



JOURNAL

A Public Policy Monthly from the Citizens League

INSIDE

Health Care Special Issue

This month, the Minnesota Journal focuses on another policy point from the Minnesota Anniversary Project (MAP 150) agenda.



Prevention: A critical step toward health care reform

A sustainable system must address the root causes of preventable disease

By Dr. Mark W. Banks

Minnesotans consider access to affordable health care a top priority for our state, and they clearly understand that achieving the goals of a more affordable, more accessible health care system requires a commitment to prevention. These views were confirmed by last fall's Citizen's League MAP 150 survey. Yet, too often prevention and efforts to encourage healthy lifestyles are absent from discussions about meaningful health care reform. That's a costly mistake.

The challenge

The root causes of some of the costliest diseases are preventable. Tobacco use is the leading cause of disease and death in the state and costs Minnesota \$2 billion a year in excess medical expenditures. Physical inactivity and poor nutrition combined are the second-leading cause of disease and death. Physical inactivity alone costs the state nearly \$500 million a year. Moreover, preventable diseases are not equal opportunity killers—heart disease and cancer are found in greater numbers in certain populations, such as African Americans and American Indians.

If we truly want to address the health care challenge in Minnesota, it's time to pay more attention to how healthy Minnesotans *really* are. Today, about one in five Minnesota adults smoke. According to the CDC, about half of all Minnesotans do not achieve recommended levels of physical activity, and more than three-quarters of Minnesota adults don't meet important nutrition standards.

The problem will only get worse if we don't start now to improve Minnesota's future health. Unhealthy behaviors will impact the future affordability and accessibility of health care. That concern is increasingly drawing the attention of the state's business community, opinion leaders, and policymakers.

The 2020 Conference, a bipartisan group of legislators working to address issues that could impact the state in the future, are exploring potential policy solutions

based on prevention and health improvement that can reduce the strain on the health care system. In discussing the problem, state Rep. Joe Atkins and state Sen. Geoff Michel have noted that the key to establishing a sustainable health care system is to address the risk factors at the root of so many preventable diseases.

The opportunity

Fortunately, we know that prevention works. But to significantly impact health care reform, we can't just rely on individual efforts; prevention must also involve the decisions we make as a broader community. Sound policy decisions based on proven strategies can have a real impact on health in this state. In order to achieve this aim, Minnesota leaders must make prevention a priority.

Last year, Blue Cross and Blue Shield of Minnesota launched Prevention Minnesota, a long-term, statewide investment in prevention to benefit all Minnesotans. Funded from the settlement Blue Cross received following our historic lawsuit against tobacco companies, Prevention Minnesota offers sustained and significant (\$240 million) funding for health improvement in the state, and represents an historic opportunity for Minnesota to make a long-term commitment to prevention efforts.

Prevention Minnesota's ultimate goal is to reduce heart disease and cancer by attacking the preventable root causes—tobacco use, physical inactivity, and unhealthy eating. To achieve that ambitious goal, Blue Cross is investing in efforts to drive ambitious changes in Minnesota's health:

- Cut tobacco use in half.
- Protect everyone from exposure to second-hand smoke.
- Increase levels of physical activity by 50 percent.
- Double the intake of fruits and vegetables.

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Connections



Viewpoint: Seeing policy problems as puzzles and mysteries may offer different solutions



Facts Unfiltered: Information on health care quality



Policy redux: A look back at the Citizens League's evolving work on two important issues



Perspectives: three views

Health care that keeps us healthy

Better, not just more, health care

Is it time for portable health care?

CONNECTIONS

Building a League of Citizens



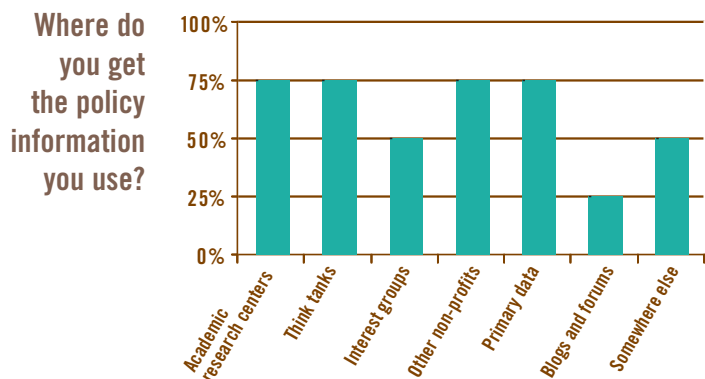
"We have to Googleize health care," pronounced MPR's chief economics correspondent Chris Farrell at the Citizens League Policy and a Pint event, *Health Care Handcuffs*, on March 7. Not sure what that means? This group talked it over after the event—and you can join in on the conversation in an online forum at Gather.com. Photos, audio, and a link to the forum are online at www.citizensleague.org/events/pint

The Citizens League is on fire...

