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Minnesota Health Care Commission

Minnesota Health Reform Master Plan

Summaries and Progress Reports
for All MinnesotaCare Programs

Minnesota Health Care Commission
June 1994

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**Summaries and Progress Reports
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**Minnesota Health Care Commission
June 1994**

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Components of MinnesotaCare

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Health Care Reform in Minnesota

INTRODUCTION

Minnesota is entering its third year of health care reform. In 1992, the HealthRight Act was enacted as a result of an historic bipartisan agreement between legislators of both parties and the Governor. The HealthRight Act was a comprehensive approach to health care reform designed to improve access, quality, and affordability of health care. The Act included a new program to provide subsidized health coverage for the uninsured, data collection programs, programs to improve rural health care, a purchasing pool for small employers, strategies to control costs, insurance reforms to make private health coverage more available and more affordable, and other provisions. A second major health care reform act was passed during the 1993 session. The 1993 Act enhanced and refined existing reform programs and established a comprehensive cost containment plan based on the plan developed by the Minnesota Health Care Commission. The 1994 Act continued the state's progress toward implementing quality and cost containment programs and placed in statute a comprehensive plan developed by the commission for achieving universal coverage by 1997. Minnesota's health care reform effort is now known as "MinnesotaCare."

Master plan. This master plan brings together, in one document, descriptions and progress reports for all of the major components of MinnesotaCare. Programs and activities that require further legislative action are identified. Areas where progress is not being made are also identified.

Minnesota Health Care Commission. The Minnesota Health Care Commission is a 27-member commission that was created by the 1992 HealthRight Act to advise the Legislature and the Governor on health reform policy. The commission's members represent consumers, employers, health care providers, health plan companies, labor unions, and state government.

HEALTH REFORM GOALS

The three goals of Minnesota's health reform programs are quality, access, and affordability. Every component of MinnesotaCare addresses one or more of these goals. The goals are, of course, interrelated. For example, affordability of health care affects access to care. The primary strategies for each goal are:

Quality

- Improved data and information about quality, outcomes, and consumer satisfaction
- Incentives to improve quality
- Practice parameters
- Technology assessments

Access

- Subsidized health coverage for low-income uninsured persons
- Insurance reforms to make private health coverage more accessible and affordable
- A requirement that all Minnesotans maintain health coverage
- Rural health programs to improve access to services in rural communities
- Public health programs

- Market reform to improve access and purchasing power for individuals and small groups
- Strategies to address non-financial barriers to access to services and coverage

Affordability

- Growth limits to control the rate of increase of health care costs
- Delivery system restructuring: the Integrated Service Network (ISN) system and the Regulated All-Payer Option (RAPO)
- Insurance reform
- Promoting competition between health plan companies
- Practice parameters
- Technology evaluations
- Prevention
- Market reform
- Uniform billing forms and procedures
- Antitrust protection for cooperative activities that improve access, quality, and affordability
- Major expenditure reporting and review

MinnesotaCare Programs Summaries and Progress Reports

Universal coverage: Minnesota's commitment to cover the uninsured

Minnesota made progress toward improving the availability and affordability of health coverage as a result of the 1992 and 1993 MinnesotaCare Acts. The MinnesotaCare program offers subsidized coverage to the uninsured. Insurance reforms have improved the availability of affordable private coverage. These programs are described in other sections of this report.

The 1994 MinnesotaCare Act contains a legislative expression of the state's commitment to achieve universal health coverage for all Minnesotans by July 1, 1997, and places in statute the principles and strategies for the state's universal coverage plan. The universal coverage plan was developed by the Minnesota Health Care Commission, and is designed to achieve the following broad goals:

- Every Minnesotan will have health coverage and will contribute to the costs of coverage based on ability to pay;
- No Minnesotan may be denied coverage or forced to pay more because of health status;
- Quality health services must be accessible to all Minnesotans;
- All health care purchasers must be placed on an equal footing in the health care marketplace; and,

- A comprehensive and affordable health plan must be available to all Minnesotans.

The universal coverage plan contains the following major strategies: *insurance reform* to ensure that affordable private coverage is available to persons who have the means to purchase it on their own, *subsidized coverage* for persons who cannot afford to pay the entire cost of coverage, and *purchasing pools* to provide individuals and small groups an opportunity to purchase coverage as part of a large group. To assure that state programs are affordable and have adequate funding, the universal coverage plan calls for major *financing reform* to be enacted in 1995 based on a report to be submitted by the Minnesota Health Care Commission.

The major strategies of the universal coverage plan have the following features:

Insurance reform (*effective July 1, 1997*)

- **Guaranteed issuance:** all private health plan companies will be required to issue coverage without regard to health status or preexisting conditions

Insurance reform *(continued)*

- **Community rating:** health plan companies will be required to charge everyone the same premium for the same health coverage, rather than charging higher premiums for persons who represent a higher risk because of their health status or the existence of preexisting health conditions
- **No underwriting:** health plan companies will be prohibited from charging higher premiums or restricting coverage for persons because of their health status or the existence of preexisting health conditions
- **No preexisting condition exclusions:** health plan companies will be prohibited from excluding coverage of preexisting health conditions
- **Portability of coverage:** persons will be able to change jobs or switch health plan companies without facing the risk that they will lose health coverage or be charged unaffordable premiums

Subsidized coverage

- **MinnesotaCare subsidy program:** The MinnesotaCare subsidy program will continue its phase-in to provide basic health coverage for uninsured Minnesotans

- **Consolidation of state programs:** A goal of MinnesotaCare is that all of the state of Minnesota's health coverage programs will be combined into one streamlined program, and eventually combined with health programs for state employees.

Purchasing pools

- All Minnesotans will have opportunities to purchase health coverage as part of large groups, either through state-administered purchasing pools or through private purchasing pools

Financing reform

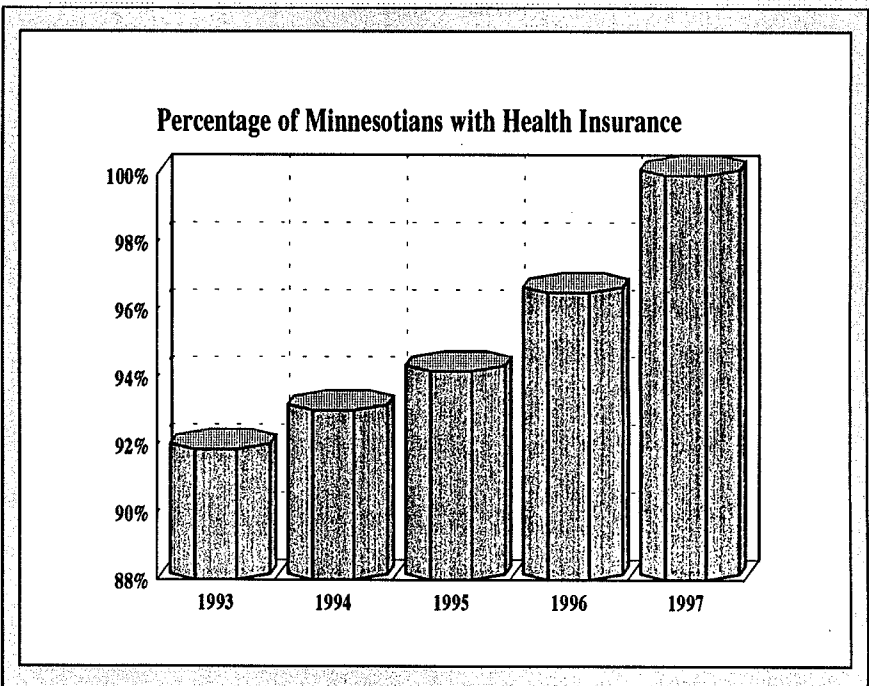
- The state's goal is to achieve universal coverage without a net increase in public and private spending in health care.
- Methods will be developed to identify and recapture savings from universal coverage to offset the costs of covering all Minnesotans.
- Perverse incentives in the existing financing and taxation systems will be eliminated

The state's universal coverage commitment and general strategy is now spelled out in state law. However, most components of the universal coverage plan will require further legislative action. Financing reform is likely to be a major issue during the 1995 legislative session because revenues from existing provider and premium taxes are expected to be inadequate to fully fund the MinnesotaCare Program through the state's 1996-1997 fiscal biennium.

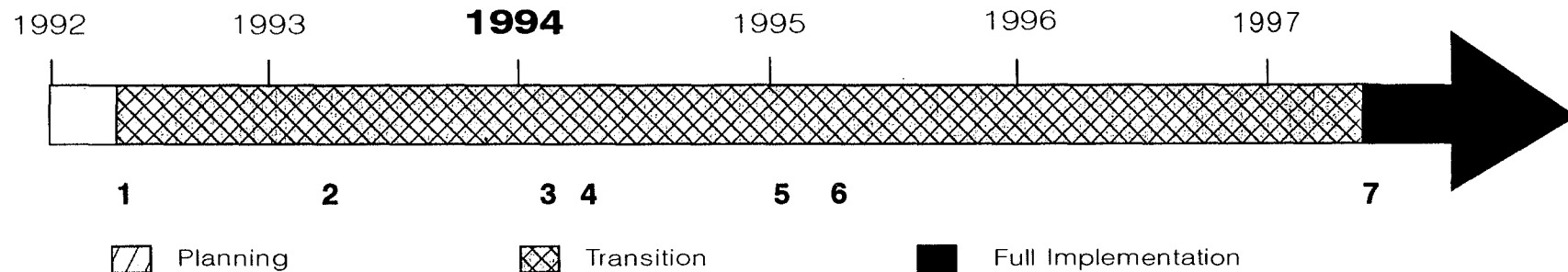
During 1994, the Minnesota Health Care Commission will obtain updated data on the number and characteristics of the uninsured, and will complete a financing study by January 1995 with recommendations to the Legislature on a stable, long term funding system for universal coverage. The Commission will also study and make recommendations to the 1995 Legislature on further market reforms, possible elimination or standardization of pre-existing condition limitations, health care affordability, and desirability of requiring all health plans to offer individual health policies.

Under the 1994 Act, a number of insurance reforms and requirements become effective in 1997. An individual mandate will require all Minnesotans to obtain and maintain qualifying coverage. Insurers will be required to renew or sell policies to anyone seeking to purchase coverage. Only very limited premium rate variations will be allowed among insurers. Insurance reforms are described in more detail in a later section of this report.

Minnesota Health Care Commission Universal Coverage Goals



Universal coverage



Key Dates

(Also see the progress reports for the MinnesotaCare subsidy program and insurance reform.)

- 1 **May 1992.** The 1992 MinnesotaCare Act establishes the MinnesotaCare program to provide subsidized coverage to the uninsured. The Act also contains insurance reforms and other strategies for improving access to health coverage. The Act represents a significant step to improve access but is not designed to achieve universal coverage.
- 2 **May 1993.** The 1993 MinnesotaCare Act directs the Minnesota Health Care Commission (MHCC) to develop a comprehensive plan to achieve universal coverage by 1997.
- 3 **February 1994.** The MHCC submits its universal coverage plan to the legislature and the governor.

- 4 **May 1994.** The 1994 MinnesotaCare Act, including the MHCC's universal coverage plan, is signed into law. The legislation contains a commitment to achieve universal coverage by 1997, and spells out the state's universal coverage strategies.
- 5 **January 1995.** The MHCC's recommendations on financing universal coverage will be submitted to the legislature and the governor.
- 6* **May 1995.** Anticipated date of enactment of financing reform, including stable, long-term financing for universal coverage.
- 7* **July 1997.** The target date for achieving universal coverage.

* Requires further legislative action.

MinnesotaCare Health Plan: subsidized health coverage for low-income uninsured Minnesotans

Minnesota's reform strategy includes insurance reforms and cost containment measures that are designed to increase the availability and affordability of private health coverage. These strategies are described in later sections. Even with full implementation of these reforms, however, many low-income Minnesotans will be unable to afford to pay the entire cost of private health coverage. The MinnesotaCare Health Plan was created in the 1992 HealthRight Act to provide state-subsidized health coverage to low-income, uninsured Minnesotans.

The MinnesotaCare Program began providing subsidized health coverage for low-income, uninsured Minnesotans in October 1992. Initially, the program covered only families with children. The program is scheduled to expand to include single adults and couples with no children on October 1, 1994. Over 91,000 individuals have enrolled in the program since October 1992. Over 70,000 individuals are currently enrolled.

To be eligible, applicants must have been without insurance coverage for at least four months and must not have had access to employer-subsidized coverage for at least 18 months (with some exceptions). Families with children with incomes up to approximately 275% of the federal poverty guideline are eligible for coverage. (The income cutoff for a family of three is \$32,640 a year.) Single adults and couples without children are eligible if their income does not exceed 125% of federal poverty guideline. This amount will increase to approximately

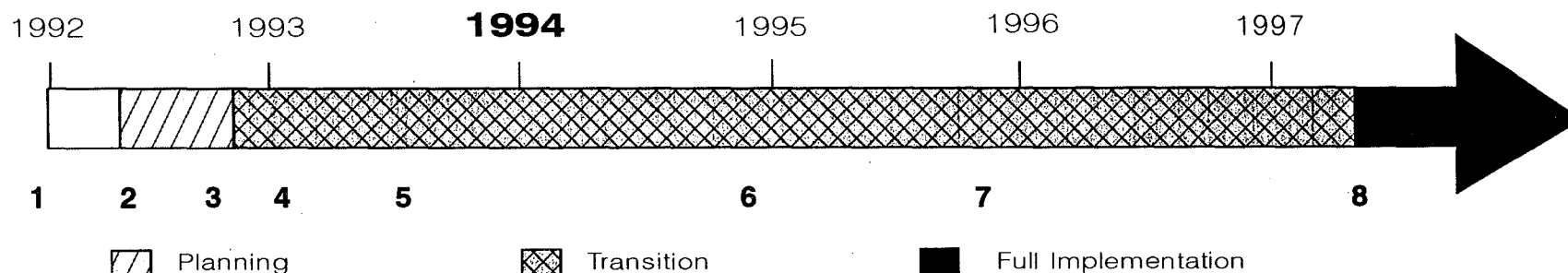
275% of the federal poverty guideline on October 1, 1995.

Enrolled individuals and families pay a premium that is based on their ability to pay.

The MinnesotaCare Health Plan covers a comprehensive array of services, including primary and preventive care as well as acute care and inpatient services. Inpatient hospital coverage for adults is limited to \$10,000 per year, in order to prevent erosion of the private insurance market and to facilitate the movement of individuals with catastrophic conditions to the federally subsidized Medical Assistance program.

The MinnesotaCare Health Plan is only one of several state health care programs. Reform goals and strategies for the state's health care programs are described in a later section.

