National Health Service Corps uses a population to physician ratio of 3,500:1 for its designation as a Health Professional Shortage Area. Designation as a Medically Underserved Area is determined according to federal criteria by some consideration of the infant mortality rate, the population poverty level and the size of the elderly population. From the state perspective, federal criteria often seem inflexible and not adaptable to relevant local conditions.

The U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions defines primary care services as first contact care for persons with any undiagnosed sign, symptom, or health concern. Other definitions may include: comprehensive care for the person which is not organ or problem specific; longitudinal or continuous care for the patient; and responsibility for coordinating other health services as they relate to the patient's care.

Transportation needs

Eighty-seven percent of Minnesota medical physicians practice in urban areas which encompass less than 20 percent of the state's land area and approximately 2/3 of the state's population. Additionally, over 70 percent of Minnesota's licensed hospital beds are in the urban areas. Yet, transportation problems may result in significant travel time in both urban and rural areas for certain pulations. While there is no urban area that is greater than 30 minutes from primary care services or greater than 60 minutes from most specialty care, many lack the means of transportation needed to use these services.

Transportation problems may be the result of financial constraints or special needs that people have, for example loss of sight, or another health condition which prevents their driving. Transportation as a barrier to health care in the rural areas is much more pronounced because of the increased distances and the fact that public transportation systems are almost non-existent.

Thirteen percent of Minnesota medical physicians practice in rural areas which enco: pass more than

80 percent of the state's land area and approximately 1/3 of the state's population. According to the American Medical Association, in 1989 there were 1,235 physicians practicing in rural Minnesota. Approximately 65 percent (or 834) are considered primary care medical physicians. This means that outside the metropolitan areas, there is approximately one primary care medical physician for every 78 square miles.

Rural residents are characterized by relatively low mortality but relatively high rates of chronic disease. Two notable exceptions to the mortality rates exist: infant mortality and injury related mortality. The infant mortality rate in Minnesota is 8.0 deaths among persons younger than one year per 1,000 live births. The range, by county, is from 0 in Rock and Wilkin Counties to 18.5 in Clearwater County. All counties with infant mortality rates higher than 10.5 from 1986-1990 were rural counties. Two potential contributors to the relatively poorer health of rural mothers and infants are the limited availability of obstetric providers and access to specialized care for women with difficult pregnancies and deliveries.

The fourth leading cause of death in Minnesota is unintentional injury with an overall five year rate of 34.5 per 100,000 population for 1986-1990. Rates range from a low of 16.5 in Stevens County to a high of 92.1 in Cook County. All counties with rates higher than 46 were rural counties.

OTHER BARRIERS

Even if all financial and provider supply issues were resolved, some people would still not have full access to appropriate health services. Minnesota's health care system will have to reflect the increasing diversity of our population by tailoring services, health education and delivery systems to meet the needs of various population groups. Access needs in this sense may require solutions as different as having longer clinic hours for working families who cannot take time off work for well child visits, walk-in clinics for urgent care needs, transportation and child care assistance for low-income persons so that appointments are kept, foreign language interpreters, physically accessible buildings and providers who are knowledgeable and sensitive to cultural preferences and alternative practice styles.

Minnesota changed ethnically from 1980 -1990 in the following ways:

- the White population increased by 4.9%
- the Black population increased 78%
- the Native American population increased 42.5%
- the Asian population increased 193.5% and
- persons of any race who are of Hispanic origin increased by 67.7%.

Because the entire non-white population in Minnesota in 1980 was only 3.4 percent, this dramatic rate of increase among ethnic minorities results in a 1990 total of a 5.6 percent minority population. In some communities, however, such as Willmar, Worthington, and Moorhead, the population changes

have been more intense necessitating adaptation among all institutions in the community including the health care system.

In their recent survey of approximately 2000 Medicaid recipients, the MEDICA foundation discovered that "this population is composed of multiple subgroups and diverse cultures, each with unique needs and challenges which cannot be met with a blanket approach". The MEDICA foundation survey also supports one of the conclusions of the Pepper Commission regarding the integration of some traditional social services with a health delivery system to assure access. In their the final report from September, 1990, the Pepper Commission stated, "The logistics of seeking health care can be particularly difficult for some groups.... Mentally ill or retarded individuals may not have the skills necessary to negotiate the health system--such as making an appointment.... Some may not recognize their need for treatment.... Other populations, and often their families, have special needs requiring multidisciplinary health care or social services to complement or augment their health care. Experience shows that medical care cannot be fully accessible and effective for such segments of the population unless it is accompanied by education and outreach and by systems to coordinate a broad range of services."

Conclusion

The outstanding issues relating to access are varied. The Commission will be addressing these issues and others related to access in much greater detail in the upcoming months.

CHAPTER FIVE:

Quality

Quality

Introduction

Minnesota's health care system is one of the best in the world, for those who have access to care. The Commission's goal is to control costs and improve access while maintaining or improving health care quality. The Commission believes that many of the components of the cost containment plan not only control costs, but also improve quality. Examples include practice parameters, technology evaluation, and outcomes research, to name a few.

The cost containment plan includes numerous discussions of quality. The plan presumes that Minnesota will make significant progress toward defining and measuring the quality of health care services. Information on quality is necessary to facilitate competition, to develop and evaluate practice parameters, to evaluate technology, and to evaluate the success of cost containment strategies. Monitoring and evaluating the performance of the various components of the health care system in Minnesota is fundamental to the successful implementation of the cost containment program. While one critical component of that performance is the cost of care, it is essential to promote cost containment strategies that encourage the use of those services that provide maximum benefit to patients, and discourage those that do not, while minimizing the cost of services.

Objectives

The purpose of this chapter is to identify the methods by which health care quality will be monitored, maintained and enhanced under the cost containment program, and to identify the methods through which the use of quality data in the health care marketplace will actively contribute to the goals of the cost containment program.

The key objective with respect to quality in the cost containment program is to promote the ongoing improvement of the quality of health care provided in Minnesota. This will be accomplished through the use of standard measures of health care quality in both the development and refinement of health services by health plans and providers, and in the evaluation and purchasing of health services by health plans, group purchasers and consumers. In addition, it is important to emphasize that the systematic use of standardized health care quality data by health care providers and Integrated Service Networks (ISNs), and by health plans, group purchasers and consumers, will contribute significantly to making the delivery of services more cost effective and efficient and to making health care purchasing decisions more informed with respect to quality and cost.

Assumptions and observations about quality

Two major assumptions are reflected in the discussion of quality in this chapter. First, the Commission believes that health care cost containment can be accomplished without compromising

health care quality, and can in fact even improve the quality of care provided to Minnesotans.

There is growing evidence of substantial variation in the patterns and outcomes of care which cannot be explained by differences in patient sickness, both nationally[1] and in Minnesota[2]. These observations suggest that some treatment patterns may be less effective, and that patient outcomes are being affected in unknown ways. Efforts to reduce health care costs must focus on reducing the use of those components of the health care system that are not cost effective. The development of a system which allows for objective, standardized quality comparisons across provider groups and health plans requires a statewide effort to define the methods of measuring, analyzing, and comparing health care quality in a uniform, unbiased way.

Second, the Commission assumes that the dimensions of health care quality can be defined and measured in a useful and equitable way. The quality measurement methods used will incorporate a conceptual framework which focuses on the entire episode of care, measuring the outcomes of care in relation to the "structural" features of care (i.e., system, provider, and patient characteristics such as case-mix, severity and/or complexity) and "processes" of care (e.g., treatment patterns, resource use).

Defining Quality

Before widespread development and use of uniform quality data can be realized, a consensus must be reached among health care providers, health plans, group purchasers, and consumers on the concepts or dimensions comprising the quality of health care in general, and for specific conditions; and the general and disease specific health care quality indicators and measures to be collected and used.

The framework for the assessment and improvement of health care quality will reflect and incorporate the elements of the continuous quality improvement (CQI) initiatives in health care.[3] The goals of medical outcomes studies are to systematically study the relationships between health and its outcomes for the purpose of improving the quality and effectiveness of health care. The CQI model focuses on improving the processes of producing care rather than on identifying individual or unusual patterns. The CQI model is based on the assumption that substandard care is generally caused by poor process design, inadequate information, and inadequate use of information. Implicit in this approach is an emphasis on the collection and feedback of data that reflects the entire scope of the health care process from the inputs or structural characteristics of health care to the processes and outcomes of care.

Characteristics of health care. The collection of quality data will focus on the entire range of the health care process. Assessing the inputs or structural characteristics of health care makes it possible to adjust for and estimate the influence of system, provider, and patient characteristics on the health care process and outcomes, which will permit the identification of typical as well as unusual patterns of care. These structural characteristics may include:

1. **System characteristics:** practice characteristics (fee-for-service vs. prepaid, solo vs. group practices, ISN vs. non-ISN), provider/specialty mix, financial incentives (organizational level), work load, access/convenience of services;

2. **Provider characteristics:** age, gender, specialty training, year of professional school graduation, financial incentives (provider level), beliefs/attitudes, preferences;

3. **Patient characteristics:** age, gender, diagnosis/condition, severity, complexity, comorbid conditions, race/ethnicity, health habits/risk factors, functional status, health status, quality of life, preferences.

Components of process. The process of care would include parameters reflecting characteristics of the health services supplied, resources expended, and subjective evaluations of the application of health services. Process measures include a descriptive component and an evaluative component.