Not literally but it's beginning to burn up the landscape with policy conversations that are on the top of the minds of Minnesota's opinion leaders and elected officials. Under the supreme leadership of Sean Kershaw (formerly with the City of St. Paul), the Citizens League has made itself the most relevant (and realistic) thinking group in Minnesota.

—*Politics in Minnesota*, Feb. 28, 2007

February poll results



March member poll

What is the most important change necessary to make the health care system more affordable and secure for all Minnesotans?

- Patients need better information so they can take more responsibility for their own health
- The system should focus more on prevention
- Employer-based health insurance should be replaced with mandatory portable plans
- Government should invest more in public health
- Something else—tell us!

Go to www.citizensleague.org to vote!

New members, recruiters, and volunteers

New and rejoining members

David Aafedt
Ann Aronson
Jessica Ayers-Bean and Ryan Bean
James Boyle
Bob Butterbrodt and Angie Schaffer
Teresa Callies
Leo Christenson
Burton and Audrey Cohen
Theresa Coleman
Paul DeGeest
Kathy and Steve Dougherty
Angie Eilers
Matt and Anna Finesgard
Kristin Rosel Fischer and Jesse Rosel
Angela Garcia
Jennifer Godinez
H. Thomas Blum
Jeremy Hanson
Al Hester and Elaine Dunbar Hester
Michael Hohmann
Linda Hopkins
Laura Kelnhofer and Anthony Calbone
Virginia Kirby and Neal Viemeister
Don Kitzberger
Carolyn and David Kompelien
Bryan Lake
Becky LaPlant
Emily Maltz
Daniel Marx
Paul Mattessich
Paul and Lois McCarron
Kathy McGill
Melissa McLeish
Clint and Mary Morrison
Don Ness
Jeanne Olson
Allen I. and Barbara Olson
Dan Papin
Steve Piekarski

Dave and Abby Pinto
Gaius Poehler
Robb Prince
Bridget Richardson
Elizabeth Ryan
Janet and Mark Skeie
Mason and Laura Sorenson
Jon Steadland and Meredith Fox
Marilynn Taylor
Cathy Ariella Tilsen and Scott Edelstein
Judith Trepka
Kate Foate Trewick
Hugh Tyndall
Mary Vogel and Hank Fisher
Dave Walter
Willie Willette

Firms and organizations

Advance Consulting LLC
Anchor Bank St. Paul
Blandin Foundation
Blue Cross & Blue Shield of Minnesota
Cretin-Derham Hall
Flannery Construction Inc.
Fredrikson & Byron Foundation
Interior Gardens
Phillips Distilling Company
The Humphrey Institute of Public Affairs
The Sage Group
Thomson West

Recruiters

Marcia Avner
Richard Graham
Tom Horner
Jeremy Lenz
Joel Spoonheim
Paul Taylor

Volunteers

Janna Caywood
Cal Clark
Dave Walter



Finding new solutions in the puzzles and mysteries of health care reform

by Sean Kershaw

What do 9/11, the Enron scandal, and health care reform all have in common—and what is their connection to the Citizens League’s mission of building civic capacity?

It’s easy to think back to 9/11 and the Enron scandal and wonder “why couldn’t we *prevent* these from happening!” Just as it is easy to look at an issue like health care reform today and wonder “why can’t we *make* this happen!” After all, how can health care reform, a goal that is so important to Minnesotans, that has been studied so extensively (just look in this issue at our own impressive history of policy recommendations), still seem so uncertain?

The answer depends on how we frame the question. Finding and implementing new policy solutions depends on looking at old problems in new ways—and through the “lens” of our mission.