MinnesotaCare Health Plan



Key dates

- | | |
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| <p>1 May 1987. The Children's Health Plan, the precursor to the MinnesotaCare Health Plan, was enacted to provide limited health coverage to uninsured children. Enrollment began July 1, 1988.</p> <p>2 April 1992. The 1992 HealthRight Act authorized the MinnesotaCare Program.</p> <p>3 October 1992. Enrollment began for families of children who were already enrolled in the Children's Health Plan.</p> <p>4 January 1993. Enrollment was expanded to include all eligible families with children, with incomes up to 275% of the federal poverty guideline.</p> | <p>5 July 1993. Coverage expanded to include inpatient hospital services.</p> <p>6 October 1994. Eligibility expands to include adults with no children, with incomes up to 125% of the federal poverty guideline.</p> <p>7 October 1995. Eligibility for adults without dependent children expands to 275% of the federal poverty guideline.</p> <p>8 July 1997. Proposed date for full implementation of a reformed state subsidy program for all low-income Minnesotans, with a permanent, stable revenue base.</p> |
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Insurance reform: improving access and affordability in the private insurance market

In the current private insurance market, many individuals, families, and employer groups are unable to obtain affordable coverage because health care plans consider them a poor risk due to their health history, age, occupation, or other characteristics. MinnesotaCare's insurance reforms are designed to make private health coverage more accessible and affordable, particularly for those who have existing health conditions or are considered higher risk. The two major goals of insurance reform are:

Guaranteed issuance: to require insurers to issue and renew coverage to anyone who desires it, regardless of their health status or risk

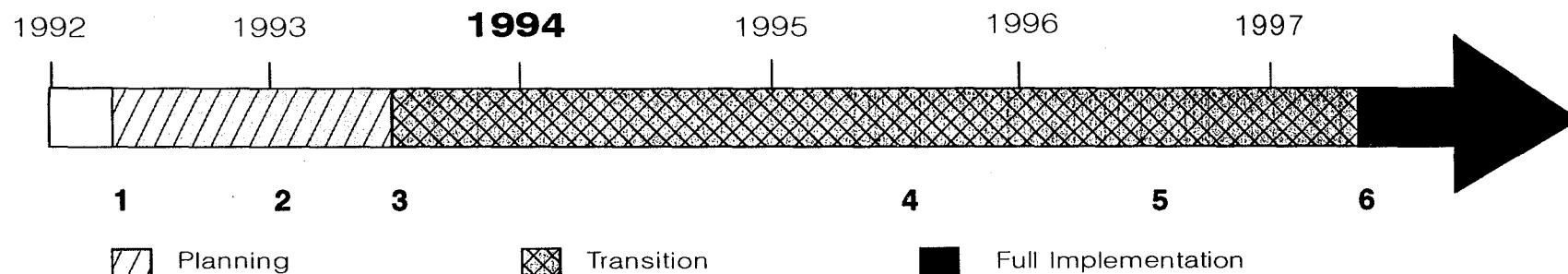
Community rating: to spread the costs and risk of health coverage more evenly across large populations.

Other insurance reform goals include portability of coverage and elimination of underwriting for pre-existing conditions.

Most of Minnesota's insurance reforms apply only to small group and individual health insurance policies. Federal Employee Retirement Income Security Act (ERISA) laws limit the ability of Minnesota and other states to regulate employee health benefit plans provided by "self-insured" employers.

Minnesota's insurance reforms are being phased-in over time, for two reasons. First, implementing insurance reforms too quickly would result in sizeable premium increases for healthy, low-risk individuals and groups, as higher cost persons reenter the market and premiums are evened out, creating the risk that insured persons will drop coverage. Second, the final steps toward guaranteed issuance and community rating must be timed to coincide with universal coverage and a fully funded subsidy program. Otherwise healthy individuals and groups would be able to choose not to obtain coverage until they need it, at which time insurers would be obligated to issue coverage, thereby driving up the cost of coverage for everyone.

Insurance reform



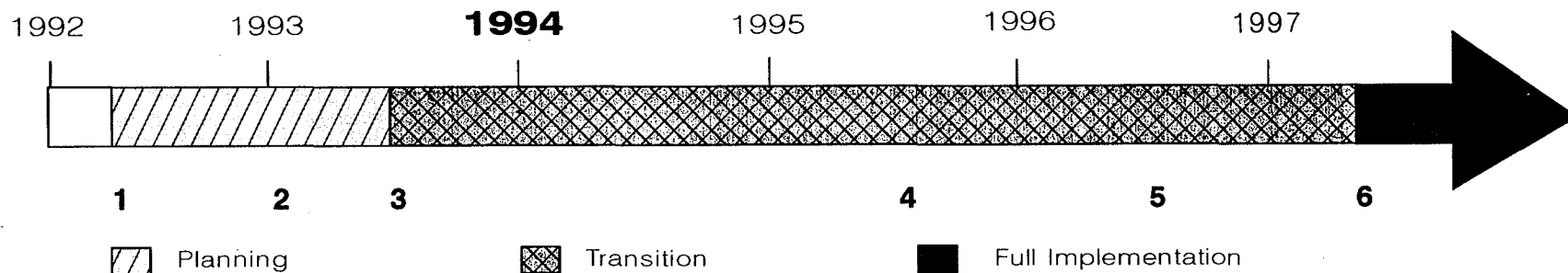
Key dates

- 1 **April 1992.** Insurance reforms enacted in the 1992 HealthRight Act.
- 2 **January 1993.** Effective date of provision allowing 100% deduction from state income for premiums for self-employed persons.
- 3 **July 1993.** Effective date for HealthRight small group and individual insurance reforms, including unisex rating, rate bands of $\pm 25\%$ for certain factors and $\pm 50\%$ for age, portability of coverage from group to individual coverage within the same

carrier, guaranteed issue in the small group market, guaranteed renewal in small group and individual markets, a new minimum benefit package for the small group market, restrictions on pre-existing conditions limitations, increasing loss ratios in small group and individual markets, rate approval for small group and individual markets, prohibition of carving out higher risk employees.

(Numbers 4-6 are on next page)

Insurance reform *(continued)*



Key Dates *(continued)*

4 July 1995. Size of employer groups eligible to benefit from guaranteed issuance and renewal, restricted rate bands, unique small group benefit packages and other projections for small groups changes from groups 2-29 eligible employees to 2-49 eligible employees. Rate bands for individual and small group narrows to $\pm 12.5\%$ for certain factors and 25% for age. Portability of coverage to any group or individual health plan will be guaranteed to individuals who maintain continuous coverage and whose preceding coverage was medical assistance, general assistance medical care or MinnesotaCare.

5 July 1996. Rate bands for individual and small group narrows to $\pm 7.5\%$ for certain factors and $\pm 15\%$ for age.

6* July 1997. Proposed effective date for requiring all Minnesotans to have health coverage, and for full implementation of the following insurance reforms in all markets over which the state has regulatory authority: unconditional guaranteed issue and renewability, portability of coverage across all markets, elimination of underwriting and preexisting condition limitations, full community rating.

* Requires further legislative action.

Data initiatives: collecting and disseminating useful information on health care costs, quality, and outcomes

The success of MinnesotaCare's quality, access and affordability programs depends on having better data on cost, quality and outcomes. An essential component of MinnesotaCare is the development of a data system. Data is needed for four important purposes:

- to monitor the broad effects of health care reform on quality, access, and affordability;
- to set and enforce growth limits (systemwide, and for individual health carriers and providers);
- to make health plans and providers publicly accountable for quality, access, and costs;
- to help consumers and purchasers compare health plans and providers on the basis of quality, access and cost.

Some of the specific types of information that will be available because of the data collection program are:

- Statewide information on health care spending, revenues, prices and risk factors;
- Data to monitor the short-term reduction in spending;
- Comparative information on health plan costs, quality,

access, utilization, and benefit structures;

- Hospital quality reports;
- Information on outcomes and consumer satisfaction;
- Data on administrative costs;
- Studies of regional and county differences in health status and access;
- Data on major capital expenditures (more than \$500,000).
- Data from "action plans" that must be submitted annually by all health plan companies to the state beginning July 1, 1994.

Minnesota Health Data Institute

The Minnesota Health Data Institute is a public-private mechanism for coordinating data collection activities. The Institute is a partnership between the Commissioner of Health and a Board of Directors. The Institute and the Commissioner will work together to establish a centralized cost and quality data system that will be used by both public and private "customers." The goal is to create an integrated data system that will provide clear, usable information on the cost, quality and structure of health care services in the state of Minnesota in a publicly accountable manner. The data system will be structured to utilize "electronic data interchange" (EDI) mechanisms.

The Data Institute is governed by a 20-member Board of Directors. The board is appointed by a variety of organizations, as specified in statute, and represents hospitals, HMOs, Blue Cross and Blue Shield, insurers, consumers, purchasers, physicians, teaching institutions, nurses, and state agencies.

Analysis and development of reports

The data collected through the Data Institute, together with data from aggregate surveys and other sources, will be used by the Department of Health to develop reports and other information for a variety of audiences.

Reports on Quality and Outcomes of Care

The Data Analysis Program in the Department of Health will develop health plan report cards, reports on outcomes of care for specific health conditions, provider profiling reports, and other reports on quality of care for consumers, policymakers, purchasers, providers and health plans. Hospital quality reports will also be developed.

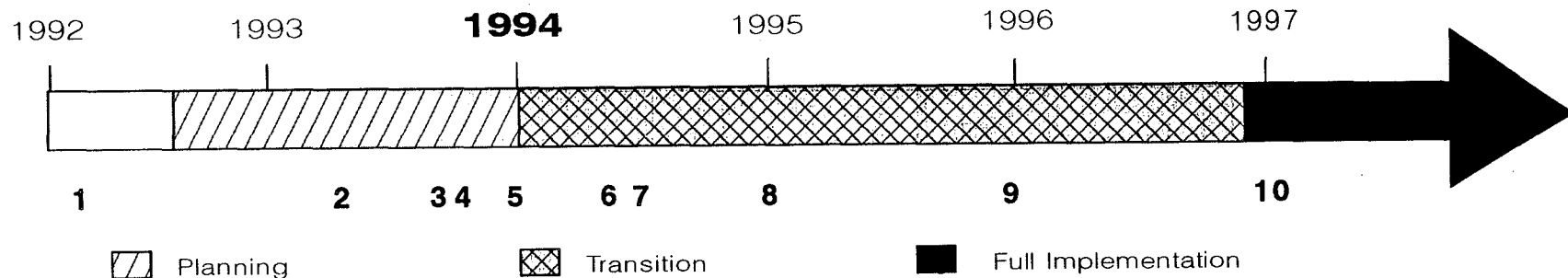
Economic studies

The Health Economics Program in the Department of Health will develop economic analyses for policymakers, and use the data for monitoring and enforcing the limits on the rate of growth in health care expenditures in the state.

Dissemination of Reports

Information will be provided to consumers, providers, insurers, employers, and others through the Health Information Clearinghouse. This information will help consumers and purchasers make more informed decisions about purchasing health coverage and using health care providers and services effectively. It will also help providers and health plans evaluate and improve their quality and cost-effectiveness.

Data initiatives



Key dates

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| <p>1 April 1992. 1992 HealthRight Act establishes the Data Analysis Program in the Department of Health and the Data Collection Advisory Committee.</p> <p>2 May 1993. The Data Institute is created by statute.</p> <p>3 September 1993. The Data Institute holds its first meeting.</p> <p>4 October 1993. Commissioner of Health submits Data Collection Plan to the Legislature.</p> <p>5 December 1993. Emergency data collection rules are adopted requiring providers, insurance companies, and group purchasers to submit data.</p> <p>6 May 1994. Legislature requires the Department of Health to develop hospital quality measures and to conduct a pilot study on provider perspective on access</p> | <p>and quality. Legislature authorizes the Data Institute to develop a standard patient satisfaction survey.</p> <p>7 June 1994. Target date for the development of a standard patient satisfaction survey by the Data Institute.</p> <p>8 December 1994. Anticipated date for development of first health plan report cards.</p> <p>9 December 1995. Anticipated date for completion of reports on outcomes and practice patterns associated with the first three health conditions. Quality indicators are expanded and reported for all health insurance companies.</p> <p>10 December 1996. Target date for full implementation of data collection plan and electronic data interchange standards.</p> |
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Health care information: providing information on health care costs and quality

A recurring theme in many of MinnesotaCare's programs is providing better information about health care costs and quality. The Health Information Clearinghouse was established in the 1993 MinnesotaCare Act to provide easy access to health information for consumers, employers, providers, health carriers, and the public.

The Clearinghouse will provide information to diverse audiences, including providers, health insurance administrators, hospital administrators, health policy analysts, managed care professionals, legislative staff, employers, and the general public. Among the types of information that will be distributed by the Clearinghouse are:

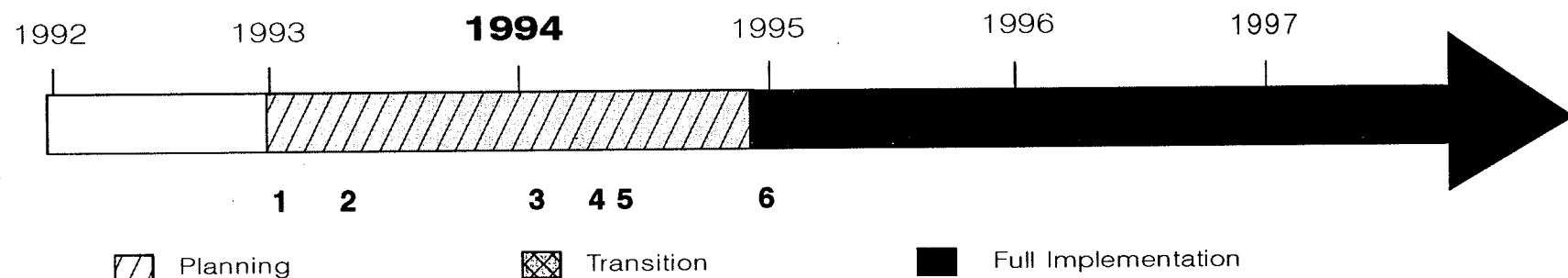
- Report cards for ISNs and other health carriers
- Practice parameters
- Technology assessments
- Information on health reform programs
- Information about purchasing pools
- Quality and outcomes information
- Hospital quality data
- Information on health plan companies by geographical areas

During the 1994 Minnesota legislative session, the Legislature authorized the creation of an Office of Consumer Information

within the Health Information Clearinghouse. The office was created to assist health plan company enrollees and to serve as a resource center for enrollees. As mandated by the 1994 Act the office will:

- Assist enrollees in understanding their rights;
- Explain and assist in the use of all available complaint systems, including internal complaint systems within health carriers, community integrated service networks, integrated service networks, and the departments of health and commerce;
- Provide information on coverage options in each regional coordinating board's region of the state.
- Provide information on the availability of purchasing pools and enrollee subsidies; and
- Help consumers use the health care system to obtain coverage.