1. **Descriptive:** visit rates, medications prescribed, referrals made, tests ordered, hospitalization rates, expenditures (aggregations of above), continuity and coordination of care, respect, courtesy, sensitivity, patient participation in treatment decisions, counseling regarding lifestyle, personal and emotional problems, compliance with treatment recommendations; the overall degree of communication;

2. **Evaluative:** appropriateness: expert judgements of "doing what works"; technical competence: "doing well what works."

Outcome measures. Finally, the results or outcomes of care focus on what happens to the patient after care. Although there may be considerable scientific knowledge available from carefully controlled clinical trials about the efficacy of clinical diagnostic and treatment interventions under ideal, controlled conditions, knowledge of the effectiveness of treatment interventions under average or typical circumstances is notably unavailable.

Therefore, data on the outcomes of care should include:

1. **Clinical efficacy data:** symptoms, laboratory values, mortality, morbidity, complications, readmissions;

2. **Patient-centered data:** general and disease specific functional status (i.e, as measured by the Interstudy's SF-36 and TyPEs[4]), general well being, quality of life, satisfaction with care.

Standardized research methodology and practice parameter development processes

Once agreement on the framework and quality dimensions that are to be measured is achieved, a standardized research methodology and practice parameter development process will be established statewide. There are a variety of public and private outcomes research and practice parameter/clinical guideline development efforts taking place both nationally and within Minnesota. Efforts by a variety of public and private organizations are at various stages of development. For example, federal agencies such as the Agency for Health Care Policy and Research (AHCPR) and the National Institutes of Health, academic centers such as the Institute of Medicine and RAND, the National Academy of Sciences, and local efforts such as the Minnesota Clinical Comparison Project of the Health Education and Research Foundation, Health Risk Management, Inc., Blue Cross Blue Shield/Value Health Sciences, Inc., and an array of physician professional and specialty organizations are involved in projects relating to practice parameters or outcomes research. The uncoordinated proliferation of these efforts has resulted in non-standard methods, which produce non-comparable data. In addition, a fragmented approach to outcomes research and practice guideline development creates additional administrative complexity in terms of both data collection and use of the guidelines for practitioners.

Through the Data Collection Advisory Committee and Practice Parameters Advisory Committee, the state will develop standardized health care quality measurement and data collection methodologies for conducting the large-scale condition-specific outcomes research required by the 1992 HealthRight Act. The state will ensure that data systems developed will have the following characteristics:

1. Outcomes will be measured over time and across health care settings, provider and service mixes, and health plans for the population of all patients (i.e., with a specific condition) in Minnesota.

2. Data will be collected in a common format using standards defined and approved by the Data Collection Advisory Committee and the Commissioner of Health.

3. Raw (unaltered, unaggregated) data will be submitted to the Department of Health for non-biased, objective analysis.

4. Standardized and valid methods of assessing the effects of alternative medical strategies on the outcomes measures will be used.

With respect to clinical practice parameters, a development and dissemination strategy that is coordinated and standardized statewide will also serve to ensure both that the products are comparable and that the development reflects a balance of professional judgement. Unless the guideline development process is truly multi-disciplinary, the nature and character of the guidelines can be subject to dominance by particular perspectives.

Facilitating quality-based comparison and competition in the health care system

Ensuring access to and utilization of the quality data will promote an effective quality-based health care marketplace and will serve to improve health care quality. Although many plans and providers have collected information on the quality of care within their system, little information has been available for meaningful comparisons of the quality of care delivered across providers, groups of providers or plans. Public access to quality information will help to monitor the quality of our health care system, detect when quality is enhanced, and provide the information necessary to refine the health care system on an ongoing basis. In addition, there is growing evidence that health providers will alter their practice patterns when given feedback of how they deviate from local or national norms[5].

Dissemination. The development, implementation, and ongoing evaluation of an information dissemination system for use by providers, purchasers and consumers will be established that will systematically improve the quality of health care provider decision-making and facilitate ongoing quality assurance and continuous quality improvement activities. Through the development of a resource center, (See Chapter One: Information and Technical Assistance) providers, purchasers and consumers will have access to a wide array of information on the cost and quality of services, on practice parameters, wellness programs and other health care quality issues. The resource center may utilize an electronic network providing health care providers and Integrated Service Networks (ISNs) with immediate access to condition specific outcomes-based research, clinical practice parameters, evaluations of new technologies, and efficient data collection and analysis tools for use in ongoing outcomes management and methods of improving quality.

The centralized resource center will make outcomes data and practice parameters more accessible to rural purchasers. Traditionally, there have been substantial geographical differences in access to and utilization of health care quality data such as outcomes research and clinical practice parameters. The Commission recognizes that rural purchasers and consumers may not have the health care choices available to urban consumers. However, by making quality data accessible statewide differences in access to this information will be reduced, and rural purchasers will be able to make regional comparisons of costs and quality for use in negotiations with local health plans and provider groups.

In addition, AHCPR sponsored research and demonstrations have focused on effective dissemination, based on the growing recognition that distribution of information does not guarantee adoption or use. The definition of effective dissemination goes beyond the traditional concepts of diffusion and distribution of information and encompasses the process through which target groups become aware of, receive, accept, and utilize disseminated information[6]. Within Minnesota, dissemination efforts will include evaluation of various methods of disseminating health care quality data to health care providers, health plans, group purchasers and health care consumers. It will also include an evaluation of the effectiveness and cost effectiveness of the dissemination methods.

Chapter Five: Quality

The overall objective is to facilitate the use of health care quality data both in the outcomes management and continuous quality improvement activities of providers and ISNs, and in the evaluation and purchasing of health services by health plans, group purchasers and health care consumers.

Technical Assistance. A final component of the strategy of ensuring effective quality-based competition in the health care marketplace is to facilitate the utilization of health care quality data by providers, health plans, group purchasers and health care consumers. The Minnesota Department of Health has been specifically directed to develop mechanisms to provide technical assistance to health plans and purchasers through the collection of data on premiums, benefits levels, managed care procedures, and outcomes. Various potential users of comparative health care quality data are likely to need technical assistance to use the data effectively in making purchasing decisions. While many health plans and large group purchasers are likely to have the skills necessary to use outcomes data and practice parameters, consumers and smaller employer groups may be less capable. To maximize the use of outcomes research and practice parameters in the purchasing and health care decisions of health plans, health care purchasers, and consumers, technical/expert assistance resources will be supported.

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CONCLUSION

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 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.

Appendix A:

Summary of 1992 HealthRight Act

1. Cost Containment

Establishes the 25-member Minnesota Health Care Commission, comprised of consumers and providers, employers, unions, state agencies, and health plans to:

- develope a plan for reducing growth rate of health care costs by 10 percent per year adjusted for population growth for 5 years beginning in 1993;
- help improve the affordability, quality and accessibility of health care;
- monitor new technology and procedures and take into consideration clinical effectiveness, cost effectiveness, and health outcomes;
- establish locally controlled regional coordinating boards to make recommendations on ways to improve affordability, accessibility, and quality of health care in each region.

Institutes uniform claim and billing forms to streamline administrative efficiency and reduce costs.

Requires providers to participate in Medicaid, General Assistance Medical Care and MinnesotaCare as a condition for participating in any state program. This will decrease the need for patients to seek more costly emergency room care because of lack of access to primary health care providers. To increase participation, provider reimbursement rates under most programs have been increased by 25%.

Phases out Medicare balance billing, to prevent providers from billing seniors more than the amount reimbursed (including co-pays) under the federal Medicare program.

Develops and implements practice parameters to avoid unnecessary and ineffective treatment and services. Compliance with these practice parameters will be considered an absolute defense as to the standard of care in malpractice cases.

Requires the collection of data on health care spending from providers and group purchasers.

Requires the collection of data on health care outcomes from providers to support development of practice parameters.

Requires the Commissioner of Health to conduct consumer education and wellness programs resulting in better informed consumers and more informed health care decisions.

Requires all providers to comply with Medicare antikickback provisions that prohibit financial gain from referrals or recommendations of particular procedures; grants authority to the Commissioner to promulgate more restrictive rules.

Improves efficiency and coordination of state health programs. The new program for the uninsured will be coordinated with the Medical Assistance program to make sure that persons who become eligible for Medical Assistance are transferred smoothly to that program. The Department of Health is studying methods of coordinating all state health programs to improve efficiency and increase the state's bargaining power.

Requires that health care providers report the establishment of new services and expenditures of over $500,000 on equipment or capital improvements. Providers who fail to cooperate with cost containment strategies or who use procedures or technologies that are not clinically effective or cost effective may be required to submit plans for future major expenditures for prior approval.

Establishes a process to allow the state to sanction agreements between providers or purchasers that might otherwise be construed to be violations of state or federal antitrust laws, but which will reduce health care costs or improve access to or quality of services.

Recommends moving the state toward system of managed care.

Requires the Minnesota Health Care Commission to seek full participation of federal health care programs in the state's cost containment system.

2. Insurance Reform

SMALL EMPLOYER INSURANCE REFORM

General Small Employer Market Reform:

Requires carriers to guarantee issuance and renewability of any products offered to small employers.

Eliminates gender and family medical history as underwriting criteria.

Increases the limiting age of dependents to 25 for full-time students.