Puzzles and mysteries

Author Malcolm Gladwell (*The Tipping Point*) and national security expert Gary Treverton recently described the policy implications of two types of problems, puzzles and mysteries. Each problem requires a different solution.

“Puzzles” are problems that suffer from a lack of information. Solving the puzzle means finding the missing information. “Where is Osama Bin Laden?” is a puzzle. “What are the true costs of our proliferating medical facilities?” is a health care puzzle. Solving puzzles usually hinges on getting the source of the missing information to reveal it; they are what Gladwell calls “transmitter dependent.” In policy, puzzles can be solved in part with good data, like our *Facts Unfiltered* work, and good ideas. They are the realm of research and think tanks—of white coats and white papers.

“Mysteries” are problems that are characterized by *too much* information, and they don’t have simple factual answers. Solving a mystery requires judgment, analysis, discernment, and social/political context: the ability to make sense out of

We need new strategies that build our capacity to better understand, react to, and resolve these problems.

the mountain of available information. Mysteries are “receiver dependent.” They depend on the capacity of the person or institution analyzing the information. Mysteries also challenge these institutions to build the capacity of their members to solve these types of problems.

Gladwell suggests that Enron’s failure was actually a mystery—the information on their financial misdeeds was almost all public. It was just buried in reams of tax returns and financial statements. Treverton points out that avoiding the 9/11 attack was also a mystery. We didn’t have the institutional capacity to sufficiently analyze and act on our intelligence data.

The skills required to solve these mysteries (analysis, discernment, relationship-building, etc.) happen to be civic skills. They are the civic leadership capacity we hope to cultivate in our work at the Citizens League.

Our mysterious new world

In the wiki/open-source/World Wide Web reality of our lives, where we have access to information on an unprecedented scale, our policy problems are part puzzle, but mostly mystery. We need new strategies that build our capacity to better understand, react to, and resolve these problems, and allow us to accomplish the policy reforms Minnesota needs.

For example, there are many health care puzzles that demand better information. As our 2006 medical facilities report highlights, we lack some obvious data. We don’t know the true costs resulting from

the explosion of out-patient care facilities, and can’t sufficiently evaluate the quality of the care these facilities deliver. We can’t determine health care “value” or create market mechanisms to control costs without this information. And as our work on the Minnesota Anniversary Project (MAP 150) highlights, we also lack “unobvious” information, like what incentives work best to help people to become “co-producers” of their own health.

But even with this data, our health care problem moves from puzzle to mystery. We need to help citizens develop the capacity to understand this information.

And all of our institutions (from employers to nonprofit service providers) have a role in building this capacity and in providing the necessary data to help their employees and stakeholders become better decision makers—and better producers of their own health in the process. Achieving these changes will require new leadership capacity in every sector and at every level of authority.

As our medical facilities report recommends, we have to change the institutional dynamics and relationships so that patient/consumer interests have a more meaningful role in determining when and where new medical facilities are established.

Success is no mystery

We don’t want to look back in 10 years and wonder why we “blew it” on health care reform in 2007. Why our good intentions and white papers weren’t enough.

This is why the Citizens League’s mission of building civic capacity is so important right now. Ideas and facts help solve puzzles. But we can’t solve the mysteries of health care reform if we don’t have the civic leaders, civic capacity, and institutional relationships in place to analyze, synthesize, and resolve one of our most important policy priorities. ●

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Prevention

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Success in these endeavors will yield huge benefits. Minnesota could expect to see up to 30 percent fewer cases of heart disease, stroke, colon cancer, and osteoporosis, an 18 percent reduction in cases of Type 2 diabetes and high blood pressure, and 5 percent fewer cases of breast cancer if all Minnesotans became moderately physically active. Even a 25 percent increase in the number of Minnesotans engaging in regular physical activity would have a major impact on health care costs, productivity, absenteeism, and premature deaths.

Engaging all Minnesotans in prevention

Prevention Minnesota is designed to prompt innovative, community-based approaches to these health challenges. It's also a catalyst for community engagement to make prevention an essential part of our day-to-day lives. Community leaders and interested citizens can make decisions about the places in which we live, work, and play that support healthier choices.

Success requires commitment beyond public health departments and health plans. Everyone has a role to play.