Health care information



Key dates

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| <p>1 January 1993. The MHCC recommends creating an information clearinghouse.</p> <p>2 April 1993. The MinnesotaCare Act authorized the creation of the Information Clearinghouse.</p> <p>3 January 1994. The Clearinghouse released its first health reform newsletter.</p> <p>4 April 1994. The Clearinghouse makes available numerous Minnesota health reform publications.</p> | <p>5 May 1994. Minnesota Legislature authorized the creation of the Office of Consumer Information.</p> <p>6 December 1994. Release of first health plan report card. Release of practice parameters and patient guides for first three condition areas.</p> |
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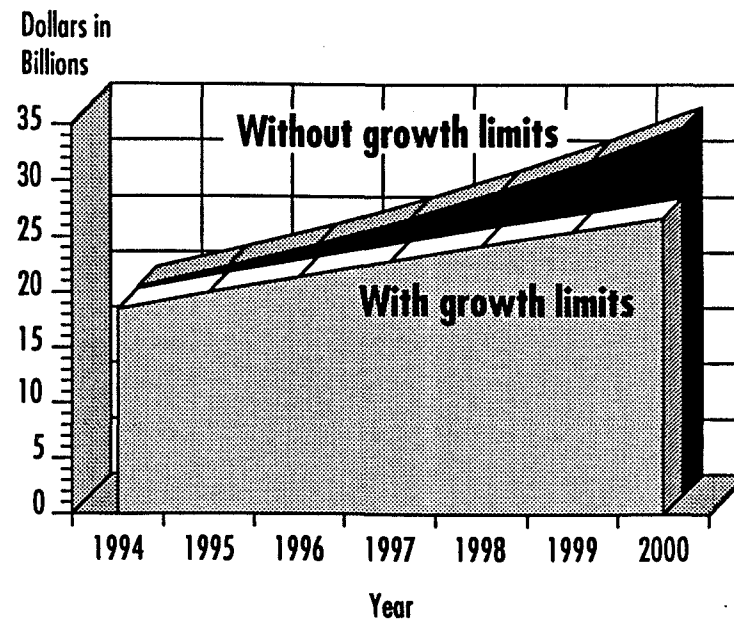
Growth limits: limiting the annual rate of increase in public and private health care costs

The Commissioner of Health is responsible for enforcing annual limits on the rate of increase in total public and private health care spending in Minnesota. The growth limits are designed to reduce the rate of growth by at least ten percent each year for the next five years. Growth limits will be enforced through overall global limits on Integrated Service Networks (ISNs), and through the regulated all-payer option (RAPO) which will control price and utilization for all services that are not covered by an ISN. (The ISN/RAPO system is described in more detail in the next section.) Interim growth limits will control increases in health plan spending and provider revenues until the ISN/RAPO system is in place.

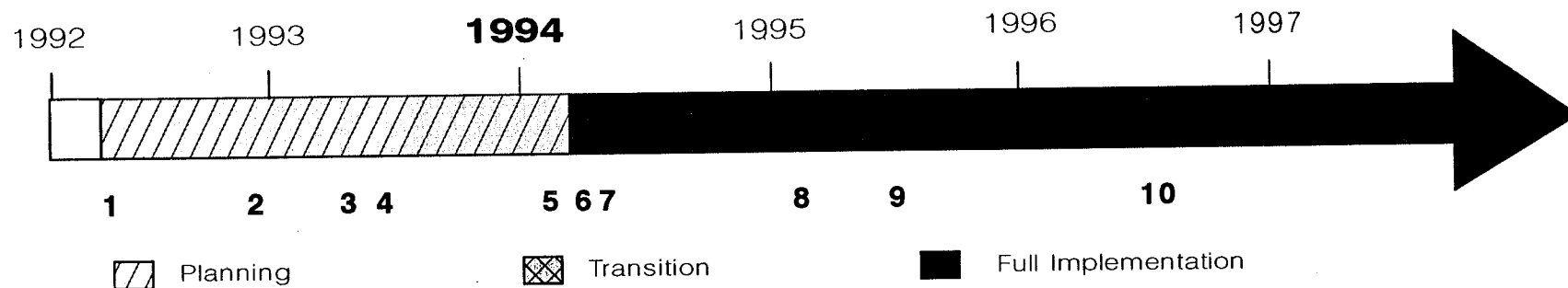
In addition, the Commissioners of Health and Commerce will monitor health plan company reserves and net worth for the company each commissioner respectively regulates to ensure that savings from expenditure limits are passed on to consumers in the form of lower premium rates. Health plan companies with reserves less than the required minimum or greater than the allowed maximum at the end of the year will submit a plan of corrective action to the appropriate commissioner. The plan of correction must show how the health plan company will come into compliance, and a timetable for achieving compliance.

Growth limits: on health care spending 1994 - 1998		
1994	-	9.4%*
1995	-	8.3%**
1996	-	7.4%**
1997	-	6.7%**
1998	-	6.0%**
* Actual		
** Projected		

Minnesota Health Care Spending 1994-2000



Growth limits

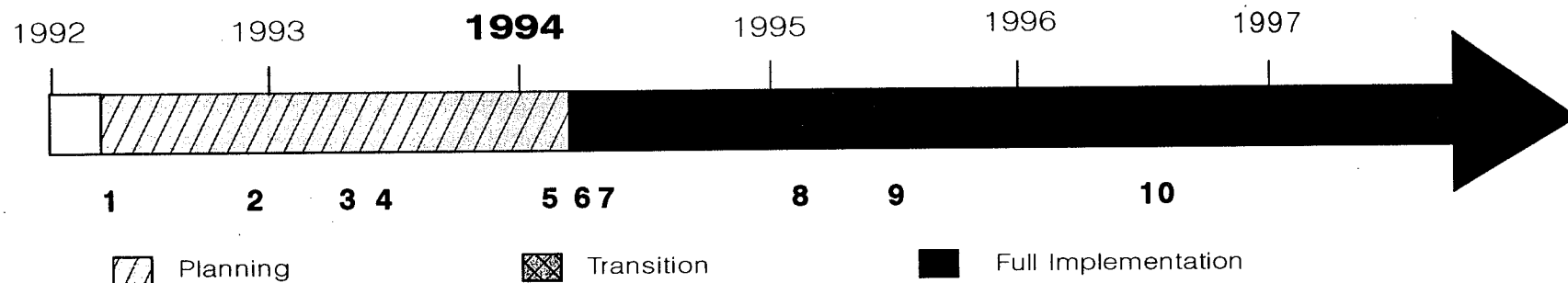


Key dates

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| <p>1 April 1992. The 1992 HealthRight Act establishes growth limit targets to reduce the rate of growth in public and private health care spending by at least ten percent a year. The Minnesota Health Care Commission is assigned the task of developing a plan to implement the growth limits.</p> <p>2 November 1992. Interim data collection is commenced to collect data on rates of growth in health care spending.</p> <p>3 April 1993. The Commissioner of Health establishes the 1991 baseline growth trend at 10.8%; estimates 1994 health care spending at 10.2%; and develops a methodology to set growth limits.</p> | <p>4 May 1993. The 1993 MinnesotaCare Act is passed. It includes annual growth limits for the next five years and establishes a methodology to implement interim growth limits for 1994 and 1995.</p> <p>5 April 1994. Baseline data for 1993 submitted by payer and providers.</p> <p>6 May 1994. The 1994 MinnesotaCare Act is passed. It extends the interim growth limits for 1996 and 1997 until the ISN and RAPO systems are fully developed.</p> |
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(Numbers 7-10 are on next page)

Growth limits *(continued)*



Key Dates *(Continued)*

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| <p>7 May 1994. Commissioners of Health and Commerce will monitor health plan company reserves, and require plans of correction from health plan companies outside of required reserve requirements.</p> <p>8 February to July 1995. Data and reports are evaluated and audited to determine compliance with the first full year under growth limits (over 1993).</p> | <p>9 July 1995. Names of payers that exceeded the growth limit for 1994 are published.</p> <p>10 July 1996. Enforcement process begins for payers and providers that exceeded the growth limits based on two-year aggregate data.</p> |
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ISN/RAPO system: improving quality, access and affordability through restructuring the health care delivery system

Expanding health care coverage to the uninsured, while maintaining or improving quality, requires systemwide changes to contain health care costs and to get more value from each health care dollar already being spent.

A dual system of Integrated Service Networks (ISNs) and a Regulated All-Payer Option (RAPO) will contain health care costs and improve access and quality. ISNs are a new kind of health plan that will be accountable for the cost and quality of health care services provided to its members and communities served. Under the ISN system, providers and insurers will have incentives to prevent illness, improve quality, and control costs. Competition between ISNs will be encouraged and facilitated. "RAPO" is the name for the cost containment and quality regulations that will govern all health care services that are not covered by ISNs. RAPO will include a uniform fee schedule and standardized payment and utilization review systems. RAPO requirements will be managed to ensure that the rate of growth of health care costs in the non-ISN sector will remain under the annual growth limits. The ISN/RAPO concept was developed by the Minnesota Health Care Commission, and had the support of all the major stakeholder groups through their appointed representatives on the Commission.

The ISN/RAPO system approved by the 1993 Legislature, was further refined in the 1994 MinnesotaCare Act, and will be phased in between 1994 and 1997.

The plan for phasing in ISNs and the RAPO was developed by the Minnesota Department of Health in consultation with the Minnesota Health Care Commission. The planning process also incorporated extensive research of issues and options, and many opportunities for public and stakeholder group input, including six public hearings around the state, and wide dissemination of two discussion drafts.

The transition to the ISN/RAPO system will begin July 1, 1994, with requirements for fuller disclosure to consumers, purchasers, and communities of the characteristics and performance of existing health plan companies such as HMOs, Blue Cross and Blue Shield of Minnesota, and traditional indemnity insurers. Standard billing and utilization review processes will also be instituted to reduce paperwork and costly administration. Small, locally governed "Community ISNs" will be allowed to form in January 1994. Rules will be developed in 1995 and 1996 to further describe the details of the ISN/RAPO system. Beginning July 1, 1997, health plan companies will operate under regulations governing ISNs, or under regulations governing the RAPO.

Serving high risk and special needs populations through risk adjustment

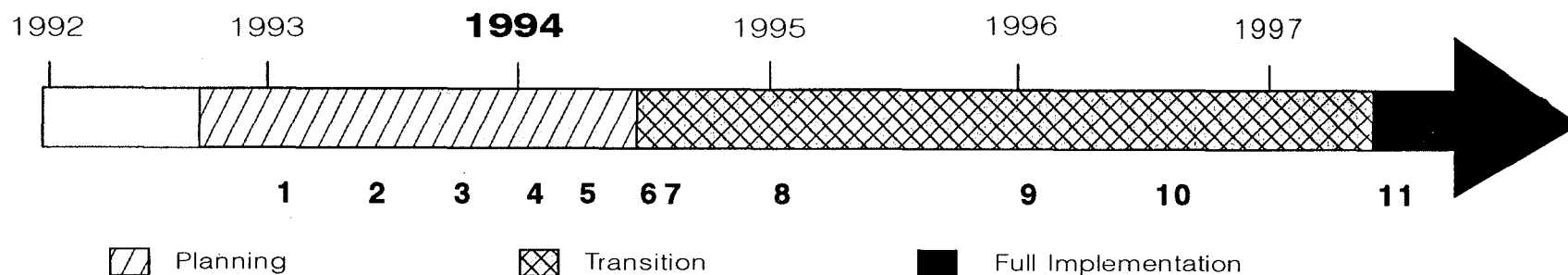
Also by July 1, 1997, the state will develop and implement a risk adjustment system. Risk adjustment is needed to remove current disincentives to insure and serve high risk and special needs populations, and to help assure the viability of all health plan companies by promoting fair competition on the basis of efficiently providing services rather than on the health status of a plan's insurance pool.

Action plans: improving accountability of health plan companies

Beginning July 1, 1994, all health plan companies will be required to begin submitting annual "action plans" to the state as a condition of doing business in Minnesota. The purpose of the action plan requirement is to achieve fuller disclosure of health plan company practices and operations that will promote sound, well-informed decisions by consumers, purchasers, and government. The action plans must include the health plan company's policies and practices regarding its: selection, use, and availability of health care providers; enrollment of high risk and special needs populations; use of quality data to monitor and improve quality; and planned or existing efforts to offer coverage in rural and other communities it currently does not serve.

Action plans are required solely to provide information, and copies of the plans will be available to a large variety of potential end-users through the state's health care Information Clearinghouse. Health plan companies with fewer than 50,000 members must submit action plans, if they have no plans or policies with regard to categories above, they have only to report this on their submission.

ISN/RAPO system



Key dates

- | | |
|--|---|
| <p>1 January 1993. The Minnesota Health Care Commission unanimously passes a cost containment plan containing the ISN/RAPO concept.</p> <p>2 May 1993. The ISN/RAPO system is enacted into law, and the Commissioner of Health is assigned the task of developing an implementation plan and proposed legislation, in consultation with the Commission.</p> <p>3 August 1993 through January 1994. Development of implementation plan, including public hearings around the state, wide dissemination of discussion drafts for review and comment, and numerous public meetings and discussions.</p> <p>4 February 1994. The Commissioner of Health's implementation plan is submitted to the Legislature.</p> | <p>5 May 1994. Enactment of ISN/RAPO revisions and implementation timeline. Some new requirements for all existing health plan companies take effect.</p> <p>6 July 1994. Effective date of legislation which allows formation of new, small, community-based ISNs. Additional new requirements for all existing health plan companies take effect.</p> <p>7 July 1994. "Action plans" must be submitted to the state by all health plan companies describing whether and how the company addresses or plans to address issues of: provider selection, use, and availability; enrolling high risk and special needs populations; and initiatives to improve quality and serve communities it current does not serve.</p> |
|--|---|

(Numbers 8-11 are on next page)

Key Dates *(continued)*

- 8 **January 1995.** Community ISNs may begin proving coverage. Due date for ISN/RAPO transition plan from the Minnesota Department of Health (MDH) and MHCC. Effective date for standard billing and utilization review process and first stage of risk adjustment implementation.
- 9 **January 1996.** ISN and RAPO rules and laws must be enacted or adopted. Phase-in of RAPO begins.

10 **July 1996.** Voluntary formation of ISNs may begin.

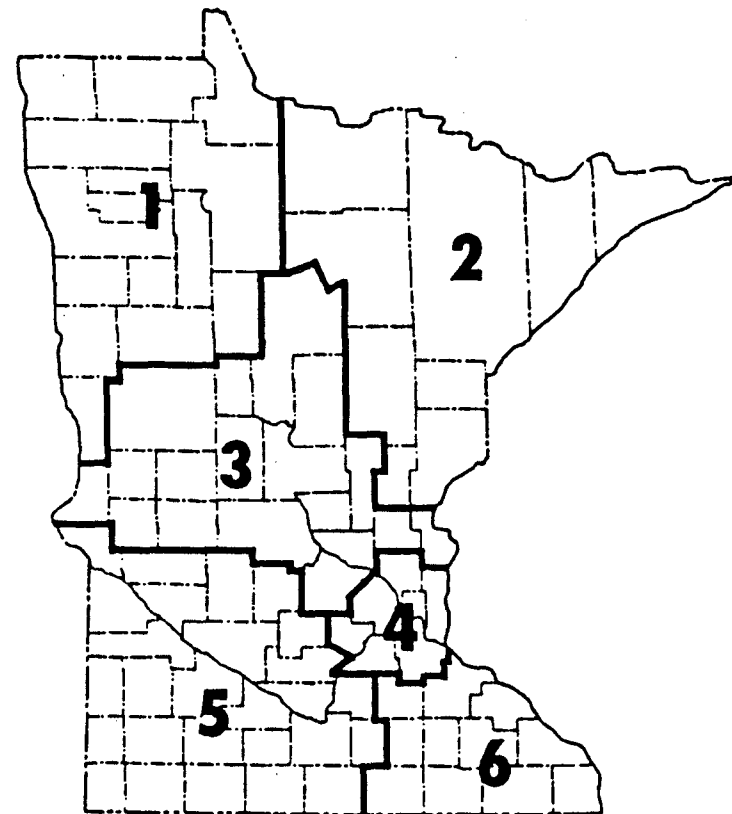
11* **July 1997.** Anticipated date for full implementation of the ISN/RAPO system, including recodification and reform of all laws regulating health carriers. Anticipated date for full implementation of a risk adjustment mechanism.

* Requires further legislative action.