Imposes the following premium restrictions:

- variations of no more than ± 25 percent from the index rate for health status, claims experience, industry and duration of coverage;
- variations of no more than ± 50 percent for ages of eligible employees and dependents;
- carriers may establish three geographic regions and separate index rates for each, not varying by more than 20 percent between any two regions;
- premiums may vary based on actuarially valid differences in benefit designs.
- prohibits employer from carving out high-risk employees.

Small Employer Plans:

Requires health carriers to offer two "small employer plans" (exempt from some mandated benefits, and therefore less expensive).

- **Employer Eligibility for small employer plans:**
- employers with 2 - 29 employees;
- 75 percent of eligible employees must participate in the plan;

- **Requirements of health carriers regarding small employer plans:**
- must offer the two small employer plans as a condition of doing business in the small employer market;
- must guarantee issuance and renewability of any products offered to small employers;
- must require employer contribution of at least 50% of the premium for small employer plans;
- permits a 12 month pre-existing condition limitation, but requires credit for time covered under prior coverage (18 month limitation for late entrants);

- **Required benefits for the small employers plans are:**
- one plan must pay 80 percent of charges, with a deductible of $500 per person and $1,000 per family per year;
- one plan must pay 80 percent of covered charges, with certain copayments: child health supervision services and prenatal care are not subject to co-insurance and deductibles. Maximum out-of-pocket costs are set at $3,000 per individual and $6,000 per family per year, and maximum lifetime benefits at $500,000.

- **Minimum benefits under both small employer plans are:**
- inpatient and outpatient hospital services, excluding chemical dependency and mental illness;
- physician and nurse practitioner services;
- diagnostic x-rays and lab tests;
- ambulance services;
- home health care if services are payable under Medicare or are reimbursable under carrier's most commonly sold plan;
- private duty nursing;
- durable medical equipment other than eyeglasses or hearing aids;
- child health supervision services;
- maternity and prenatal care services;
- inpatient and outpatient services for diagnosis and treatment of certain mental illnesses;
- 10 hours of outpatient mental health services;
- 60 hours chemical dependency outpatient treatment;
- 50% of eligible charges for prescription drugs, up to a separate maximum out-of-pocket expense of $1,000/individual, and 100% of costs above $1,000.

Appendix A

Reinsurance:

- **Establishes** the Health Coverage Reinsurance Corporation consisting of all health care plans doing business in the small employer market.

- **Authorizes** Corporation to assess member insurers to fund the reinsurance.

An insurer may transfer up to 90 percent of the risk above $5,000 per individual; if charges exceed $50,000, insurers may transfer 100 percent of the risk. Insurers ceding individuals to reinsurance shall be assessed a reinsurance premium five times the adjusted average market price and insurers ceding entire groups to reinsurance must pay a premium one and a half times the adjusted average market price.

Private Employers Insurance Program:

- **Vehicle** by which private sector employers can pool their resources and employees to leverage greater health care purchasing power.

INDIVIDUAL INSURANCE REFORM

Guarantees renewability of coverage at premium not based on experience rating or medical underwriting.

Eliminates gender and family medical history as underwriting criteria.

Premium rating and restrictions are the same as those for the small employer market.

Limits the use of pre-existing condition clauses to those in the small employer plans.

Requires that health care plans offer individual coverage to any individual previously covered under a group without imposing pre-existing condition limitations if there is not a lapse in coverage of more than 30 days.

3. Coverage for the Uninsured

ELIGIBILITY:

- Uninsured low-income families with children and individuals will be eligible for health services phased in as follows:

    - 10-1-92: low-income families of children previously enrolled in the Children's Health Plan;
    - 1-1-93: families with children up to 275 percent of poverty; and
    - 7-1-94: single adults and households without children up to 275 percent of poverty.

- Enrollees must have been uninsured for at least 4 months, not have had access to employer-subsidized coverage for at least 18 months, and have resided in Minnesota for at least 180 days with the intent to remain permanently.

- Premiums: All enrollees must pay a premium to obtain coverage through the program. The amount of the premium will depend on income. Those whose income is above the income limit for the Medical Assistance program will pay a very small premium, and those with incomes approaching 275% of the federal poverty guideline will pay almost the entire cost of coverage. Persons and families with incomes over 275% of the poverty guideline are not eligible.

OUTPATIENT BENEFITS

- Physician, chiropractic and other health clinic services
- Outpatient hospital services
- Mental health ($2,500 per year child limit and $1,000 per year adult limit)
- Ten hours chemical dependency treatment
- Dental (50% co-pay for adult non-preventive services)
- Prescription drugs ($3.00 co-pay for adults)
- Eye care ($25.00 adult co-pay for glasses)

INPATIENT BENEFITS (beginning 7-1-93)

- No limit for children under 18
- MA spenddown for single parents and unemployed households
- $10,000 per year limit for adults with a 10% co-payment ($3,000 maximum co-pay per family).

4. Rural Health

Funds two grant programs to assist rural hospitals in isolated areas or in transition.

Allows small rural hospitals to get the value of the 2 percent tax back in grants if the tax would force them to close.

Provides loan forgiveness programs to physicians, nurses, and midlevel practitioners who agree to serve in rural Minnesota.

Requests the University of Minnesota to work to increase the number of graduates of residency programs of the medical school who practice primary care by 20% and to encourage these graduates to establish practices in areas of rural Minnesota.

Expands the Office of Rural Health to serve as a clearinghouse of information, coordinate the state's efforts regarding rural health, assist local communities in seeking federal or state funds, and act as an agent in the recruitment of providers to rural Minnesota.

Helps rural communities establish community health centers in underserved areas.

Allows Commissioner of Health to define exemptions to antitrust law to allow health care providers and purchasers to share resources and services or enter into other types of collaboration in areas when these arrangements are in the best interests of the region.

5. Malpractice Reform

Requires that attorneys in medical malpractice cases obtain the signatures of all expert witnesses on court documents early in a lawsuit.

Requires that attorneys in medical malpractice cases use uniform interrogatory forms to obtain information from the other party.

Requires the parties to a malpractice lawsuit to discuss forms of alternative dispute resolution to determine whether alternatives to a trial are realistic or feasible.

6. Data Collection

- **Expenditure data:** For the purposes of setting expenditure limits, the Commissioner is directed to collect information from providers on patient revenues, and data on health care spending for group purchasers.

- **Capital expenditure reporting:** Any provider making an expenditure in excess of $500,000 is required to report this expenditure and relevant background information to the Commissioner.

- **Database on health services personnel:** The Office of Rural Health is directed to develop a database on health services personnel.

- **Health conditions database:** The Health Care Analysis Unit will develop a database on specific high-cost conditions, which will include data on: mortality, morbidity, functional status, quality of life, symptoms, patient satisfaction, severity of illness. Data must allow for comparisons between providers, carriers, public programs and other entities.

• **Technical assistance:** The Health Care Analysis Unit will collect information about premiums, benefits levels, managed care procedures, and other features of health plans, and information on prices, outcomes, provider experience, to assist consumers and purchasers in making health care purchasing decisions.

7. Financing

Costs: The program for low-income, uninsured persons is expected to cost about $254 million in state fiscal year 1997, when the program is fully implemented and growth and enrollment are expected to begin to level off. The total cost of the health care reform package for 1997 (at full implementation), including rural health initiatives, higher education programs, cost containment initiatives, insurance regulation, and other activities, is expected to be about $295 million. Funding for the Act is provided by:

Cigarette Tax

• 7-1-92 to 1-1-94: 5 cent increase in cigarette tax. Revenue from this tax will be transferred to the general fund beginning 1-1-94. The increase is expected to generate revenues of $16.9 million in fiscal year 1993, and level off at $17.2 million for fiscal year 1994 and beyond.

Hospital Tax

• 1-1-93: 2 percent tax on gross patient revenues of hospitals and surgical centers. For the first year hospitals can pass through the tax to third party payers. The hospital tax is expected to generate $14.5 million in fiscal year 1993 (six months). Revenues from the hospital tax will increase each year due to health care inflation and are expected to reach $71.1 million in 1997.

Health Care Provider Tax

• 1-1-94: 2 percent tax on gross revenues of licensed health care providers including doctors, dentists, chiropractors, wholesale drug distributors, etc. The provider tax is expected to raise $4.3 million in fiscal year 1994, (six months). Revenues will increase to an estimated $133.7 million in 1997.

Tax on Nonprofit Health Service Plans

• 1-1-96: 1 percent gross premium tax on HMOs, Blue Cross, Delta Dental and other non-profit health service companies. These taxes are expected to raise $32.3 million in fiscal year 1996 (6 months).

A study is being conducted to determine if the health care provider tax is the best revenue source.

Medicare, Medical Assistance, General Assistance Medical Care, MinnesotaCare, nursing home services and other specified payments to providers are not subject to the tax.

Appendix B:

Antitrust Law

The principal federal antitrust statutes are the **Sherman Act** (prohibiting contracts, combinations, and conspiracies in restraint of trade, monopolization), the **Federal Trade Commission Act** (prohibiting "unfair methods of competition" and "unfair or deceptive acts or practices," including false or misleading advertising or representations), and the **Clayton Act** including the **Robinson-Patman Act** amendments (prohibiting discrimination in prices between different purchasers in the sale of a commodity, exclusive dealing arrangements, tying sales and requirements contracts involving the sale of commodities). In addition, there are state antitrust laws, including Minnesota Statute §§ 325D.49 to 325D.66.