Improving health in Minnesota ultimately comes down to making prevention an individual commitment and a community priority. Yes, each of us has an obligation to make our own healthy choices—choosing healthy snacks, taking the stairs instead of the elevator or taking advantage of stop-smoking services offered in the state. But what experts understand better every day is the crucial role that our environment and surroundings play in influencing those individual decisions. People will make better choices if communities are designed to encourage walking, if workplaces offer resources for employees to be more physically active, if healthy foods are more readily available.

Public policy plays a huge role in Minnesota's health. There is clear evidence that policy interventions can promote improved community health. Minnesota has experienced first hand the positive impact that effective policy can have on individual choices. In the first two weeks after Minnesota's 75-cent tobacco price increase went into effect in August 2005, enrollment in Blue Cross' stop-smoking program increased 65 percent. Requests for cessation services sponsored by other organizations in the state also increased dramatically.

In 2006, the U.S. Surgeon General issued the most comprehensive study ever produced on the negative health impacts of second-hand smoke. This landmark study concluded that there is no risk-free level of exposure to second-hand smoke. On a local level, cities and counties throughout Minnesota have recognized the science by implementing policies to limit exposure to second-hand smoke. Their actions have also built momentum toward a statewide law. These efforts work. Those states that have implemented comprehensive policies to protect people from second-hand smoke have seen a drop in the number of people smoking and a reduced incidence of diseases associated with second-hand smoke.

Among community leaders, there is growing recognition that community design impacts how active citizens are. With funding from Prevention Minnesota, several Minnesota communities are working with the national organization Active Living by Design to find ways to encourage people to be more physically active. The solutions are common sense. When communities are designed so necessities can be reached more easily on foot than by car, people will become more active in their everyday routines. And having safe, well-lit and accessible sidewalks and trails encourages more walking and biking.

Mark Dessauer with the Active Living by Design program put it simply: "If we're to get 30 minutes a day of physical activity (the prescription) and our neighborhood or community doesn't have sidewalks or safe streets, then we're getting a prescription you can't fill."

The first step is making a commitment. "Communities have to decide that this is a priority," national walkability expert and Active Living by Design collaborator Mark Fenton explains. "If all we care about is moving cars faster, we're never going to get our hands around this problem."

Creating a healthier state is not the responsibility of government alone, however. Private policies, such as those implemented by employers, impact the health of employees. In addition, families can make different choices about the activities in which they engage. Similarly, civic and faith leaders can encourage and foster healthier choices among members and congregants.

Employers have a major role to play. For example, General Mills has long understood its role in helping employees

live healthier lives. In the recent public television program, "Prevention: Rx for a Healthier Minnesota," Dr. Tim Crimmins, medical officer at General Mills, shared the philosophy that guides the company's health improvement work. "A company is all about its people," he said. "And, if you have healthy, empowered, productive people, you're going to have a successful company."

Improving health in Minnesota ultimately comes down to making prevention an individual commitment and a community priority.

General Mills offers an on-site fitness center, a clinic, access to wellness classes and, perhaps most important, a supportive culture that encourages healthy behavior. The investment has produced positive results with employees while giving the company a competitive edge. Obviously, not every company has the resources to dedicate to health improvement, but what employers of all sizes can take from General Mills' example is the willingness to create an organizational culture that enhances its employees' health.

Minnesotans should be encouraged by efforts like these that are already underway, but there's more to be done. We need creative approaches to make sure healthy foods are more readily available and affordable. More communities should be designed or redesigned to encourage regular activity. Minnesota can once again be a leader in public health policy by adopting a comprehensive, statewide smoke-free workplace policy.

Ultimately, realizing the health and economic benefits of comprehensive prevention efforts will take a shared commitment among all Minnesotans. Prevention isn't a silver bullet. It won't address every challenge we face in health care today, and it certainly doesn't offer a quick fix. But it must be part of the solution. The costs of ignoring the causes of preventable disease and death are just too high—in dollars and in the impact on Minnesotans' lives. ●

Dr. Mark W. Banks is Chief Executive Officer of Blue Cross and Blue Shield of Minnesota.

FACTS UNFILTERED

Health Care Quality Information

Purchasing health care is expensive, sometimes uncomfortable, and often confusing: which doctor/hospital/therapist/health plan/diagnostic test/treatment is best?

Much of the information we need to make these critical decisions is technical and difficult for the layperson to understand, or only readily available to health care professionals.