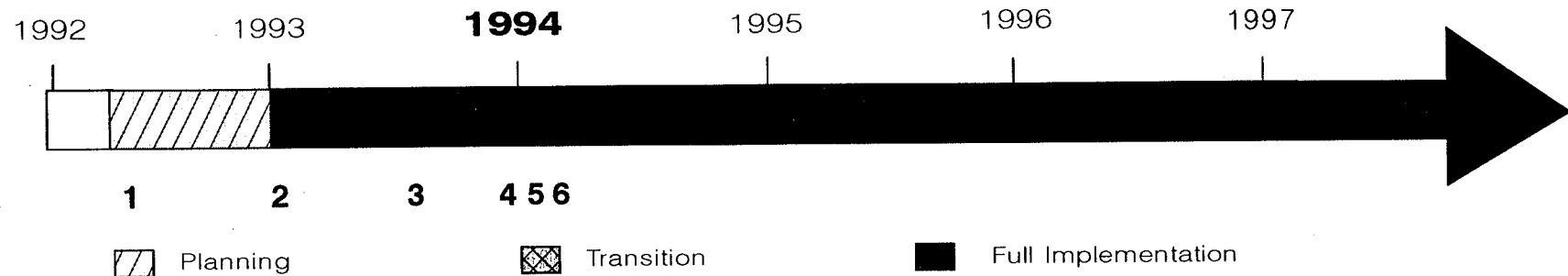
Regional coordinating boards: assuring regional involvement and advice on health care issues

Six Regional Coordinating Boards (RCBs) advise the Commissioner of Health on issues relating to access, quality, and affordability of health care in each region. The boards also function as a community forum to bring together representatives of consumers, providers, insurers, employers, and other major stakeholders to discuss ways of improving the effectiveness of the regional health care system.

Each RCB has 17 members representing consumers, employers, health care providers, health plan companies, labor unions, county commissioners, and state agencies.



Regional coordinating boards



Key dates

- | | |
|---|---|
| <p>1 April 1992. The 1992 HealthRight Act authorizes the formation of Regional Coordinating Boards.</p> <p>2 January 1993. RCB members are appointed and the boards begin to meet.</p> <p>3 June 1993. RCBs submit their work plans to the Commissioner of Health.</p> | <p>4 November/December 1993. RCBs host public hearings on ISN/RAPO drafts.</p> <p>5 January 1994. RCBs submit Interim Report to the Commissioner of Health.</p> <p>6 January 1994. Pilot project initiated to determine a process for adopting regional public health goals.</p> |
|---|---|

Public health: strengthening and supporting the public health system

Our present health system is composed of two subsystems--the public health subsystem and the health care delivery subsystem. In Minnesota, the public health subsystem is anchored in the state's Community Health Services system, a partnership between the Minnesota Department of Health and the 49 local Community Health Boards around the state. The public health system will continue to play an important role in Minnesota's reformed health care system.

The primary goal of public health is to fulfill the community's interest in assuring the conditions in which members of the community can be healthy. Achieving the goal of public health is a shared responsibility of our citizens, their communities, and their elected officials. Under the state's health care delivery subsystem reforms, private sector providers and health plan companies will have stronger incentives and obligations to improve not only the health of their own patients and enrollees, but also the health of the entire community. As a result, the public health community will be better able to pool resources with its new partners to help achieve public health goals.

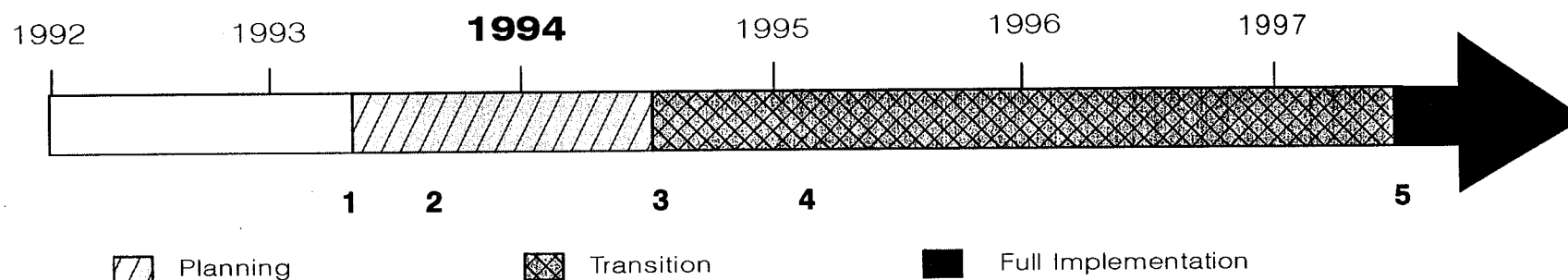
To most effectively and efficiently achieve these public health goals, health plan companies will work in tandem with public health agencies and others in the community on planning and developing innovative strategies to achieve the joint goals. The public health subsystem will have a continued responsibility to routinely assess the health status of the community and bring

people together to plan and implement strategies to improve community health. It will also continue to work to assure that systems and services are organized efficiently to maintain and promote the health status of Minnesotans and prevent unnecessary disease and disability.

The health care delivery and public health subsystems are interdependent. Both systems do, and must, complement and interact with each other. Health care delivery subsystem reform will change the service mix provided by the public health system, as universal coverage is achieved and private sector providers and health plan companies become more effective in serving the needs of high-risk and special needs populations.

For overall health reform to be successful, health care delivery subsystem reform must be paralleled by reform of the public health subsystem, including definition of core function and agreement on priorities. Careful planning is needed to coordinate the two subsystems. Funding systems must also be reformed and restructured to make sure the public health system is supported and to assure that all Minnesotans receive quality services. Planning for public health subsystem reform is currently underway at the county and state levels. Implementation of public health subsystem reform will take place in coordination with health care delivery subsystem reform.

Public health



Key dates

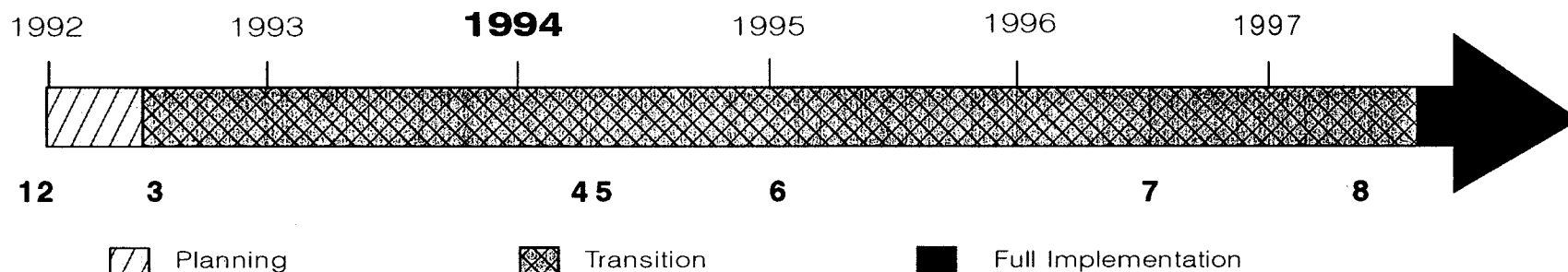
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| <p>1 May 1993. The 1993 MinnesotaCare Act is enacted, including provisions requiring ISNs to cooperate with communitywide efforts to improve the health of communities and requiring them to serve high-risk and special needs populations.</p> | <p>3 July 1994. First draft of statewide and regional public health goals are published. Final approval by the Commissioner of Health scheduled in November 1994.</p> |
| <p>2 September 1993. The Commissioner of Health releases a discussion paper on the health reform impact on the public health system, and asks the State Community Health Service Advisory Committee to provide advise on this issue.</p> | <p>4 February 1995. Proposed date for the Commissioner of Health to release recommendations for core public health functions and stable funding source.</p> |
| | <p>5 1997. Proposed date for implementing a new funding structure for the public health system.</p> |

State health programs: simplifying and improving state health care programs

Minnesota has a complicated, fragmented system of programs to provide health care to low-income individuals and individuals with special needs. Health-related programs are administered by the departments of Human Services, Health, Employee Relations, Labor and Industry, Education, and other agencies. Each program has its own eligibility requirements, forms, procedures and administrative structure.

Under MinnesotaCare health reform, the Medical Assistance, General Assistance Medical Care, and MinnesotaCare programs will be integrated and delivered through managed care health plans. Another goal of MinnesotaCare is to eventually coordinate all of the state's health care purchasing programs, including workers' compensation and state employee health plans. An overhaul of the tax and financing system is needed to produce a rational, stable financing system for all government programs.

State health programs

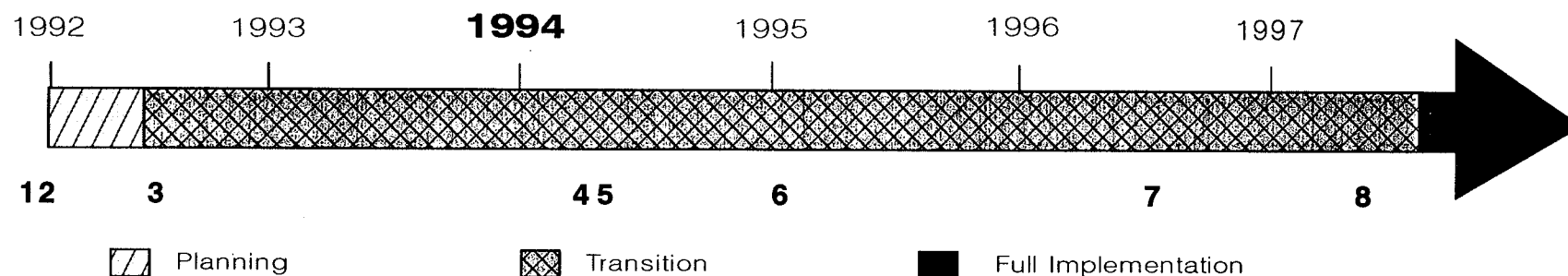


Key dates

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|---|---|
| <p>1 1976. Department of Human Services began contracting with managed care plans for MA, GAMC clients who voluntarily choose to enroll in HMOs.</p> | <p>4 March 1994. Plan describing state agency health care activities and proposal to consolidate purchasing is sent to Legislature.</p> |
| <p>2 July 1985. The Medicaid Prepayment Demonstration Project began contracting with managed care health plans for services to Medical Assistance and General Assistance Medical Care clients who are required to enroll in their choice of plans.</p> | <p>5 May 1994. Legislation is enacted authorizing state agencies to proceed further with plans to consolidate state programs and to seek federal approval of the consolidation. MinnesotaCare Legislation authorized Department of Human Services to begin combining administrative functions with the Department of Employee Relations to purchase health services.</p> |
| <p>3 May 1992. The HealthRight Act required a plan for consolidating state health care purchasing.</p> | |

(Numbers 6-8 are on next page)

State health programs *(continued)*



Key dates *(continued)*

6 January 1995. Proposed date for MHCC to submit recommendations to the Legislature on financing reform and revenue sources for fully funded state health care programs.

7* July 1996. Proposed date for combining the MinnesotaCare and general assistance medical care programs.

* Requires further legislative action.

8 July 1997.** Proposed date for full implementation of a state program to provide comprehensive health coverage to all low-income uninsured persons. Proposed date for combining Medical Assistance and MinnesotaCare Program.

** Requires further legislative action and federal waivers.

Prevention: preventing illness and injury and improving the health of communities

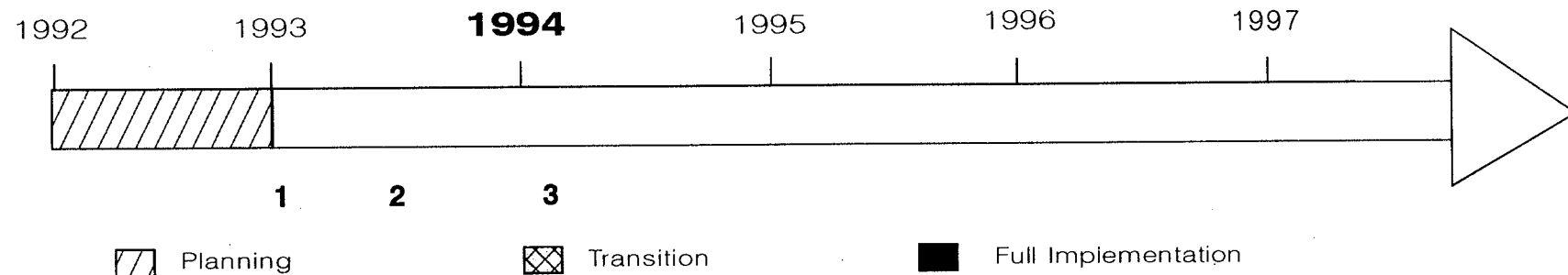
To achieve Minnesota's cost containment goals, prevention activities must be expanded and improved. ISNs and growth limits will increase the incentives for health plans and providers to prevent illness. However, communitywide support for preventive services that have been proven to reduce health care costs must be expanded. Unhealthy lifestyles which contribute to high health care costs must also be discouraged. In its 1993 report, the Minnesota Health Care Commission recommended a package of prevention programs that were designed to produce significant cost savings through the prevention of illness and injury. Most of the prevention strategies proposed by the commission were not enacted. Enhanced statewide and regional prevention programs remain a missing piece in Minnesota's otherwise comprehensive reform strategy.

MHCC recommendations.

In February 1994, the Minnesota Health Care Commission issued another report with new recommendations for prevention. These recommendations include:

- Tobacco and alcohol tax increases to prevent smoking and excessive alcohol use
- Violence prevention programs
- Make non-use of vehicle restraints a primary offense
- Require use of helmets on motorcycles, snowmobiles and all-terrain vehicles
- Worksite wellness and health promotion
- Programs to improve birth outcomes

Prevention



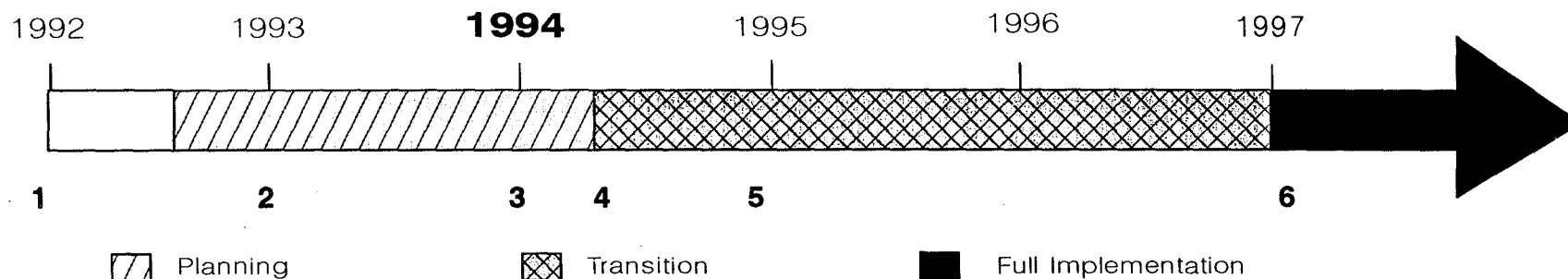
Key dates

- 1 **January 1993.** The Minnesota Health Care Commission submitted its recommendations for prevention initiatives.
- 2 **May 1993.** The fine for not using automobile child restraints was raised to \$50 effective August 1, 1993.
- 3 **February 1994.** The commission submits new prevention recommendations.