Some antitrust violations are considered per se violations, that is, the violations impose such a detrimental restraint on competition that just by their nature, they are presumed to be unreasonable and illegal. Examples of per se violations include price fixing, division of markets, group boycotts, and tying arrangements. For other restraint of trade violations which are not considered per se violations, the courts have applied the "rule of reason" approach. Under the "rule of reason," courts will analyze particular arrangements or conduct, on a case by case, fact specific basis, in terms of the nature, purpose and effect of the restraint.

There is no dispute that health care providers are subject to antitrust laws. Even when providers have argued that they are acting in the public interest, rather than in their own commercial interest, courts have found violations of the antitrust laws. Courts have imposed a per se standard on certain conduct (e.g. price fixing) within the health care industry as in other industries. On other conduct, depending on the transaction (e.g. some mergers), courts will utilize a "rule of reason" analysis to scrutinize the arrangement; courts apply this analysis to arrangements between health care providers in the same situations as when they consider arrangements between entities in other business industries. Enforcement actions for antitrust violations can be brought by the Department of Justice, the Federal Trade Commission, the Attorney General's Office, and private parties.

Federal courts recognize state action exemptions for certain arrangements which would otherwise violate federal antitrust laws. As established in California Retail Liquor Dealers Association v. Midcal Aluminum, Inc., 445 U.S. 97 (1980), in order to be immune from antitrust enforcement action, an arrangement must satisfy a two-part test. First, the anticompetitive conduct must be conducted pursuant to an affirmatively expressed and clearly articulated state policy to supplant competition. Second, the state has an affirmative obligation to actively supervise the anticompetitive conduct.

The Minnesota legislature has created "an opportunity for the state to review proposed arrangements and to substitute regulation for competition when an arrangement is likely to result in lower costs, or greater access or quality, than would otherwise occur in the competitive marketplace." Specifically, the legislature, in Minn. Stat. § 62J.29, Subd. 2, authorizes the Commissioner of Health (Commissioner)

to "establish criteria and procedures to review and authorize contracts, business or financial arrangements, or other activities, practices, or arrangements involving providers or purchasers that might be construed to be violations of state or federal antitrust laws but which are in the best interests of the state and further the policies and goals of this chapter." No proposed arrangement will receive approval unless it "is likely to result in lower health care costs, or greater access to or quality of health care, than would occur in the competitive marketplace." In order to prevent abuses of private economic power, the legislature imposed an affirmative duty on the part of the Commissioner to "actively monitor and regulate arrangements approved under this section to ensure that the arrangements remain in compliance with the conditions of approval." Finally, the legislature granted the Commissioner the power to "revoke an approval upon a finding that the arrangement is not in substantial compliance with the terms of the application or the conditions of approval."

Another important exception to antitrust liability is the Noerr-Pennington Doctrine, which provides that people cannot be subjected to antitrust liability for exercising their constitutional right to petition the government. Under Noerr-Pennington, providers or purchasers are not only free to bring proposals to the Commissioner of Health for approval, but may also meet together to discuss whether to make such a proposal to the Commissioner, and what form the proposal should take. Providers or purchasers do not need any prior approval to hold such discussions; all such discussions related to petitioning the government are constitutionally protected. However, providers or purchasers holding such discussions should clearly agree upon beginning such discussions that such discussions are held only to explore options for petitioning the Commissioner for an antitrust exemption or for entering into collaberative arrangements that do not violate the antitrust laws. It should be clearly understood and stated that the participants will not agree to implement any arrangement that violates the antitrust laws without first seeking and receiving approval from the Commissioner of Health. In October 1992, the Commissioner of Health and the Attorney General jointly sent a letter to Minnesota health care providers summarizing the Noerr-Pennington Doctrine, and explaining how providers could discuss collaberation with each other without running afoul of antitrust law. A copy of that letter is included with this appendix.

Appendix C:

Provider Conflict of Interest Restrictions

In order to prevent conflicts of interest that lead to fraud and abuse, federal law restricts certain types of financial relationships and payment arrangements among providers. The 1972 fraud and abuse provisions (42 U.S.C. § 1320a-7b(b)) explicitly prohibited the solicitation, offer, or acceptance of any kickback, bribe, or rebate. No specific intent was required and violation was a misdemeanor. In 1977, the prohibitions within the statute were broadened, through the Medicare and Medicaid Antifraud and Abuse Amendments, to include the solicitation or receipt of any remuneration, whether direct or indirect, overtly or covertly, in cash or in kind. Violation of the statute became a felony. The amended statute created two exceptions: 1) discounting and 2) payments pursuant to bona fide employment relationships. The statute was amended through the Omnibus Reconciliation Act of 1980 to require specific intent in order to convict. To expand enforcement, the antikickback statute was amended by the Medicare and Medicaid Patient and Program Protection Act of 1987. The amendments included the imposition of civil money penalties (permitting the Secretary of Health and Human Services to take enforcement action without having to rely on the U.S. Attorney and requiring a lower burden of proof than criminal sanctions). Also included in the amendments was a Congressional mandate to establish "safe harbor" regulations. Compliance with the "safe harbor" provisions exempts a provider-investor from criminal prosecution and exclusion from Medicare. The safe harbors exist only to provide protection to certain specific types of arrangements; they are not used to automatically impose liability on any arrangement falling outside their scope.

In 1989, Congress enacted what is commonly known as the Stark Amendment (Ethics In Patient Referrals Act, 42 U.S.C. § 1395nn). Like the other amendments, the Stark Amendment imposes civil money penalties for physician ownership of, and referrals to, certain health care entities. The statute makes various specific compensation arrangements illegal, but its applicability is limited only to those entities that provide clinical laboratory services. There are distinctions between the "safe harbor" regulations and the Stark Amendment. Enforcement under the antikickback statute is separate from enforcement under the Stark Amendment. The Stark Amendment requires different elements of proof and imposes civil penalties, not criminal penalties. The Stark Amendment requires no specific intent. If a financial relationship exists, civil money penalties and program exclusion will be imposed.

Minnesota has enacted two statutes restricting the types of referral arrangements in which providers can engage. Under Minn. Stat. § 147.091, Subd. 1(p), physicians are prohibited from "fee splitting," which includes: (1) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, or remuneration, directly or indirectly, primarily for the referral of patients or the prescription of drugs or devices; (2) dividing fees with another physician or a professional corporation, unless the division is in proportion to the services provided and the responsibility assumed by each professional and the physician has disclosed the terms of the division; (3) referring a patient to any health care provider as defined in section 144.335 in which the referring physician has a significant financial interest unless the physician

has disclosed the physician's own financial interest [disclosure requirements are described in Minnesota Rule 5620.0130]; and (4) dispensing for profit any drug or device, unless the physician has disclosed the physician's own profit interest. Disclosure must be made in advance and in writing to the patient and must include a statement that the patient is free to choose a different health care provider.

The federal Medicare antikickback statute and regulations have been incorporated into Minn. Stat. § 62J.23, Subd. 1. The Commissioner of Health is to adopt rules restricting financial relationships or payment arrangements involving health care providers that receive a financial benefit as a result of referring a patient to another provider, recommending another provider, or furnishing or recommending an item or service. The rule must be compatible with, and no less restrictive than, the federal Medicare antikickback statute, in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and regulations adopted under it. The Commissioner may impose greater restrictions than provided by federal law and regulations as long as the restrictions are clearly identified in the rule.

Unlike the recognized state action exemption that may protect collaborative arrangements from federal antitrust liability, there is technically no equivalent protection that a state can apply to protect providers from federal antikickback liability. Therefore, the federal antikickback law may conceivably prevent certain arrangements that are beneficial to consumers.

However, enforcement of the sweeping antikickback laws is largely a matter of prosecutorial discretion. By emphatically endorsing ISNs as the best method for containing cost and halting over-utilization, the Commission and the Legislature can make it highly unlikely that the antikickback law would be applied to bar the formation or operation of ISNs, even if the structure of some ISNs could otherwise be viewed as potentially being technically contrary to the antikickback laws.

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October 13, 1992

Minnesota Health Care Providers:

One of the objectives of the 1992 health care reform legislation (formerly HealthRight) is to encourage collaborative arrangements among providers that promote cost-effective access to high quality health care services. It is our understanding that there continues to be some fear among providers about discussing such ventures. The State is relying on your participation to assist us in improving our health care system. We want to assure the health care community that it is possible to conduct discussions about collaborative arrangements without violating the law. The following guidelines are intended to help you and your colleagues avoid antitrust problems.

First, some things you should do:

DO participate in the regional planning processes, which call for providers and others to collaboratively develop plans to present to the Minnesota Department of Health, the Regional Coordinating Boards, and the Health Care Commission. **It is not against the law for people to get together to discuss proper public policy, or develop proposals to submit to their governments!**

DO feel free to discuss with other providers transactions that would be prohibited under antitrust law. However, it is critical that all participants understand and agree that such a transaction would proceed only after an antitrust exception is received from the Commissioner of Health, and that the participants do not agree to enter such a transaction absent approval from the Commissioner.

DO carefully document the purposes of any meetings or other joint activities, especially those involving conversations among competitors about such matters as fees and market structures. Such discussions are not unlawful if directed at developing proposals to

achieve the goals of the 1992 health care reform legislation. Providers will benefit by scrupulously documenting proper purposes, and all will have greater faith in the process if providers take pains to maintain the appearance as well as the reality of propriety.