This situation, called “information asymmetry,” means health care providers know much more than health care consumers, and it is a significant problem in the market for health care. Too often, the lack of good information prevents consumers from making the purchases that would most benefit their health.

But efforts are underway to address this information asymmetry, including the development of generally accepted diagnostic and treatment standards, the conversion of those standards into quality measurements, and dissemination of those standards and measures to consumers.

For example, one standard for the control of hypertension is a blood pressure reading no higher than 140/90. The associated quality measurement for a health plan might be the proportion of subscribers whose blood pressure falls below that threshold. If health plans published their results in meeting that standard, consumers concerned about hypertension could make a more fully informed choice between plans.

Q. Is more information always better?

A. Not necessarily. One obvious exception is when the information is inaccurate. Bad information might be worse for consumers than no information. If cardiac surgeons are rated solely on outcomes (e.g., the proportion of patients surviving five years), and if there are differences in patient characteristics across surgeons, then the ratings might falsely elevate a lower-skilled surgeon whose patients are “healthier” above a higher-skilled surgeon whose patients are “sicker.”

In order to be accurate, ratings based on surgical outcomes would need to be adjusted for key patient characteristics. Otherwise, surgeons may “game” the quality measure, changing their behavior in ways that raise their scores without improving the quality of their care. For example, if the surgeon rankings are not adjusted to reflect patients’ pre-surgery health, then surgeons may respond by treating fewer seriously ill patients. In that case, the reporting of those rankings will have done little to improve the overall welfare of health care consumers.

Q. Does information on health care quality improve provider and consumer decision making?

A. While by no means exhaustive, two studies illuminate some of the issues this question raises.

In the early 1990’s, state health departments in New York and Pennsylvania began to release mortality data for patients undergoing coronary artery bypass graft (CABG) surgery. In their study of consumer and provider responses to this initiative, researchers note three findings:

First, over a few years, patients receiving CABG in these two states tended to be less seriously ill relative to patients in states without report cards, and surgery tended to be performed on healthier patients.

Second, patients tended to sort themselves across hospitals, with the more severely ill choosing teaching hospitals.

Third, the rise in surgery performed on healthier patients did not lead to substantial health benefits, but the decline in surgery for sicker patients worsened their health outcomes, so there was an overall decline in patient welfare.

A second study, conducted in 1999–2000 of Medicare HMO (Medicare Advantage) enrollees, found that when the government issued quality report cards for Medicare health plans, enrollment changes between plans reflected the information in the report cards devoted to consumer satisfaction ratings (large parking lots and nice waiting rooms). Disconcertingly, consumers appeared to ignore the more objective information in the report cards on best practices in disease screening and prevention.

Q. How is health care quality measured?

A. The two most common standards used to measure health care quality are the Health Plan Employer Data and Information Set (HEDIS), and the Consumer Assessment of Health Plans Study (CAHPS).

HEDIS gathers data on a broad range of measures, including patient access to care, adherence to best practices care standards, provider qualifications, and financial stability. HEDIS data is collected, standardized, and released by the nonprofit National Committee for Quality Assurance (NCQA). Federal law requires all managed care plans participating in Medicare to report HEDIS data to the Centers for Medicare and Medicaid Services (CMS). Many state Medicaid agencies also use HEDIS data to assess quality, as do many employer-based health plans.

CAHPS asks Medicare beneficiaries to rate their satisfaction with various aspects of their health care, including physicians’ communication skills and the ease of obtaining care. The data are collected by the Centers for Medicare and Medicaid Services (CMS) in an annual survey.

Q. How does the quality of health care in Minnesota compare with other states?

A. The Kaiser Family Foundation provides cross-state comparisons on 500 health topics. Culled from multiple data sources, this website documents, as examples, that Minnesota ranks 28th (out of 50 states) in the number of infant deaths; 36th in hospital expenses per inpatient day; and 49th in the number of paid medical malpractice claims (www.statehealthfacts.org/cgi-bin/healthfacts.cgi).

America’s Health Rankings, produced by United Health Foundation, provide snapshots of health status across states. Both in 2005 and 2006 Minnesota was the top-ranked state. The rankings are based on measures of personal behaviors (smoking, obesity), community environment (violent crimes, infectious diseases), public and health policy (percentage without health insurance, immunization coverage) and health outcomes (rates of cardiovascular and cancer deaths, number of poor physical health days). Louisiana ranked 50th in 2006. North Dakota and South Dakota ranked 8th and 18th, respectively. Wisconsin ranked 10th and Iowa 11th.