Uniform billing and claims forms: reducing administrative cost by standardizing billing and payment forms

Health care providers, third-party payers, and purchasers currently use hundreds of different billing and payment forms and procedures. The 1992 MinnesotaCare legislation directs the Commissioner of Health to develop uniform billing forms, uniform electronic billing procedures, and other uniform claims procedures. The Commissioner and the MHCC recognized the Administrative Uniformity Committee (AUC) as the major vehicle to develop these recommendations. The AUC is a statewide, voluntary group representing public and private payers, hospitals, physicians, and other health care providers. Its purpose is to develop consensus regarding uniform billing and other administrative policies and procedures that will reduce costs and improve the quality of health plan and provider administrative functions. The AUC has developed recommendations on the designation and use of standard claims forms (the UB92 for institutions, the HCFA 1500 for providers, and the ADA form for dental services), electronic data interchange, uniform patient and provider identifiers, and standardization of patient ID cards. The AUC is also involved in national Workgroup on Electronic Data Interchange (WEDI) committees and discussions to stay informed on national efforts in this area, and also to influence these national efforts. Recommendations developed by the AUC were implemented through legislation in 1994, with full implementation in 1997.

Uniform billing and claims forms



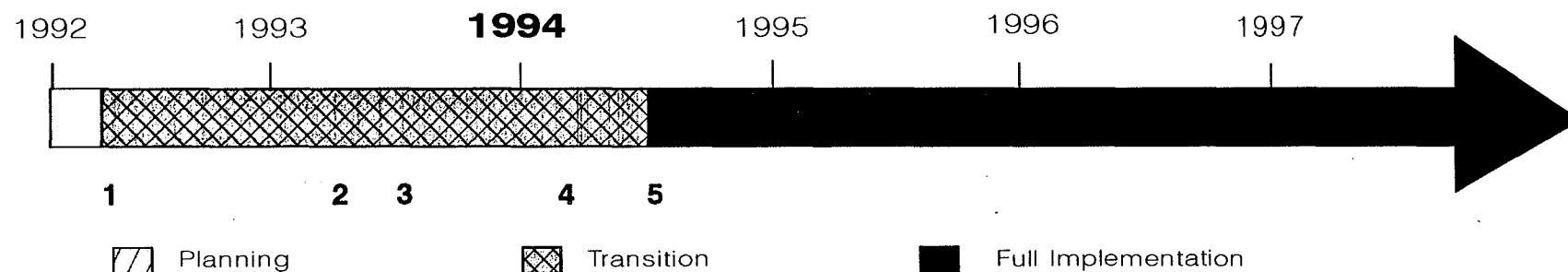
Key dates

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| <p>1 1991. Administrative Uniformity Committee (AUC) is formed to develop recommendations on uniform billing forms and procedures.</p> <p>2 December 1992. The AUC presents preliminary recommendations to the MHCC and Commissioner of Health.</p> <p>3 December 1993. AUC finalizes recommendations on standard billing forms, definitions and specifications.</p> <p>4 May 1994. The Administration Simplification Act is enacted requiring use of UB92, HCFA 1500 and ADA forms by all payers and providers, mandating the use of a standard patient, provider, and group purchaser identifier consistent with WEDI recommendations, and requiring the phase in of standards for patient ID cards. Phase in of</p> | <p>UB92, HCFA 1500 and ADA billing forms, definitions, and specifications begins. Phase in of standard patient and provider identifiers begins.</p> <p>5 December 1994. Anticipated date for dissemination of information on rules covering uniform definitions for claims forms, standard ID cards, and additional documentation.</p> <p>6 January 1997. Target date for full implementation of standard billing forms, definitions, and specifications; and full implementation of standard patient and provider identifiers.</p> |
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Practice parameters: developing statements regarding effective courses of treatment and providing malpractice protection for providers who follow them

The practice parameter initiative of the MinnesotaCare health care reform program has been established for the purpose of promoting the use of the best available knowledge about the most cost-effective courses of health care statewide. Practice parameters are statements designed to guide the clinical decision-making of health care providers and patients that are supported by outcomes research, or approved by the federal Agency for Health Care Policy and Research or national health care associations. Practice parameters are approved by the Commissioner of Health, based on the advice and recommendations of the Minnesota Health Care Commission and the Practice Parameter Advisory Committee. Practice parameters are not compulsory. Compliance with a practice parameter approved by the Commissioner of Health is an absolute defense against an allegation that a provider did not comply with accepted standards of practice in the community. Comparisons of individual practice to such practice parameters are admissible only by the defense in malpractice proceedings.

Practice parameters



Key dates

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| <p>1 April 1992. The 1992 HealthRight Act created the practice parameters program and the Practice Parameter Advisory Committee (PPAC).</p> <p>2 April 1993. The PPAC adopts criteria for assessing and approving practice parameters.</p> <p>3 June 1993. Initial health condition areas selected (prenatal care, unstable angina, and low back pain).</p> | <p>4 March 1994. Expert review panels appointed.</p> <p>5 July 1994. Anticipated date of completion of process of assessing and approving practice parameters for the first three condition areas.</p> |
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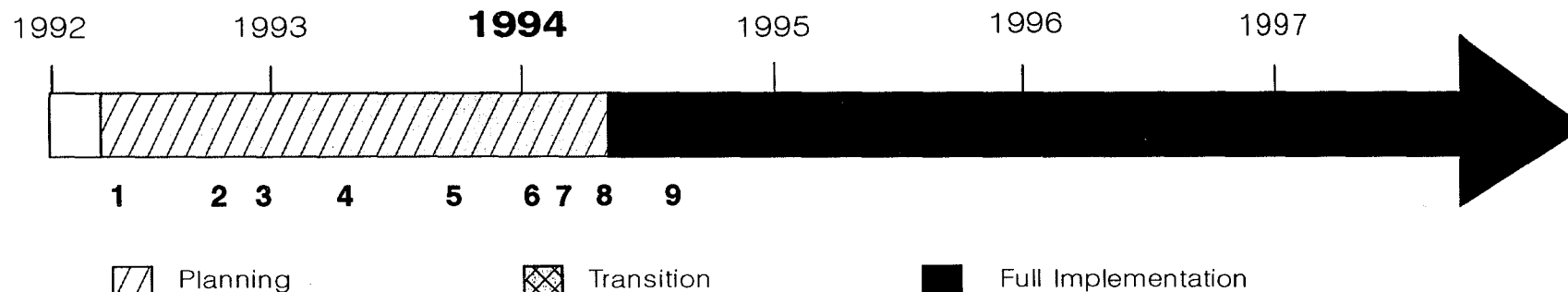
Technology evaluation: information about the value and effectiveness of health care technologies

New technologies often add to the cost of health care, but they can also have the effect of reducing costs. The Health Technology Advisory Committee (HTAC) was created by the 1992 HealthRight Act to conduct evaluations of technologies in order to improve the ability of consumers, providers, and insurers to assess the value and cost-effectiveness of technology. "Technology" includes not only high-tech equipment, but also new drugs and procedures. The technology evaluations do not involve new research, but are based on an assessment of existing research. The purpose of conducting the technology evaluations is not to bar or screen technology, but to provide better information that will lead to appropriate and cost-effective use of technology.

The 1994 MinnesotaCare Act addressed the distribution of technology by permitting the Minnesota Health Care Commission to promote and facilitate an open, voluntary, nonregulatory, and public process for regional and statewide discussion regarding the appropriate distribution of health care technologies, facilities, and functions. The purpose of the process is to facilitate collaboration to achieve health reform goals. Participation in the forums is voluntary and agreements or distribution plans that may be developed are not binding on any person or organization.

HTAC reports to the Minnesota Health Care Commission, and the commission appoints its members.

Technology evaluation



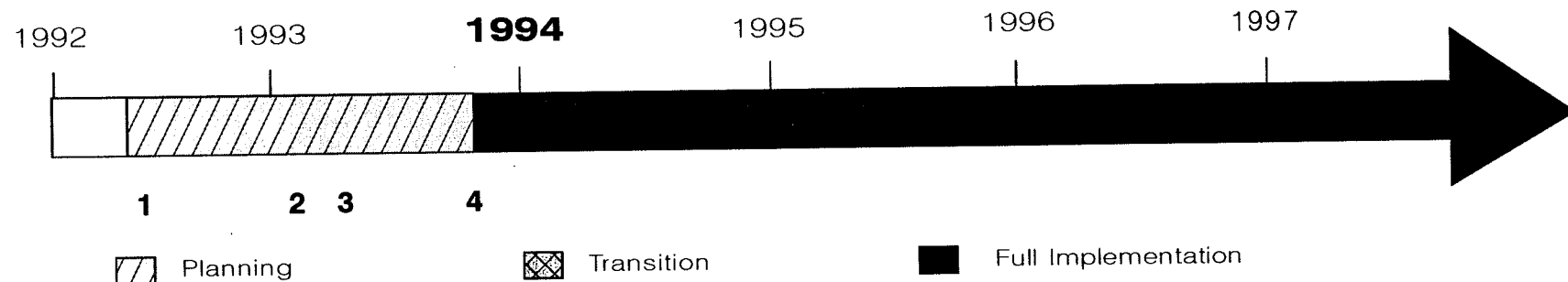
Key dates

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| <p>1 April 1992. The 1992 HealthRight Act creates the Health Planning Advisory Committee to conduct technology evaluations.</p> <p>2 August 1992. The Minnesota Health Care Commission appoints HPAC members.</p> <p>3 December 1992. HPAC submits recommendations for the process and criteria for selecting technologies for review and for conducting the technology evaluations.</p> <p>4 May 1993. The 1993 MinnesotaCare Act renames the committee the Health Technology Advisory Committee and clarifies its functions.</p> <p>5 September 1993. HTAC selects its first technology for review.</p> | <p>6 January 1994. HTAC Use and Distribution Report is submitted to the MHCC. The report is revised and approved by the MHCC and sent to the Legislature.</p> <p>7 February 1994. Preliminary technology evaluation report on thrombolytic therapy is completed.</p> <p>8 May 1994. HTAC's first technology evaluation is completed and approved by the MHCC. Legislation is enacted authorizing the MHCC to convene public forums on distribution of technologies, facilities and functions.</p> <p>9 July 1994. HTAC is expected to undertake 6-8 technology evaluations per year.</p> |
|---|--|

Antitrust exceptions: antitrust safe harbor for beneficial cooperative activities

Competition is an important component of Minnesota's strategy. However, competition can at times lead to inefficient duplication of resources and a counterproductive health care "arms race" between providers or health plans. The 1992 HealthRight Act authorized a process to provide antitrust protection under certain circumstances. The details of the process were enacted in the 1993 MinnesotaCare Act. If it can be demonstrated that a collaborative arrangement is more likely to control costs or improve quality or access than a competitive marketplace, the Commissioner of Health may sanction the arrangement to provide protection from state and federal antitrust laws.

Antitrust exceptions



Key dates

- 1 **April 1992.** The 1992 HealthRight Act creates the antitrust exception process and authorizes the Commissioner of Health to develop detailed procedures and criteria.
- 2 **February 1993.** The Commissioner of Health submits to the legislature proposed criteria and procedures for the antitrust exception process that was developed in consultation with an advisory committee.
- 3 **May 1993.** The 1993 MinnesotaCare Act is passed, including the provisions contained in the proposed rule.
- 4 **September 1993.** The first application for antitrust protection is submitted to the Commissioner of Health.

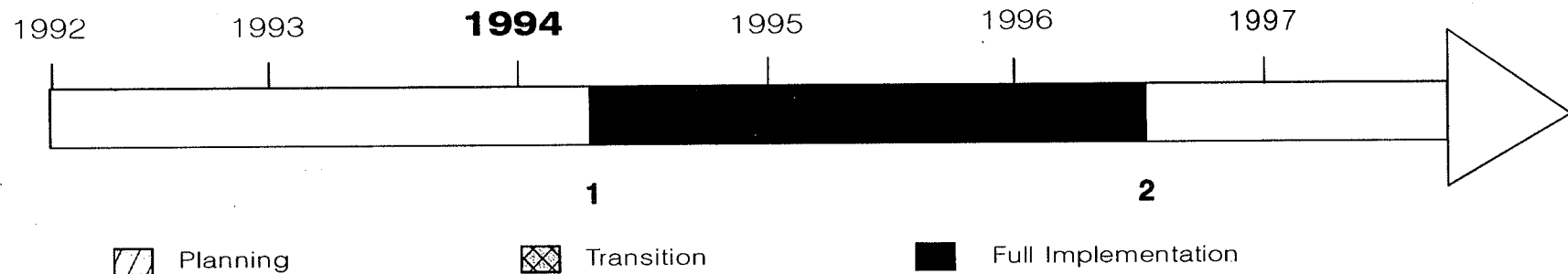
Moratorium on mergers and acquisitions: prohibiting mergers and acquisitions by large health carriers

Competition is a major theme of Minnesota's health care reform strategy. Competition on the basis of quality and efficiency will be encouraged. At the same time, MinnesotaCare encourages cooperation and sharing of resources when this approach best serves consumers. MinnesotaCare's strategy represents a balancing of competition and collaboration.

During the 1994 legislative session, concerns were raised about recent merger activity involving the state's largest health plan companies and provider chains. Legislative debate centered around the possibility that mergers may lead to anti-competitive market domination by a few giant corporations and may put small, locally controlled organizations at a competitive disadvantage. To help alleviate these concerns, the 1994 MinnesotaCare Act imposes a temporary moratorium on mergers and acquisitions by large health carriers, including insurance companies, nonprofit health service plan corporations (such as Blue Cross Blue Shield), and health maintenance organizations (HMOs).

Under the new law, health carriers having more than 5 percent of statewide enrollment or more than 10 percent of the metro area enrollment are prohibited from merging with, or acquiring, any other health carrier. The moratorium went into effect immediately and will last until July 1, 1996.

Moratorium on mergers and acquisitions



Key Dates

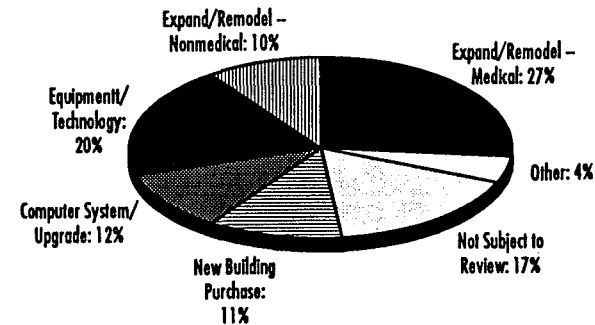
- 1 **May 1994.** The 1994 MinnesotaCare Act is passed, including a moratorium on mergers and acquisitions by health carriers.
- 2 **July 1996.** The merger moratorium, as passed by the 1994 MinnesotaCare Act, expires July 1, 1996.

Major expenditures: promoting appropriate, cost-effective decisions about major health-related expenditures

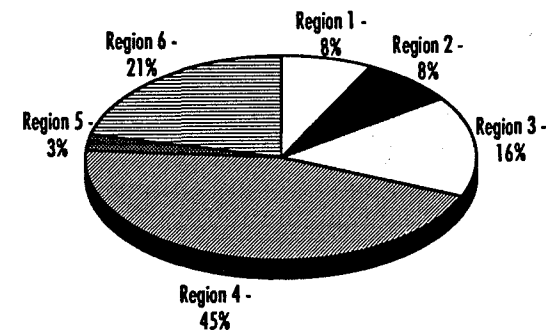
Large investments in buildings and equipment or the development of new expensive specialties and procedures can contribute to rising health care costs. The 1992 HealthRight Act and the subsequent 1993 MinnesotaCare Act set in motion a process to restructure the delivery system and the incentives that drive health care purchasing decisions. Under a fully reformed system, both ISNs and RAPO providers and insurers will have incentives to make appropriate cost-effective decisions about major health care expenditures. The Legislature concluded that, before full implementation of the new system, providers and health plans may be inclined to make major expenditures "under the wire" in anticipation of later controls on such expenditures. For this reason, the 1992 Act created a reporting and review process for major health care expenditures.