DO consult an attorney as to whether you need to follow the statute's state action exemption process, and to guide you through the process.

DO call the Department of Health or the Antitrust Division of the Attorney General's Office if you have questions about these issues.

Although it is permissible to discuss various arrangements that affect the marketplace, any agreements about arrangements outside the public process may be subject to federal and state antitrust law. Therefore, here are some things you should not do:

DO NOT agree with your competitors on market changes contrary to antitrust law which will be implemented outside the statutorily-authorized process.

DO NOT bring up extraneous business dealings in meetings devoted to planning under the 1992 health care reform legislation.

DO NOT implement any jointly developed proposals on your own unless the proposals are permitted under current law. If a proposal needs a state action exemption, do not implement it without going through the process and obtaining approval from the Commissioner of Health. If you implement such a proposal without approval you are subject to antitrust liability.

DO NOT expect the Health Department or the Attorney General's Office to pre-screen every transaction, or routinely issue "business review letters." We simply do not have the resources to accommodate the anticipated volume of requests. Keep in mind that this process is for those exceptional cases which, if undertaken, would result in an antitrust violation. Many transactions will not fall into this category.

We do not believe that antitrust law poses an obstacle to implementation of this health care reform legislation. Adherence to these guidelines and the state action exemption process that will be established should help providers comply with the antitrust laws while advancing the goals of the legislation. If you have any questions about the guidelines, or about these issues, feel free to call the staff of either office.

HUBERT H. HUMPHREY III
ATTORNEY GENERAL

MARLENE E. MARSCHALL
COMMISSIONER OF HEALTH

Addendum

Position Paper on For-Profit ISNs

Position Paper on ISN Benefits and Coverage

Recommendations on Incentives for Collaboration to Achieve Public Health Goals

Rural Health Discussion Guide

ISN Discussion Guide

Minnesota Health Care Commission

The Position of the Minnesota Health Care Commission on For-Profit ISNs

The Minnesota Health Care Commission recommends that for-profit organizations be permitted to form Integrated Service Networks (ISNs) under the following conditions:

(1) the for-profit corporate entity must form a Minnesota ISN board with at least 40% consumer representation and some degree of relevant authority to advise the ISN; and

(2) the ISN must meet a specified set of requirements for its operational structure, services provided, financial solvency, and consumer protection.

The Commission does not believe for-profit organizations should be required to form a subsidiary corporation in order to operate an ISN.

Rationale:

- The options available to for-profit organizations to raise capital will facilitate the formation of new ISNs. The capital raising opportunities of for-profit organizations will be particularly appealing to those interested in starting rural ISNs and provider-governed ISNs, who otherwise might not be able to raise sufficient capital to commence operations and maintain sufficient reserves.

- The philosophy of the Commission and the principles underlying the Commission's plan emphasize the outcome (lower price and better quality) rather than the structure. If for-profit ISNs can offer a competitive product in terms of price and quality, the tax status of the organization is not important.

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- The Commission believes competition should be encouraged. Allowing a wider range of governance options and a great deal of structural flexibility will encourage the formation of a variety of competing ISNs.

- If only nonprofit organizations are allowed to form ISNs, for-profit organizations that wish to compete in the ISN market will form subsidiary non-profit corporations to operate an ISN. The corporate philosophy and perspective will not be different, but an unnecessary additional layer of administrative cost and bureaucracy will be added, making the playing field uneven from the start.

- The nonprofit/for-profit status of organizations has little bearing on the nature and philosophy of the organization. Many for-profit organizations work for the good of the general community and offer high quality products and exceptional customer service. Many nonprofit organizations work aggressively to maximize revenues, have highly compensated management, have close relationships with for-profit management companies, and engage in other activities that blur the nonprofit/for-profit distinction. Survey research has shown little difference in enrollee satisfaction between nonprofit and for-profit HMOs.

Minnesota Health Care Commission

Recommendations of the Minnesota Health Care Commission on ISN Coverage and Benefits

- In the past, cost containment efforts have focused on reducing benefits, carving out services, limiting the number of covered visits, and excluding provider groups. These approaches simply shift the cost from the payer to the consumer, state and local government programs, or providers in the form of uncompensated care.

  - *For example, when coverage of mental health benefits is limited under a health insurance policy, the need for the services does not go away--the cost is simply shifted to the patient or to state and local mental health programs.*

- Shifting costs around within the system does not help us achieve global cost containment goals. In fact, carving out services, benefits and providers makes cost containment more difficult because services are fragmented and difficult to monitor and coordinate. The ISN benefit set should promote coordinated, cost-effective delivery of all services an individual might need.

- The Minnesota Health Care Commission recommends that ISNs be responsible for a comprehensive package of services that includes all "appropriate and necessary" health services.

  - The definition of "appropriate and necessary" should be defined by laws and rules to reflect community standards and scientific evidence.

  - An ISN should not be responsible for services that are not appropriate and necessary.

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- Efforts should be made to provide better information to define which services and treatment are appropriate and necessary and which are ineffective, unnecessary, or unproven, through outcomes research, the development of practice parameters, technology assessments, and other activities.

- Affordability of health coverage is a very high priority. Lower cost coverage options would use copayments, coinsurance and deductibles to bring down the premium cost of coverage, rather than reducing costs by excluding certain services or providers.

  - For purposes of meeting global limits on growth, an ISN would be accountable for the total cost of the full range of comprehensive services, including both the premium cost and the enrollee's out-of-pocket expenses.

  - An ISN would be expected to manage the costs of all services provided to an enrollee, even if the enrollee must pay all or most of the costs of the service under the terms of the policy.

  - *For example, under the current system when an enrollee reaches the maximum number of mental health visits, their mental health treatment is no longer the concern of the health plan company. Under the Commission's proposal, at this point the enrollee might be responsible for paying most or all of the costs of additional services, but the ISN would continue to be responsible for managing the overall costs under the ISN's total budget.*

(Copayments, coinsurance and deductibles are discussed in more detail later.)

- Benefit options would be standardized to facilitate comparisons between different ISNs and coverage options. Options would range from a lost cost plan with high consumer cost sharing to a more costly plan with minimal cost sharing. The standard benefits should apply to all ISN based services including government programs such as medical assistance. All ISNs would be required to offer the standard benefit packages, but other options could be offered as well.

- Benefit options and consumer cost-sharing options must not allow cherrypicking or targeting of healthy populations.

- ISNs should be allowed to offer an out-of-network benefit, where there would be higher levels of copayments and deductibles for services provided out of the ISN provider network.

  - Part of quality improvement activities conducted by ISNs and the Department of Health would be the evaluation of out-of-network utilization.

- Benefits should be structured to discourage cost shifting to employers, consumers, providers, other insurers, health plans or government programs.

- The services provided under the comprehensive care definitions should be updated on an annual basis to reflect changes in community standards of practice for new technology, the development of practice parameters, the results of technology assessments, and other medical innovations.

- Benefits should be structured to promote the efficiency of delivering health services by use of appropriate practitioners and linkages with government programs, public health services and community based services.

- A process for consumer protection and handling complaints must be instituted by ISNs to assure the appropriate implementation of benefits.

ISN Benefit Definition

An ISN must provide appropriate and necessary comprehensive health services which are delivered by authorized practitioners acting within their scope of practice. The network of practitioners used by the ISN must assure interprofessional and intraprofessional collaboration and must incorporate established practice parameters and outcomes analyses. The ISN may define benefit levels through the use of copayments and deductibles but remains accountable for the costs of comprehensive health services defined as appropriate and necessary. Certain services such as child health supervision services, immunizations, prenatal care and other preventive services must not be subject to copayments and deductibles. The use of copayments and deductibles should reflect the ability of individuals to pay for the services. The ISN is not responsible for services that are not appropriate and necessary.

Guiding Principles for Consumer Cost Sharing

- "Consumer cost sharing" means copayments, deductibles, coinsurance and other out-of-pocket expenses paid by the individual consumer.

- Consumers should have a voice in decisions on cost sharing, and the process for setting consumer cost sharing should have consumer representation and input.

- Consumer cost sharing should empower and encourage consumers to make healthy choices and appropriate use of health care resources.

- Consumer cost sharing must be administratively feasible, and consistent with efforts to reduce the overall administrative burden of the health care system.

- Cost sharing should be based on income.

  - Cost sharing should not create a barrier to access to appropriate and effective services or result in an individual's or family's income falling below a subsistence level.

  - Sliding scales should be used, with higher income persons and families paying more. The sliding scales should have a number of steps to assure equity, and provide a "zero point" -- an income level below which individuals would not pay.

- Cost sharing should be capped at a predetermined annual limit to protect individuals and families from financial catastrophe, and to protect individuals with high health care needs.

- Cost-effective preventive services considered important to the public good should be available without cost-sharing. The standards of the United States Preventive Task Force could be used to define services that should be provided without consumer cost-sharing.

- Additional incentives should be considered for population groups for whom even no out-of-pocket costs may not be sufficient inducement to use cost-effective preventive services.

- Health care system structural and organizational requirements should reflect the needs and wants of consumers and provide them with the necessary information, assistance, and opportunities for appropriate use of health care resources that minimizes their potential out of pocket costs.

Examples:

(1) Provide consumers with information about alternative forms of treatment, and structure cost sharing to reward use of less expensive alternatives having the same or better outcome as more expensive alternatives (e.g., reduced or no cost sharing for generic prescriptions vs. greater cost sharing for use of trade name prescriptions when the effects are comparable).

(2) Cost sharing could not be imposed if an ISN did not offer at least 24 hour telephone, TTD, and interpreter services to help patients or their families determine their need for medical care, the range of alternatives available, and the direct out of pocket cost consequences to the consumer of utilizing services.

(3) Primary care providers and services must be geographically accessible and available on a timely basis if differential cost sharing based on in-network vs. non-network services is imposed.

(4) A grievance and appeals process should be available to consumers for appealing contested cost sharing.

Minnesota Health Care Commission

Recommendation · April 1, 1993

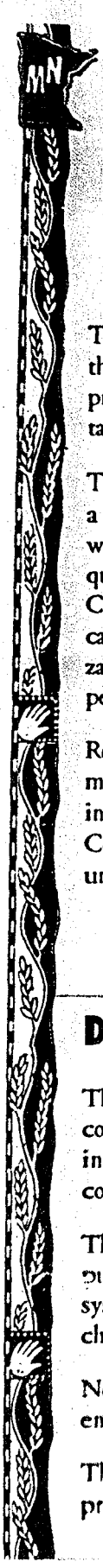
Incentives to Encourage ISNs and Other Organizations to Collaborate with Public Health Agencies to Achieve Community-wide and Regional Public Health Goals

The Minnesota Health Care Commission has recommended competition and collaboration to contain costs and meet defined public health goals. It further recommends that the Legislature consider financial incentives, such as grants programs and exemptions from spending limits, to foster statewide multi-sector collaboration between Integrated Service Networks (ISNs) and other organizations to meet defined public health goals. Funding for the financial incentives would be financed through incremental alcohol and tobacco taxes proposed by the Commission, and would be allocated for community wide assessment, grants, and performance rewards as follows:

- Ten percent of the funding would be designated to the Minnesota Department of Health, for enhancing its capacity to assist local boards of health in collecting and analyzing community-specific public health and health status data, providing necessary assistance for the Commissioner of Health to determine state and regional health goals, and coordinate local funding allocation and exemptions from spending limits using recommendations of Regional Coordinating Boards and their community health boards.

- Twenty percent of the funding would be allocated on a formula basis to the 49 community health boards to enhance their capacity to more effectively implement their current responsibilities for coordinating community-based health assessment, setting public health goals and evaluating progress toward their achievement (Minnesota Law, Chapter 145A, Local Public Health Boards). With financial incentives for integrated service networks and private organizations to participate, the likelihood of collaboration would be significantly improved from the current situation.

- Seventy percent of the funds would be made available to Regional Coordinating Boards, on a formula basis, to be able to recommend to the Commissioner of Health specific financial incentives for ISNs to 1) meet defined outcome-based cost effective health goals for the populations they serve and 2) achieve effective collaboration with public health agencies and other private organizations in implementing outcome-based cost effective wellness programs and initiatives for meeting specified public health goals. The recommendations to the Commissioner of Health would be selected from the community health assessments and goals presented to the RCBs by the community health boards in the region. Financial incentives provided to ISNs and other private organizations, in such form as awards and exemptions from spending limits, would be based on successful goal achievement and collaboration as documented by reports from Community Health Boards to the Regional Coordinating Boards.



Cost Containment in Rural Minnesota

A discussion guide for rural health care providers

The Minnesota Health Care Commission's cost containment plan includes components designed to meet the health care needs of rural Minnesota, if the reform plan is enacted by the legislature. Rural health care providers, rural consumers, and rural employers serve as members of the Commission. They were important players in the process of developing the plan and are unanimous in their continued support of the plan.

The plan offers several different options for controlling health care costs to allow each community to choose a strategy that fits its unique needs and desires. The Minnesota Health Care Commission is committed to working with rural communities to implement cost containment strategies in a way that enhances the quality, access, and affordability of the rural health care system. While the overall plan is flexible, the Commission will continue to seek local input on unique needs which must be addressed to assure the plan can be tailor-made to fit every community. The Commission encourages locally based planning and organization of strategies to implement the cost containment plan -- bringing the decision-making closest to the people it affects.

Recent discussions with health care providers, employers, consumers, and legislators suggest that the Commission's plan is not understood by many rural Minnesotans. Many have drawn conclusions based on incomplete or preliminary information about the Commission's proposals. This discussion guide is the Commission's most current thinking on rural cost containment. We hope it will help promote a better understanding of the proposal.

Tom Swain, Chair
Minnesota Health Care Commission

Dispelling myths about the Commission's plan:

The plan does <u>not</u> force rural communities and providers to go into metropolitan-designed and controlled networks.

The plan does <u>not</u> impose a punitive, heavy handed regulatory system on rural providers who choose not to join networks.

Networks are <u>not</u> a new, unproven idea for rural areas.

The plan does <u>not</u> force rural providers to join large, statewide HMOs and health plans and accept huge discounts.

The plan does <u>not</u> mean the end of small, independent providers.

Rural providers will <u>not</u> be fleeing the state because of this plan.

The plan does <u>not</u> steal control of the local health care system away from local providers and communities.

The plan does <u>not</u> try to make competition work in rural areas where it does not make sense.

Antitrust laws do <u>not</u> prevent rural providers from forming networks or working together in ways that will benefit rural communities.

Antitrust laws do <u>not</u> prevent rural providers from discussing collaboration with each other.

The health care system is changing--resisting change will <u>not</u> prevent the changes.

Questions about rural cost containment

Why should we do anything? What's wrong with the way things are?

Rapidly rising health care costs are a critical problem. Costs are expected to increase from 10 to 15 percent a year for the next five years. If we do not act now, costs will continue to rise at 3 or 4 times the inflation rate and will more than double within ten years. Without strong action, the per person costs of health care will increase from $2500 a year to $5700 a year by the year 2000.

Rapid cost increases are not just a metropolitan area problem, but are also occurring in rural areas. Although rural costs on average tend to be lower than costs in metropolitan areas, rural areas suffer from medical cost inflation comparable to that faced by metro areas. Cost containment efforts aimed at reducing this rate of growth will benefit both urban and rural communities.

In addition, there is room in rural areas for improvement in the efficiency of service delivery and use of technology. Major system reform provides the opportunity to address some of these issues unique to rural areas.

As costs go up, insurers screen out sick and high risk families and individuals who need coverage the most. Rural employers are forced to scale back or discontinue coverage. Families and individuals drop coverage. As each year passes, more and more rural Minnesotans become uninsured and cannot afford even a minor illness. Others, because of high deductibles, will delay seeking treatment, causing even more expense to the system in the future.

Until costs are under control, government cannot afford to provide subsidized coverage for all those who cannot buy it themselves.

As costs continue to escalate, rural providers will come under increasing pressure and control from insurance companies, HMOs, and other third-party payers.

Rural providers will find themselves treating more and more patients who are uninsured and cannot afford to pay for their own care. Rural Minnesotans cannot afford skyrocketing health care costs, and without patients who can pay for their care, rural providers will be unable to stay in business.

If we act now, we have a tremendous opportunity to plan for change and implement our changes carefully. If we wait, we will find ourselves in a state of emergency without any reasonable options. We will be forced into solutions that will be much more painful than those we are discussing now, and quality and access will suffer.

Why talk about networks? Can they really work in rural areas?

The idea of integrated health care networks was proposed by physicians, hospitals, and other organizations, both locally and nationally, as a way to control costs without heavy-handed governmental cost controls and regulatory micromanagement of providers.

Integrated Service Networks (ISNs) are a way to put cost control into the hands of those who know the delivery system best: hospitals, physicians and other providers, and health plans. However, under ISNs, consumers will be expected to also take responsibility for their care and their costs.

The purpose of ISNs is to reward providers for becoming more cost-effective.

- Under the current system, providers are paid to provide services and treatment with no real incentive or reimbursement for prevention efforts. The more treatment, procedures, and tests they provide, the more they get paid.
- Providers have no business incentive to work together and to collaborate on how best to serve the community. Instead, they must think about maximizing their own revenues to stay in business
- If providers form an Integrated Service Network,

they will get paid the same regardless of the number of visits, treatments, tests, or procedures they provide. Under this arrangement, preventing illness and treating patients more efficiently will be the primary motivation. If providers become more efficient and cost-effective, they may keep their savings. The entire community benefits when providers work together to find the most cost-effective method of caring for a community's residents.

Networks are not new and have been successful in rural areas. Several varieties of models for rural networks exist. The Minnesota Health Care Commission and the Office of Rural Health can provide information on existing rural networks.

What about antitrust laws? How can rural providers get together to discuss forming an ISN without getting sued?

Antitrust laws do not prohibit providers from getting together to talk about forming an ISN or discussing possible collaborative agreements.

Providers can even talk about proposals that would clearly violate antitrust laws if undertaken without governmental approval. They must simply be sure to obtain governmental approval before implementing their plan.

The Minnesota Department of Health and the Attorney General's Office have agreed to provide guidance and assistance to providers who are unclear about how to avoid antitrust problems.

Laws will be enacted that will provide antitrust protection to providers who are working together in ways that will ultimately benefit consumers. Providers who wish to work together to improve affordability, access, or quality of health care can get an exemption from antitrust laws by applying to the Commissioner of Health.