Health care expenditures greater than \$500,000 must be reported to -- and reviewed by -- the Commissioner of Health. Providers and health plans that make major expenditures that are subsequently determined by the Commissioner to have been inappropriate may be required to submit proposed future major expenditures to the Commissioner of Health for prior approval.

**Expenditure Reports Submitted for
Retrospective Review
By Expenditure Category**

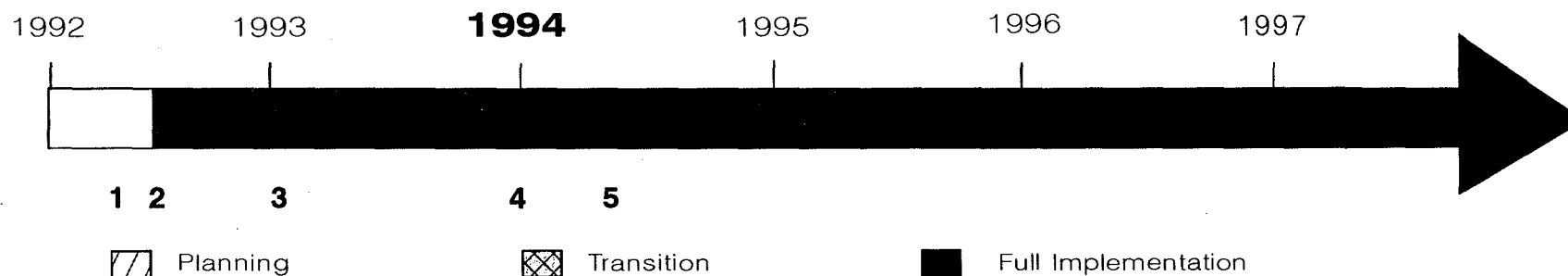


By RCB Region



Total expenditures submitted -- \$371,977,429

Major expenditures



Key dates

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|---|---|
| <p>1 April 1992. The HealthRight Act established the retrospective & prospective review process.</p> <p>2 June 1992. The first major expenditure reports are submitted to the Commissioner of Health.</p> <p>3 January 1993. Review process revised to standardize the information to be submitted by providers.</p> | <p>4 December 1993. To date, 118 reports submitted, 51 reviewed, 19 review not required, 48 pending review. No reports have failed the cost containment requirements to date.</p> <p>5 May 1994. The 1994 MinnesotaCare Act is passed providing the authority for MHCC to hold regional and statewide public forums on the distribution of technologies, facilities and function (<i>see description in the Technology evaluation section</i>).</p> |
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Rural health programs: strengthening the rural health care system

MinnesotaCare includes a comprehensive array of strategies to strengthen the rural health care system. The Office of Rural Health is responsible for overseeing rural health initiatives and working to improve access, quality, and affordability of health care in rural communities. The Commissioner of Health and the Office of Rural Health consult with a Rural Health Advisory Committee.

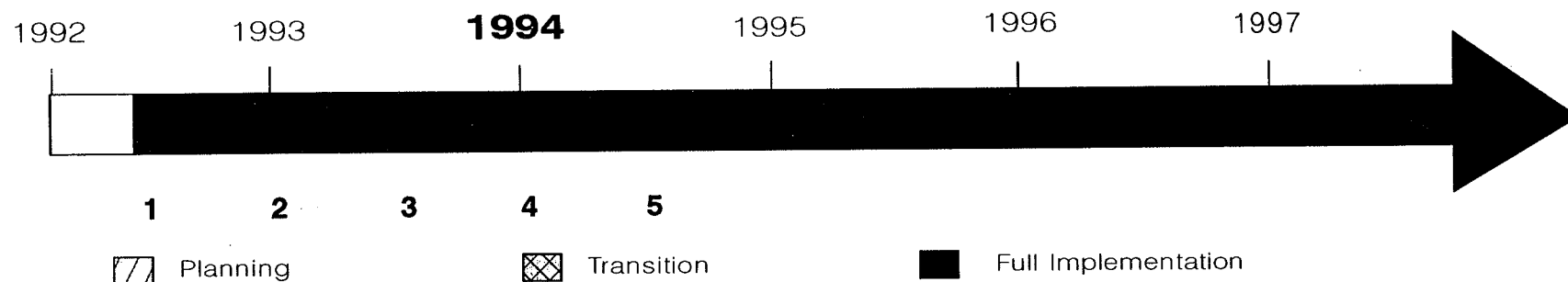
Rural health programs include:

- Rural hospital transition grants
- Subsidies for isolated, financially distressed rural hospitals
- A statewide health personnel database
- A program to establish rural community health centers
- Technical assistance regarding federal rural health care programs
- Loan repayment programs for rural practitioners
- Technical assistance to facilitate the development of community-based integrated service networks

The ISN/RAPO system is also designed to meet the needs of rural communities. A principle that guided the Minnesota Health Care Commission in developing the ISN/RAPO system is that *health care is delivered locally* and any cost containment plan must be flexible and adaptable to the unique needs and conditions of each community. The ISN system will be designed to promote the formation of local, community-based ISNs that are responsive to the local community.

In addition, the 1992 MinnesotaCare statute set a goal of increasing the number of primary care physicians trained by the University of Minnesota by 20% over the next eight years. MinnesotaCare also provided the Minnesota Higher Education Coordinating Board with funding for a grant program to increase the number of nurse practitioners practicing in rural areas of the state.

Rural health programs



Key dates

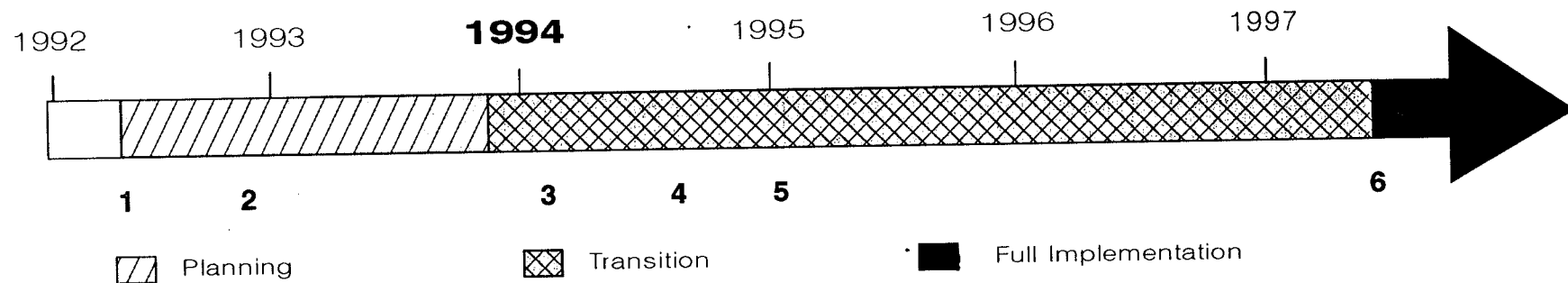
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| 1 | May 1992. The 1992 HealthRight Act establishes a comprehensive array of rural health programs, and creates the Office of Rural Health and the Rural Health Advisory Committee. | 4 | 1994. Evaluation of Rural Hospital Transition Grant Program. |
| 2 | January 1993. The Office of Rural Health completes reports on obstetrical access and mid-level practitioners. | 5 | June 1994. Anticipated date for awarding grants for Rural Health Community Center Program. |
| 3 | 1993-1994. Data collection and data entry for health personnel database. | | |

Market reform/purchasing pools: leveling the playing field for purchasers

In the existing health care market, smaller employers and persons purchasing individual health coverage often pay higher premiums due to cost shifting from large purchasers who have more clout in the marketplace, and because of higher administrative costs associated with servicing small groups and individuals. The 1992 HealthRight Act created the Minnesota Employees Insurance Program (MEIP), a state-administered purchasing pool for employers who desire to purchase health coverage for their employees through a larger pool. Private sector purchasing pools have also emerged in Minnesota, including pools administered by the Business Health Care Action Group and the Employers Association.

The 1994 Legislature enacted statutory changes to facilitate the formation of more voluntary, private purchasing pools, and authorized the commission to undertake a study to further develop the state's policies on market reform and purchasing pools. The commission believes the state's goal should be to make it possible for all individuals and groups to join a large purchasing pool by July 1997.

Market reform/purchasing pools



Key dates

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|---|---|----|---|
| 1 | April 1992. The 1992 HealthRight Act creates the Minnesota Employers Insurance Program (MEIP), a state-administered purchasing pool for private employers. | 4 | July 1994. Effective date for legislation making it easier for private pools to form and authorizing the MHCC to develop additional market reform recommendations. |
| 2 | November 1993. The MEIP program begins providing health coverage to private employers. | 5 | January 1995. MHCC 1995 market reform recommendations will be submitted to the Legislature. |
| 3 | February 1994. The MHCC recommends legislation to make it easier for voluntary, private purchasing pools to form. | 6* | July 1997. Proposed date for large purchasing pools to be available to all individuals and small employers. |

* MHCC proposal. Requires legislative approval.

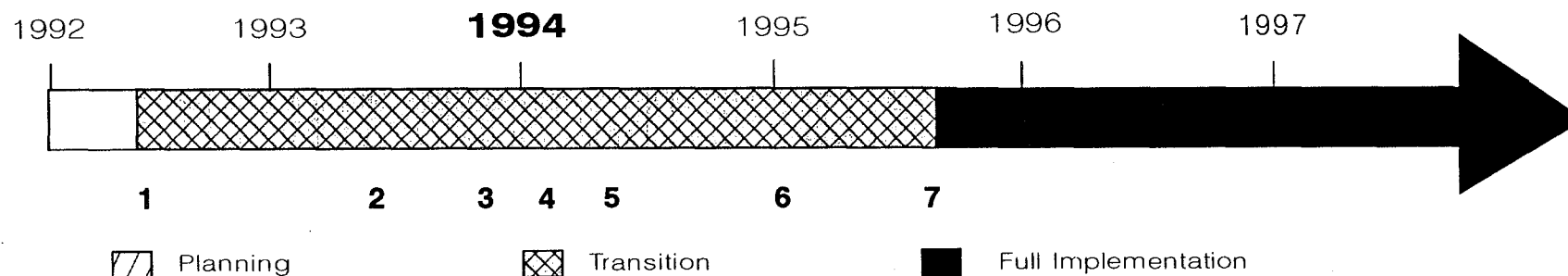
Education and research: supporting education and research systems that meet the needs of a reformed health care system

As the health care system moves toward greater accountability for its quality and efficiency, health care education and research programs must evolve to serve changing needs. The 1992 HealthRight Act requested that the University of Minnesota change its programs to graduate greater proportions of primary care providers and provide more opportunities for training and residencies in primary care, and educational programs emphasizing practice in rural communities. The Act also created loan forgiveness programs for providers who agree to practice in rural areas.

Under the new competitive health care delivery system, research and education institutions may find it increasingly difficult to attract the patients that are needed to maintain their research and education programs, particularly if their charges reflect the added costs of research and education. Financing systems must be restructured to ensure that appropriate levels of funding are maintained for education and research activities. The 1993 MinnesotaCare Act directed the Commissioner of Health to study research and education financing systems and develop recommendations.

A report was issued by the Department of Health outlining key issues and concerns involving the financing of medical education and research under health care reform. The 1994 MinnesotaCare Act directed the Department to convene an advisory task force and continue its work in this area. Reports on this study will be provided in 1994 and 1995.

Education and research



Key dates

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| <p>1 May 1992. The HealthRight Act requested that the University of Minnesota adjust its curriculum to increase emphasis on primary care and rural practice, and established loan forgiveness programs for rural practitioners.</p> <p>2 May 1993. The MinnesotaCare Act directed the Commissioner of Health to develop recommendations on financing medical education and research.</p> <p>3 November 1993. The Medical Education and Research Costs (MERC) task force was formed to advise the Commissioner of Health on this project.</p> <p>4 February 1994. First MERC report to the legislature.</p> | <p>5 May 1994. The 1994 MinnesotaCare Act authorized the Commissioner of Health to convene an advisory task force and continue its work on developing alternatives to financing medical education and research.</p> <p>6 January 1995. Second MERC report to the legislature.</p> <p>7* July 1995. Estimated effective date for alternative funding mechanism for medical education and research.</p> |
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*Requires legislative approval.

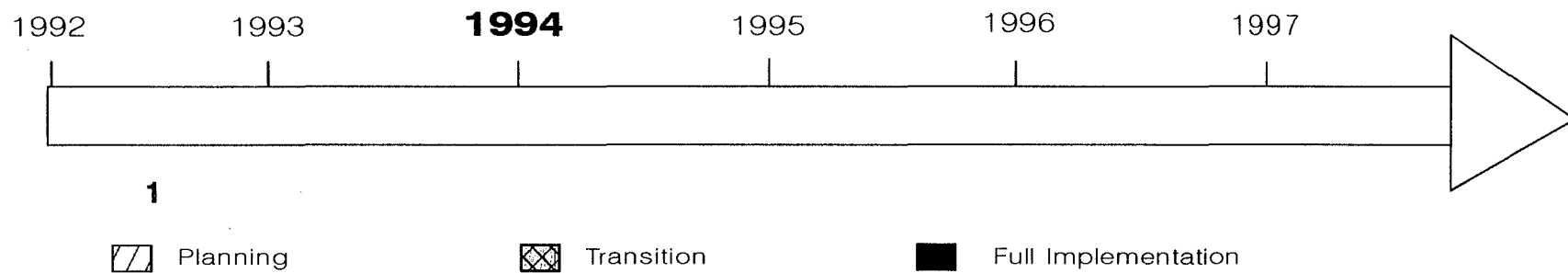
Malpractice costs: reducing malpractice costs and defensive health care practices

The 1992 HealthRight Act included some relatively minor provisions to address malpractice costs. Procedural rules for medical malpractice cases were changed to require expert witness signatures earlier in the legal process, to reduce the incidence of frivolous and groundless lawsuits. Uniform interrogatories were established to simplify and expedite the discovery process. Parties to a malpractice lawsuit are also required to consider alternative dispute resolution as an alternative to a trial.

These provisions may have a minor impact on malpractice costs. However, much more can be done to reduce the costs associated with malpractice lawsuits and judgments. Significant tort reform is a major missing piece of Minnesota's health reform strategy.

The practice parameters program also has potential for reducing malpractice risks and reducing defensive medicine. This program is described in an earlier section.