Will rural communities be forced into networks? Are there other opportunities?

Networks are not mandatory. Rural providers, employers, and consumers will be free to decide whether they believe Integrated Service Networks will best fit their community's needs.

Providers may join an ISN, form their own ISN along with others, participate in more than one ISN, or choose not to be a part of any ISN.

Employers, consumers, and other purchasers of health care may be able to choose a more traditional type of health coverage offered by an insurance company, an HMO, or Blue Cross and Blue Shield. This coverage may be offered under an "all-payer" system.

The network concept was proposed by providers and is seen by many providers as a very attractive alternative. Integrated Service Networks are an opportunity for providers to avoid excessive governmental regulation and even to pocket any savings they can produce by becoming more efficient.

What *is* mandatory is cost control. Global limits on the rate of increase in health care costs will slow down the rate of growth in health care costs. Uncontrolled growth in health care costs is not an option.

Is this an invitation to large HMOs and statewide health plans to take over the rural health care system?

Quite simply: "No."

Providers, employers, and consumers will have alternatives to health plans offered by large, statewide insurance companies and HMOs. In fact, networks are an opportunity for community leaders, such as physicians, hospital administrators and trustees, business owners,

and possibly local government officials, to work together to form arrangements that may eliminate the need for an insurance company or other third-party payer.

These collaborations can result in a stronger health care delivery system, a stronger, more vibrant community, and a healthier population.

The Minnesota Medical Association, and the Minnesota Hospital Association, the Minnesota Nurses Association, and other provider organizations support the network concept because it will create an opportunity for providers to participate in locally controlled, provider-initiated networks.

The implementation of the new system will be timed in a way that allows rural communities time to prepare and, if they choose, to form their own networks as an alternative to networks sponsored by large health plan companies.

The option of locally sponsored networks will also give rural providers more bargaining power when dealing with large, statewide health plans. To recruit them into their networks, large health plans will have to offer more attractive terms and possibly provide support services and other benefits and "perks."

Will independent providers be excluded or forced to join networks?

The Minnesota Health Care Commission believes independent providers will continue to be an important part of our health care system.

Independent providers will have several choices:

(1) They may continue to provide services through a fee-for-service system or a conventional type of health plan or HMO, much as they do now;

(2) They may join forces with other independent providers to form their own network, affiliate with a locally controlled network, or contract with a larger network;

(3) They may participate in as many networks as they choose; or

(4) They may choose any combination of the above choices.

ISNs will be required to establish relationships with many types of providers and will be prohibited from unfairly discriminating against certain types of providers.

Existing models of rural networks indicate that rural networks which allow all providers in a region to participate can be successful.

The cost containment plan is designed to lead to an environment in which ISNs will compete to recruit providers by offering benefits such as office and administrative support, simplified billing procedures, and liability coverage.

How can rural providers form ISNs? They don't have the time, expertise, or capital to start up an ISN.

The Minnesota Health Care Commission, the Legislative Oversight Commission, and the Minnesota Department of Health are committed to making it practical and feasible for rural providers and rural communities to develop locally controlled networks.

Technical assistance and start-up loans will be provided to help rural ISNs get started. The Office of Rural Health will be one important source of assistance. Industry professional organizations and trade associations have indicated that they plan to provide technical assistance and other services to facilitate the formation of locally sponsored ISNs.

Descriptions of different ISN models will be made available.

Integrated Service Networks could be sponsored by local businesses, by a local provider working with other providers in the community, by a local government, by

community organizations, by other entities, or by any combination of these groups.

A rural ISN cooperative could be formed to help rural providers, employers, community organizations, or local governments start an ISN. The coop could also manage, or contract for management of ongoing operations, billing and utilization review, and providing other services to members.

Rural providers and communities that have had positive experiences with rural networks will be recruited to help other providers and communities understand the principles and benefits of networks.

Financial solvency, reserve, and net worth requirements will be designed to make it possible for small, community-based, rural ISNs to form. While the details are still being worked out on this issue, the Commission has taken the position that these requirements should promote, not discourage, the development of new, locally based ISNs, including ISNs that are sponsored or initiated by local providers.

What is the "all-payer" system?

In order to understand the all-payer system, it is necessary to understand global limits on growth in health care spending.

Global limits are an essential component of Minnesota's cost containment strategy. They will gradually reduce the rate of growth in health care spending from the current growth rate of about 10 percent to a rate of about five or six percent within five years.

Global limits will be implemented in one of two ways:

(1) Integrated Service Networks will be required to keep their annual increases under the global limits on growth that will be established by the Commissioner of Health, but they will be free to find their own methods of controlling costs;

(2) Annual increases in costs for all services not covered through an Integrated Service Network will be kept under control by an all-payer system.

The all-payer system is a uniform, standardized payment system that will be used by all insurance companies and third-party payers other than Integrated Service Networks.

Through the all-payer system, utilization will be managed and provider fee increases will be controlled.

The all-payer system will reduce administrative costs and burdens for providers by consolidating all of the payment systems that currently exist into one system. *This is something providers have requested.* The all-payer system will replace the hundreds of different payment systems and utilization review requirements (second opinion requirements, prior authorization, medical documentation, etc.) that are used now by insurance companies and other third-party payers.

Under the all-payer system, providers can concentrate on treating the patient instead of figuring out how to get paid. The billing process will eventually be the same for every patient who walks through the door.

The all-payer system will ultimately be used as a method of controlling excessive cost increases. The goal is not to reduce provider fees, but to start with current spending and begin to slow the rate of growth in health care costs by a little bit more each year.

At some time in the future, if Minnesota is unable to control growth in utilization and costs under the all-payer system, it may be necessary to reduce provider fees in order to stay under the global limits on growth. If this continues over time, providers will probably begin to see the ISN system as an increasingly attractive alternative. The success of the all-payer system as an alternative to networks will depend on the ability of participating providers to control cost increases.

Questions about rural cost containment

Will the all-payer system force rural providers into networks?

Initially, the all-payer system may actually be an attractive alternative for some providers (and employers) because of the simplified, uniform payment system and the uniform utilization review system.

If providers who are part of the all-payer system become more efficient and control increases in costs or utilization, provider fees will not have to be reduced and could possibly be increased. If this happens, the all-payer system will be a satisfactory long-term alternative for providers.

However, if costs and utilization in the all-payer system increase, provider fee reductions may be necessary to keep costs from rising by more than the annual limits on growth.

The all-payer system is intended to be a reasonable, cost-controlled alternative to the ISN system, not a punitive measure to force providers into ISNs.

Will border communities lose access to providers located in other states?

The Commission is very aware of the patterns of use of out-of-state providers in some border communities and many of those providers have begun initial discussions on how to accommodate Minnesota's reform through the establishment of border-area ISNs.

The Commission's recommendations and enabling legislation authorize special arrangements for border communities to ensure that access to health care is not adversely affected.

Minnesota will make every effort to establish positive, collaborative relationships with out-of-state providers in order to make sure Minnesota residents continue to have access to high quality health care.

Will this plan drive rural physicians out of the state?

Rural communities have faced serious problems recruiting and maintaining rural physicians long before Minnesota's cost containment discussions began. The underlying problems must be addressed rather than blaming recent cost containment efforts.

The implementation of the cost containment plan will be an opportunity to reallocate health care resources in order to maintain and enhance effective health care delivery systems in rural areas. Reforms must be implemented in a way that increases the ability of rural communities to attract and retain needed health professionals through financial incentives and backup and support to ease the pressures and time commitment of rural practice.

While it is true that Minnesota has a provider tax, providers will generally be able to pass the tax through to insurance companies and HMOs. In addition, Minnesota uses the proceeds of the tax to provide health coverage for many low-income Minnesotans who would otherwise be uninsured. In other states, providers often would not be paid for services to these patients.

Proceeds of the provider tax are also used to fund rural provider recruitment programs, loan forgiveness programs for rural practitioners, programs to establish rural community health clinics in underserved areas, financial assistance for rural hospitals, and other activities to enhance access in rural areas.

The Office of Rural Health and the Rural Health Advisory Committee (which are also funded through the provider tax) are now organized and will be undertaking increasingly aggressive activities to improve the rural health care system.

All other states have either enacted, or are considering, cost containment measures. Providers who leave the state to avoid adjusting to change in the delivery system are only postponing the inevitable.

National reform is just around the corner. Early indications suggest that national solutions are likely to be more

painful for providers than the Minnesota Health Care Commission's plan. However, if Minnesota moves ahead with its plan, we have a good chance of being exempted from national efforts. Rural providers who leave the state for greener pastures may ultimately regret their decision.

How can competition work in rural areas?

The Minnesota Health Care Commission believes competition can be an effective force for improving quality and reducing costs. However, the Commission does not believe that competition is always the best approach. The Commission recognizes that sometimes collaboration is better than competition.

When competition is not feasible or desirable, the Commission supports collaborative relationships.

What about national reform efforts? Are we wasting our time working on a Minnesota solution?

The reforms currently being discussed in Washington would require all health care to be purchased through giant Health Insurance Purchasing Cooperatives (HIPCs) which would seek competitive bids from very large Accountable Health Plans (AHPs).

Under this approach, all providers would be forced into networks.

This national proposal would give a significant advantage to large, statewide health plans and HMOs over locally controlled networks.