Malpractice costs



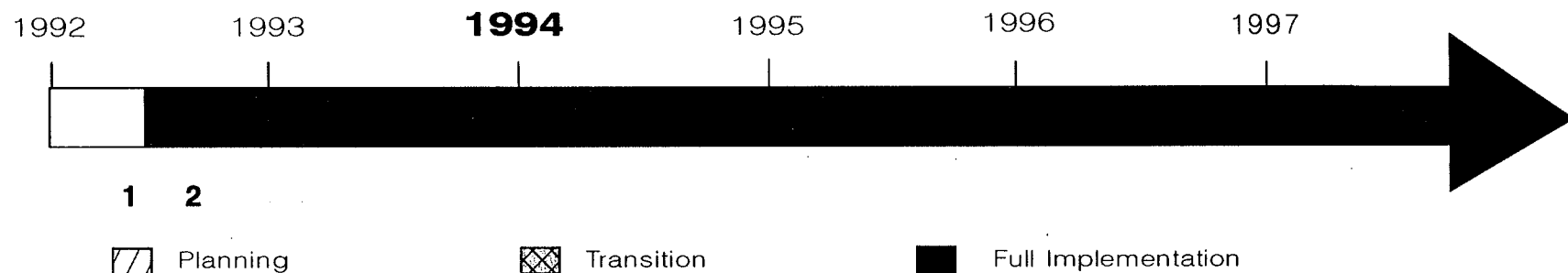
Key dates

- 1 **April 1992.** Malpractice provisions enacted in the HealthRight Act. The practice parameters program was also established (see practice parameters section).

Provider conflicts of interest: prohibiting referral relationships that create financial incentives for overutilization

The 1992 HealthRight Act authorized the Commissioner of Health to adopt rules restricting financial relationships or payment arrangements involving health care providers under which a provider benefits financially by referring a patient to another provider. The rules must be compatible with existing Medicare regulations, but cannot be less restrictive than the Medicare regulations. The Act provides that, until the rules are adopted, the Medicare regulations apply to all health care providers for all health care services (not just Medicare and Medicaid). The penalty for violation is a fine of \$1,000 or 110% of the financial benefit resulting from the arrangement, whichever is greater.

Provider conflicts of interest



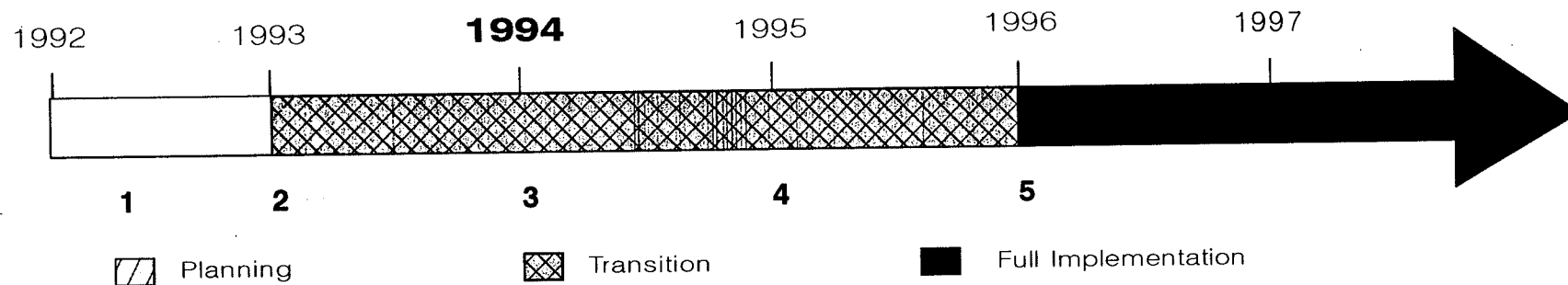
Key Date

- 1 **April 1992.** The HealthRight Act expands the Medicare provider conflict of interest restrictions to cover all Minnesota providers and services, and authorizes rulemaking to establish more restrictive requirements.
- 2 **July 1992.** Effective date of law authorizing fines for violation.

Medicare balance billing: limiting the ability of providers to bill medicare patients for the difference between the Medicare-approved payment and the provider's normal charges

The 1992 HealthRight Act restricted the ability of health care providers to bill Medicare patients for amounts above and beyond the approved Medicare payment for a service. Beginning January 1, 1996, a provider will not be permitted to bill Medicare patients for any amount beyond the Medicare approved amount and the applicable patient co-payment. Until then, the amount of "balance billing" that is permitted is reduced each year until no balance billing is allowed on January 1, 1996.

Medicare balance billing



Key dates

- | | |
|--|---|
| <p>1 April 1992. The balance billing restrictions are enacted in the HealthRight Act.</p> <p>2 January 1993. Providers cannot collect more than 115% of the Medicare-approved payment amount.</p> <p>3 January 1994. Providers cannot collect more than 110% of the Medicare-approved payment amount.</p> | <p>4 January 1995. Providers cannot collect more than 105% of the Medicare-approved payment amount.</p> <p>5 January 1996. Providers cannot collect more than the Medicare-approved payment amount.</p> |
|--|---|

Prescription drug costs: the prescription drug market and cost containment initiatives

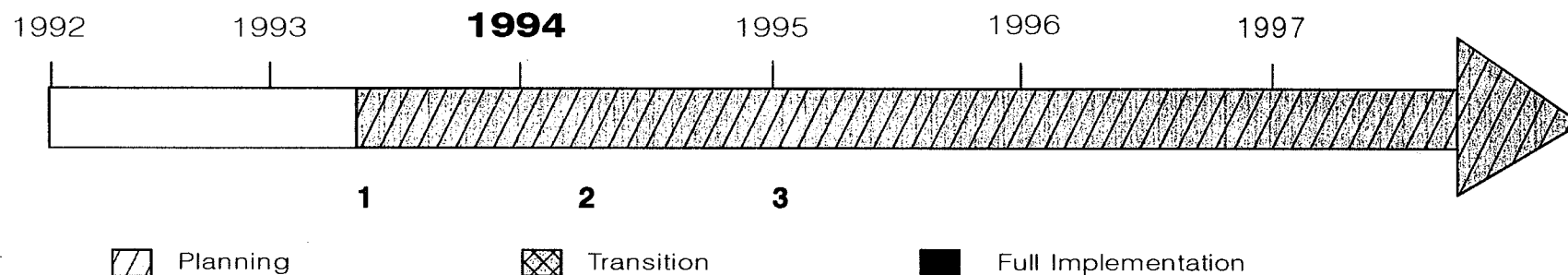
Prescription Drug Study

Prescription drugs make up approximately 8-10% of health care spending in the State of Minnesota. There is no question as to the clinical benefit of early intervention with drug therapy, or that early intervention may result in significant savings in health care spending by avoiding or preventing more costly therapies. However, the rising cost of prescription drugs has been a concern at both the national and state policy levels, particularly for those without insurance or with insurance that does not include a prescription drug benefit. Those most vulnerable to increasing cost include many senior citizens who have insurance coverage through Medicare but no supplemental coverage for the costs of prescription drugs. (Medicare does not include prescription drugs in its list of covered services). Another issue raised by community pharmacies has been "differential pricing" and the inability of community pharmacies to purchase drug products from manufacturers at the same price given to managed care organizations and mail order pharmacies.

As a result of these concerns, the 1993 MinnesotaCare Act required that the Department of Health conduct a study of the prescription drug market and the factors influencing the prices of prescription drugs. The study was conducted in 1993 and included an extensive literature review, interviews with

representatives of all components of the prescription drug market, and an evaluation of possible reform options. The study concluded that the state should allow private sector initiatives, specifically ISNs and CISNs, to develop in the state and build on past success of managed care to moderate increases in pharmaceutical drug expenditures. While there is a clear need for assistance for those who currently lack access to prescription drugs, any new program will require a substantial financial base. Given that national reform may include a prescription drug benefits in a universal benefit package or as a covered benefit under Medicare, the study recommended that the state see what happens at the national level before the state begins a new, potentially costly, program.

Prescription drug costs



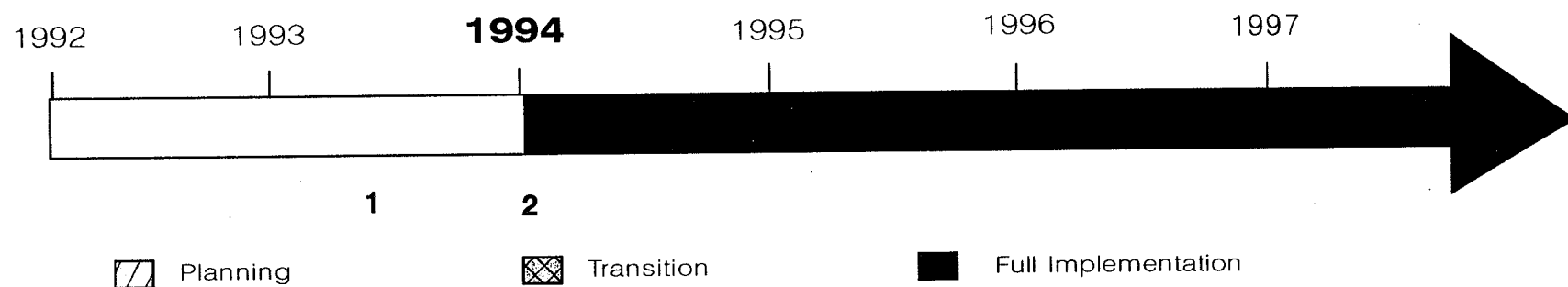
Key dates

- 1 **May 1993.** The 1993 MinnesotaCare Act passed. Included in the Act were provisions for a study on the prescription drug market and cost containment strategies. A generic substitution requirement was also included with a delayed effective date.
- 2 **April 1994.** The final report and recommendations, "Prescription Drug Study: A Report to the Minnesota Legislature on the Prescription Drug Study" was released by the Department of Health.
- 3 **1994-1995.** The Department of Health will continue to monitor the prescription drug market and national reform efforts to include prescription drugs as a covered benefit under Medicare and/or other universal benefit options.

Generic drug substitution: requiring pharmacists to substitute lower cost generic drugs in appropriate situations

Brand name drugs are often much more expensive than generic equivalents. The 1993 MinnesotaCare Act requires pharmacists to substitute the least expensive generic equivalent when filling a prescription, unless the dispensing health care practitioner specifically directed that the prescription be filled with a specified brand name drug. The pharmacist must inform the patient of the substitution and must not substitute a generic drug if the patient objects. Pharmacists are allowed to use their professional judgment to determine whether a generic drug is safely interchangeable.

Generic drug substitution



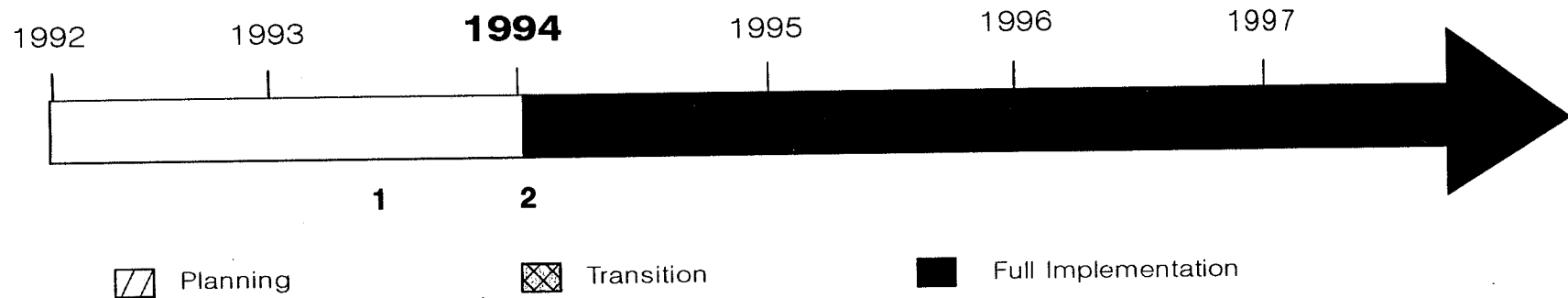
Key dates

- 1 **May 1993.** The 1993 MinnesotaCare Act passes, including the generic substitution requirement with a delayed effective date.
- 2 **January 1994.** The generic substitution requirement becomes effective.

Drug company gifts to practitioners: prohibiting drug companies from providing gifts to health care practitioners

The 1993 MinnesotaCare Act prohibits drug manufacturers and distributors and their employees from giving gifts with a combined value of more than \$50 a year to health care practitioners. The purpose of this requirement is to eliminate financial incentives for practitioners to prescribe particular drugs, so that decisions are made based on the effectiveness, appropriateness, and cost of the various drugs that are available for treatment of a patient. The requirement does not apply to samples provided for free distribution to patients, educational programs and materials, and similar activities.

Drug company gifts to practitioners



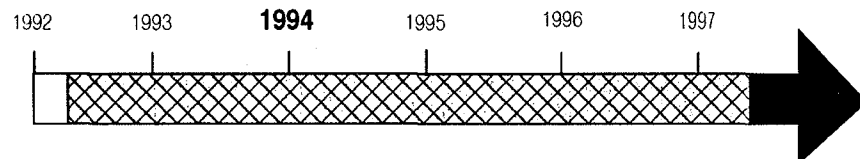
Key Dates

- 1 **May 1993.** MinnesotaCare enacted with provisions restricting drug company gifts.
- 2 **January 1994.** Effective date of restrictions.

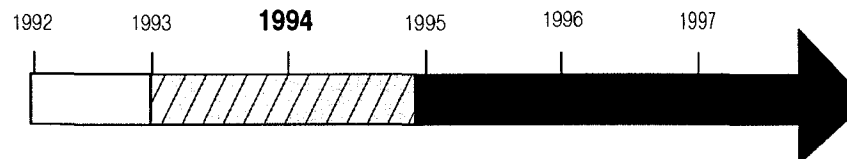
Progress Report Summary

MinnesotaCare: Progress Report

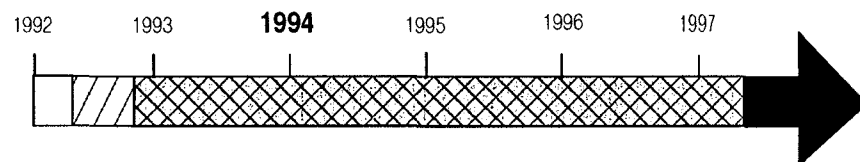
Universal Coverage



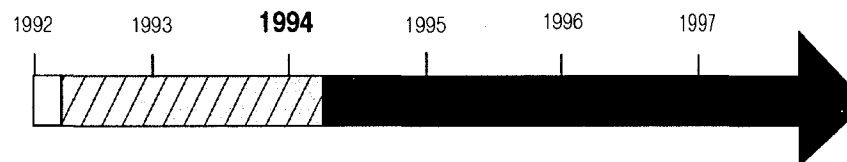
Health Care Information



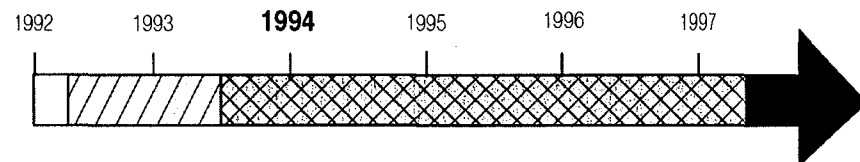
MinnesotaCare Health Plans



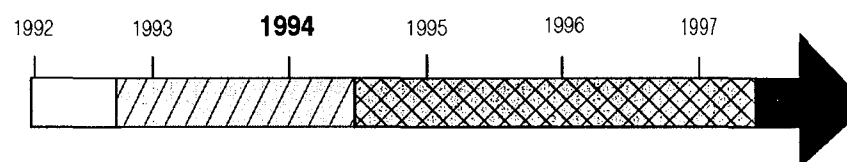
Growth Limits



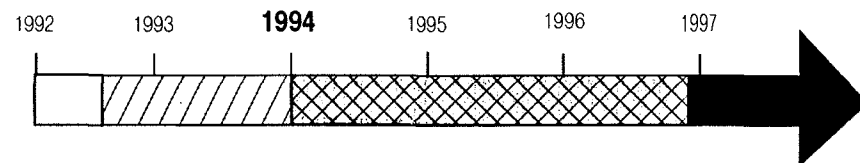
Insurance Reform



ISN/RAPO System



Data Initiatives



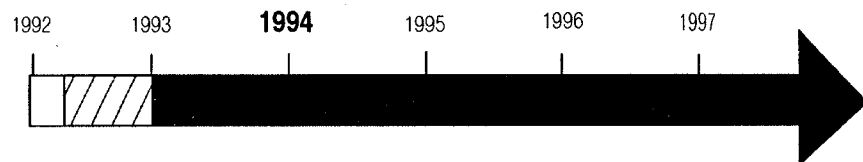
□ Planning

▣ Transition

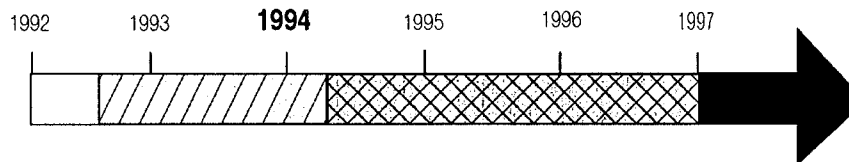
■ Full Implementation

MinnesotaCare: Progress Report

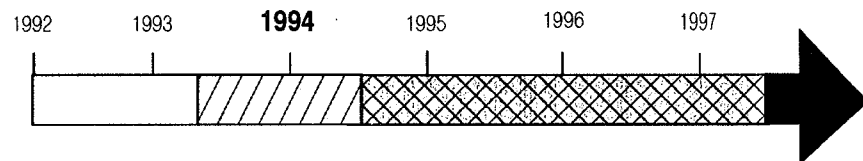
Regional Coordinating Boards



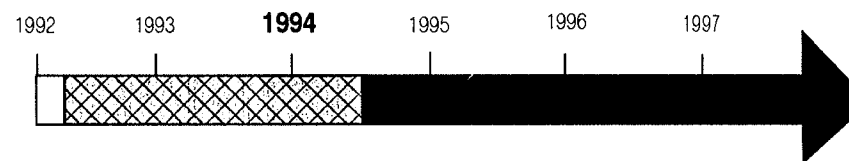
Uniform Billing and Claims Forms



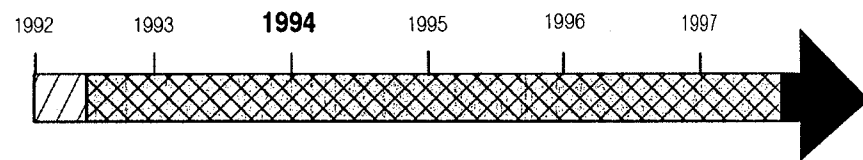
Public Health



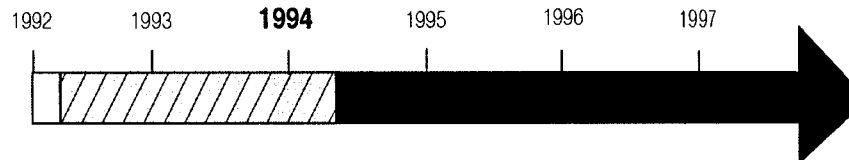
Practice Parameters



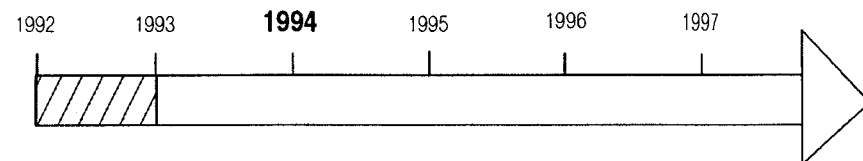
State Health Programs



Technology Evaluation



Prevention



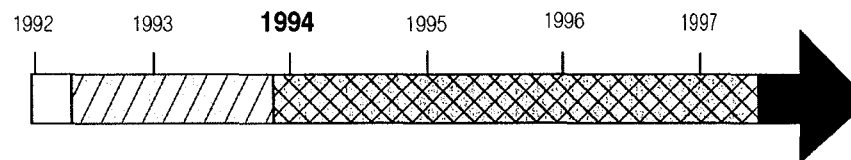
Planning
 Transition
 Full Implementation

MinnesotaCare: Progress Report

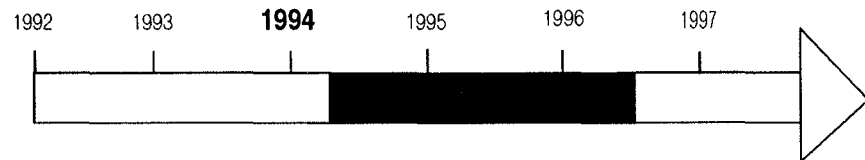
Antitrust Exceptions



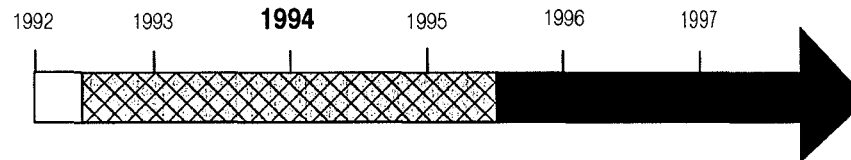
Market Reform/Purchasing Pools



Merger Moratorium



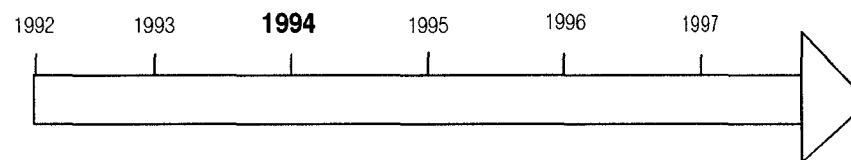
Education and Research



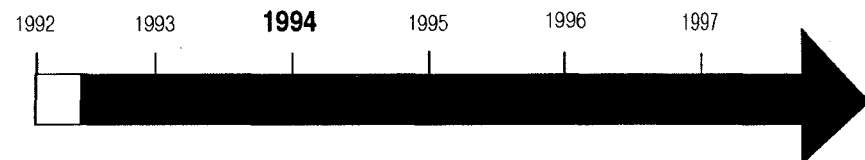
Major Expenditures



Malpractice Costs



Rural Health Programs



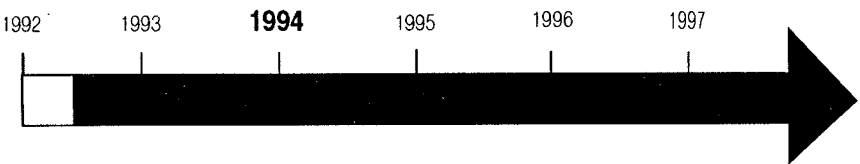
▨ Planning

⊠ Transition

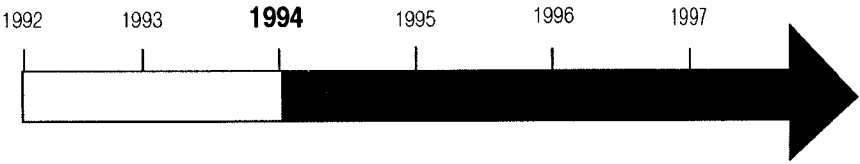
■ Full Implementation

MinnesotaCare: Progress Report

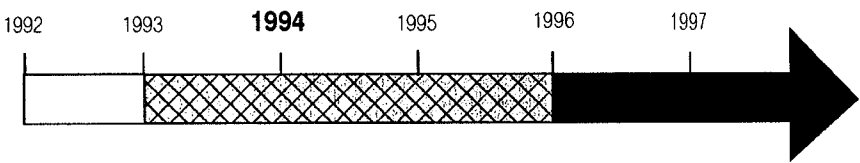
Provider Conflicts of Interest



Generic Drug Substitution



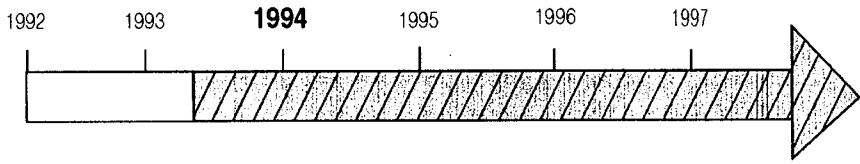
Medicare Balance Billing



Drug Company Gifts to Practitioners

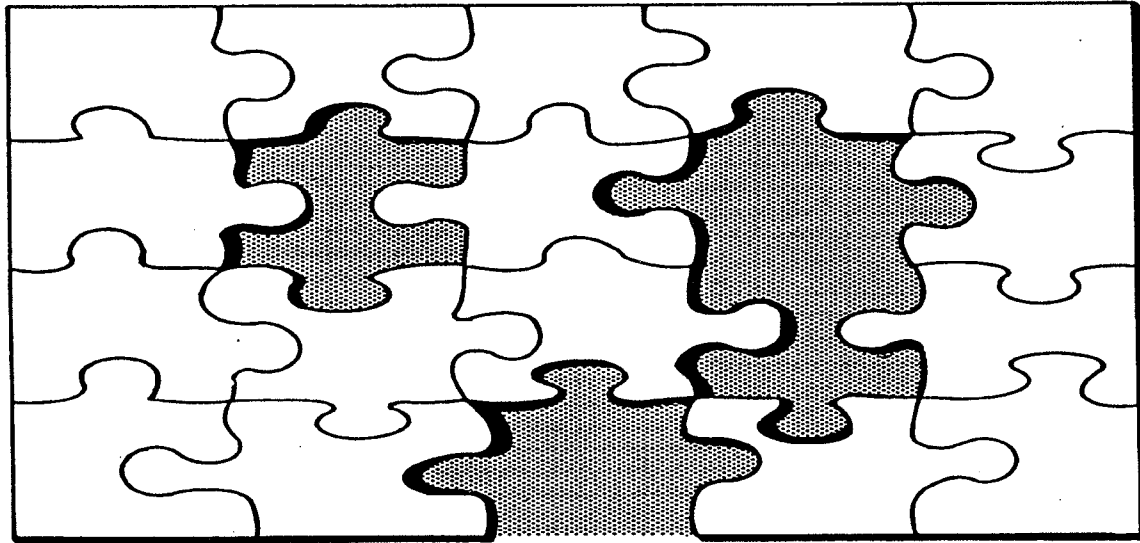


Prescription Drug Costs

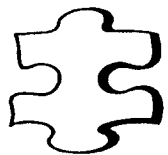


 Planning  Transition  Full Implementation

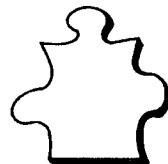
Missing pieces



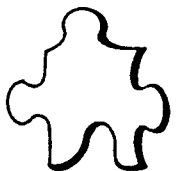
Four major areas remain where the state is not making adequate progress. These are the missing pieces in MinnesotaCare.



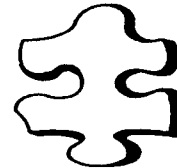
Consumer incentives and individual responsibility



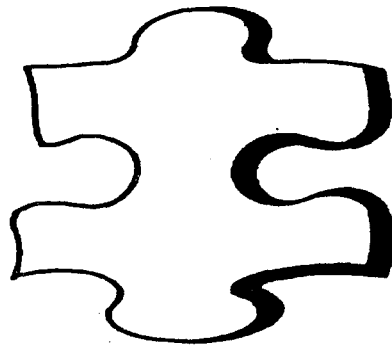
Prevention



Tort reform: medical malpractice

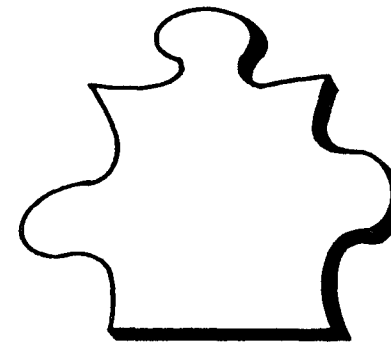


Tax and financing reform



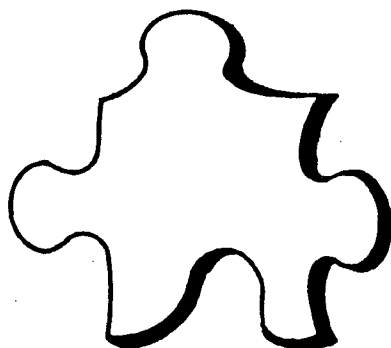
Consumer incentives and individual responsibility

MinnesotaCare includes major cost containment strategies that focus on the health care financing and delivery systems. However, individual consumers also share responsibility for the high cost of our existing system. Preventable illness and overutilization of the health care system add significant costs. A comprehensive health reform package should include programs and incentives to increase individual responsibility for reducing health care costs by maintaining healthy lifestyles and using the health care system appropriately. Alcohol and tobacco taxes, seat belt and helmet laws, consumer education and wellness programs, and insurance premium discounts for healthy lifestyles will discourage unhealthy practices and encourage healthier, safer lifestyles. In January 1993 the Minnesota Health Care Commission recommended legislation in these areas, but most of its recommendations were not enacted.



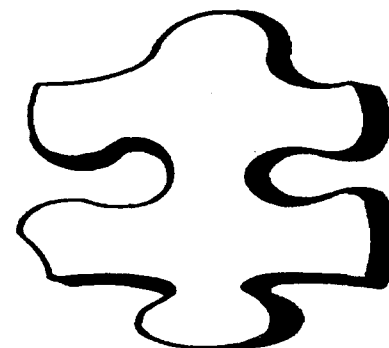
Prevention

The ISN and RAPO systems are designed to increase efforts by health plans and providers to prevent illness and injury through financial incentives and regulatory requirements. However, much more must be done to maximize the opportunities to reduce health care costs through prevention. Seventy percent of health care expenditures are spent on preventable conditions, while only three percent of resources are allocated for prevention. In January 1993, and again in February 1994, the Minnesota Health Care Commission recommended a number of targeted prevention programs to be funded by a cigarette tax increase. These programs were not enacted. Prevention remains a significant missing piece of the MinnesotaCare reform strategy.



Tort reform: medical malpractice

The 1992 HealthRight Act included some relatively minor provisions to address malpractice costs. The practice parameters program also has potential for reducing malpractice risks and reducing defensive medicine. However, significant tort reform is a major missing piece of Minnesota's health reform strategy.



Tax and financing reform

The existing system of financing government health programs is really a nonsystem of fragmented, uncoordinated programs. The MinnesotaCare subsidy program will continue to face shortfalls until adequate financing is provided. In addition, state and federal financing and tax systems provide perverse incentives that work counter to the goals of health care reform. In February 1994, the Minnesota Health Care Commission (MHCC) recommended that the tax and financing systems be reformed based on a study to be completed during 1994. The 1994 Legislature accepted this recommendation and authorized the MHCC to proceed. Financing reform will produce a more rational financing system, minimize the additional costs of achieving universal coverage, and make possible a long-term, stable funding base for all government health care programs.

Minnesota Health Care Commission

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BOOK RATE