Global limits on health care spending would also be imposed under the national proposal.

The plan recommended by the Minnesota Health Care Commission will offer rural providers and rural communities more choices and an opportunity for greater control over their local health care system.

If Minnesota moves forward with an effective cost containment program, there is a good chance that Minnesota (and a few other states that have begun to implement programs) will be granted an exception from the federal mandates.

Moving ahead with reform in Minnesota will increase the opportunity to continue with a high quality system with local control.

When will these changes begin?

At the time this was printed, the amended legislation would allow ISNs to begin to form January 1, 1994, and would phase in the all-payer system over a two year period beginning July 1, 1994.

If enacted, this time schedule will allow the Minnesota Health Care Commission and the Minnesota Department of Health to further refine the derails of the new system and develop models during the next year and bring recommendations to the Legislature during the 1994 session prior to their implementation.

Prepared by
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April 6, 1993
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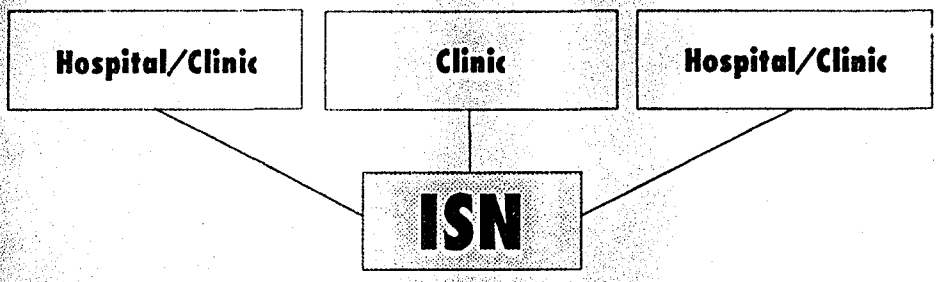
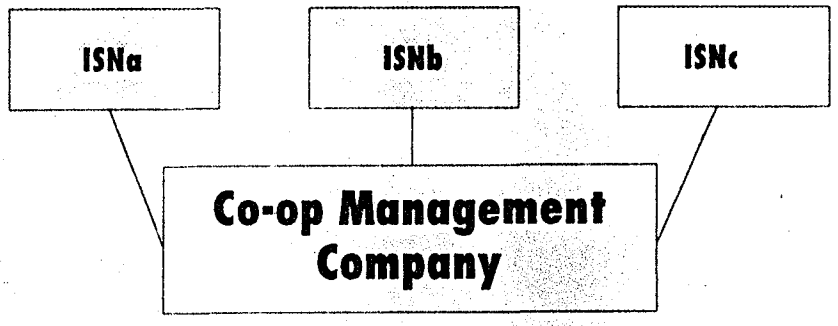
Models for ISN Structure

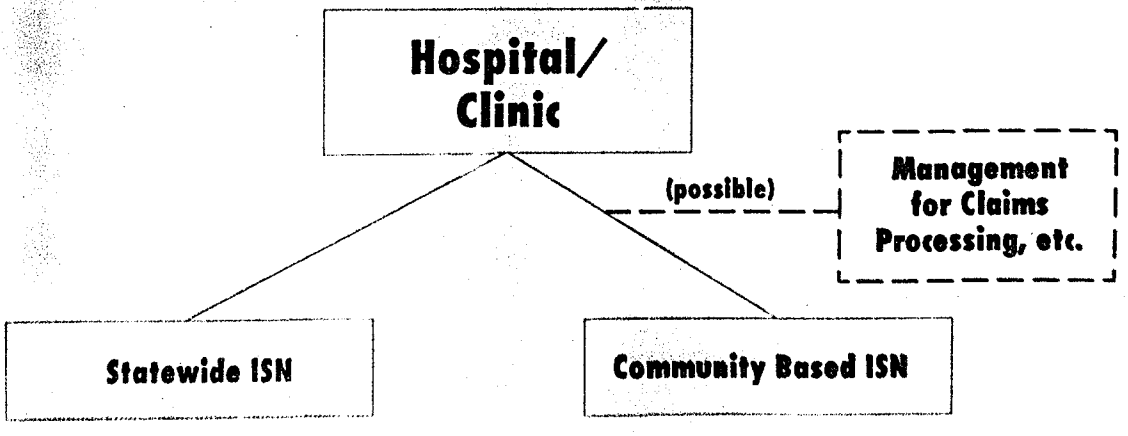
1. Multiple Provider



2. Cooperative (similar to dairy or rural electric)



3. Multiple ISN Contracts



INTEGRATED SERVICE NETWORKS:

A discussion guide

1. What is an Integrated Service Network (ISN)?

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. An ISN is a new kind of health plan under which a network of providers provides all needed health care services for a fixed payment amount. This will create an incentive for the ISN to provide care as efficiently and effectively as possible. Under the existing fee-for-service system, providers are rewarded for treating patients, not for preventing illness, hence, there is little incentive to find the most cost-effective course of treatment. Under the ISN system, providers will have the opportunity to benefit financially by becoming more efficient in their delivery of health care.

2. Who may start an ISN?

ISNs will take many forms and may be sponsored or initiated by providers, health maintenance organizations, insurance companies, employers, or other organizations.

3. How is an ISN different from an HMO?

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. The providers could also choose to form their own ISN without an insurance company partner, but still with a fixed cost to the purchaser. These kinds of arrangements are not permitted under current law.

4. How will ISNs affect individuals, employers and other purchasers?

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.

5. Are ISNs mandatory?

Formation of ISNs will occur in response to incentives, not governmental mandates:

A. Providers will not be required by the state to participate in ISNs. Providers may choose not to participate in an ISN, may participate in more than one ISN, and/or may simultaneously serve both ISN enrollees and non-ISN patients.
B. 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.)

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/or liability coverage.

6. How will ISNs affect state health care 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 Minnesota Health Care 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.

7. How will ISNs be regulated?

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 (the limit must reduce the rate of growth in each ISN by at least 10 percent a year for five years).

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, costs, and quality.

8. Will ISNs be required to maintain substantial reserves?

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. An ISN must be able to demonstrate it can bear the financial risk of providing all the agreed upon services for its enrollees. This could be accomplished through several approaches. ISNs could bear the financial risk themselves, share the risk with an insurance partner, or use other arrangements such as a state reinsurance pool. Financial requirements will be designed to make it easy for new ISNs to form and to encourage alternative forms of ISNs, while protecting enrollees from the risk that they will be left without coverage due to the financial failure of an ISN.

9. What services will an ISN cover?

ISNs will be responsible for providing needed services within a defined benefit structure that includes a continuum of care and services. A standard benefit set (the level of service which all ISNs must provide to their enrollees) will be defined. ISNs will have the option of offering additional benefit options; ISNs are expected to compete on the basis of price and quality of the standard benefit set and supplemental benefit options.

10. How will an ISN form?

There are many different possible models for an ISN. Some common examples are:

A. Providers may join together to form an ISN to offer health care to purchasers such as local employers and individuals (this model could include fee-for-service arrangements, particularly for some specialized medical services).
B. Community organizations and/or employers may initiate the formation of an ISN to serve their population.
C. Health plans and insurance companies may approach providers to enter into contracts to be a part of an ISN.
D. A combination of providers, purchasers and plans could form an ISN.

In some cases, technical assistance and start-up loans will be available.

11. How do ISNs fit in a competitive marketplace?

Competition can be an effective strategy for reducing costs and increasing quality and innovation. Therefore, competition between ISNs will be promoted and facilitated. 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. Information will be provided to consumers and providers in a form that facilitates direct comparisons between ISNs and is useful to consumers and purchasers in making decisions about ISNs.

However, ISNs are not just a tool for promoting competition. In some cases, competition may not be the most desirable or practical strategy, and regulation and state-supervised collaboration will be necessary for the benefit of consumers. In these unique situations, the ISN concept is an effective approach for controlling costs and enhancing quality and innovation even where competition does not exist.

INTEGRATED SERVICE NETWORKS: A discussion guide

12. How will providers function under the ISN?

Most providers are likely to have both ISN and non-ISN business. 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.

13. How will the ISN model serve 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 Minnesota Health Care 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 (those groups which have existing health conditions; are likely to require extensive care; and/or have special needs which add cost to providing care for them) will be included. Growth limits and payment systems will be designed to provide incentives for ISNs to enroll even the most challenging and costly groups and populations.

14. How will ISNs work 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. Perhaps more importantly, the ISN concept offers the potential for providers to be rewarded financially for becoming more efficient. The ISN concept has been tested in rural areas through several projects and has proven to be beneficial to providers, purchasers, and individual consumers when implemented properly.
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, ISNs and health plans for improvements when indicated.

Significant issues and concerns affecting rural Minnesota led the Minnesota Legislature to include in the HealthRight Act several specific rural health initiatives, including:

A. programs to increase the number of medical school graduates who practice primary care in rural areas, and loan forgiveness programs for rural practitioners;
B. financial assistance and transition grants for rural hospitals;
C. programs to establish rural community health clinics which will make greater use of mid-level practitioners; and
D. creation of an Office of Rural Health to promote improvements in the rural health care system.

The Commissioner of Health, the Minnesota Health Care Commission and the Regional Coordinating Boards are expected to remain actively involved in monitoring and promoting access while encouraging development of ISNs in rural areas.

15. What happens to services which are not provided through an ISN?

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 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.

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