(www.unitedhealthfoundation.org/ahr2006/index.html)

Policy redux

Sometimes it seems as if policy recommendations are made in one year and gone the next, replaced by a new set of policy priorities. But many of the Citizens League's past study committee reports and recommendations have built on the work of previous committees. In this issue, we take a look back at the Citizens League's evolving work on two important issues, health care capacity and cost, and on page 8, health care access.

Hospital centers ...and a health care system (1970)

Part 1: Health care capacity and cost

The health care system is not delivering care that is sufficiently accessible and available to the people of the community. One of the basic problems is that the system is oriented to treating people who are sick, rather than keeping people well.

In large part, this is because the arrangements that have grown up over the years for organizing and financing this huge system have been structured to encourage the use of relatively more expensive in-hospital care, and to discourage relatively less expensive care in out-patient facilities short of hospitalization, and in extended-care facilities after hospitalization. As a result, the Twin Cities area has become oversupplied with hospital beds.

The arrangements for financing are especially critical: with the extension of medical and hospital insurance to almost everyone, costs incurred for personnel,

More care about the cost in hospitals (1977)

The task of managing the health care system is extraordinarily difficult: Neither the doctor nor the patient pays directly for what they receive. Rather, through public and private insurance programs, the cost of health care floats out almost invisibly through premium payments, taxes, and the prices of products in the American economy, unrestrained either by public regulation or by force of competition in the market.

Twin Cities' hospitals are currently operating with relatively low levels of occupancy. Pressure to shorten the length of stay is likely to further reduce the level of hospital use. As this happens, hospital costs could rise even more rapidly.

These issues will come to focus in another round of hospital planning started by the Metropolitan Health Board and Metropolitan Council. A special task force is charged with setting guidelines for the size of the future hospital system and specific decisions about the future of particular hospitals.

Paying attention to the differences in prices: a health care strategy for the '80s (1981)

While some progress has been made in recent years with regard to the overcapacity of the Twin Cities hospital system, health care costs continue to spiral well beyond the rate of inflation for the rest of the economy. This study springs from the hypothesis that the basic problem confronting attempts to control the cost of health care is a dysfunctional market. In an industry dominated by a third-party payment system, and devoid of meaningful competition based on price or quality, no one has any incentive to restrain spending.

The way to hold down costs and uphold quality in the health care system lies in creating a realistic market characterized by competition among providers and incentives for participants to make cost-conscious decisions, the virtual opposite of the present condition. Reforming the system requires a greater reliance on individuals making responsible decisions based on the best available information.

Developing informed decisions: seeking market reforms to advise medical facility expansion (2006)

Minnesota is in the midst of a wave of medical facility investment, yet we lack the basic information to make good decisions about the expansion of medical facilities. We don't have a functioning market to do it for us, and there is no process in place to inform decisions or to make needed changes.

Conclusions

- Regulatory efforts in Minnesota do not align medical facility capacity with need and are, therefore, inadequate.
- The Legislature is not the preferred body to make decisions on facilities, but should establish a process to do so.
- Minnesota has a supplier-driven market. Medical care providers initiate the process to determine medical facility need. A process must be established where Minnesota defines "need" for medical care in medical facilities. This effort should develop a consumer perspective to balance the supplier-driven nature of the medical care market.

equipment or buildings are “passed along” to everyone who pays insurance premiums. So far, no one has been in a position effectively to ask: “Are these expenditures really needed or not? Is this the most efficient way to distribute health resources?”

Major ideas

- First, some agency needs to be made responsible for thinking about the system, and ways of improving utilization. This should be the new Metropolitan Health Board under the Metropolitan Council.
- Second, this agency needs to be given a combination of negative and positive tools. It needs the authority to regulate the expansion of hospital beds. But mainly, it needs the ability to guide the development of the hospital system,

and to encourage innovation in the delivery of care by early involvement and constructive suggestions.

- The key is to develop new incentives in the system that will reward hospitals and doctors providing care for keeping people well and for using resources for effectively. The providers need to bear some of the financial risk from calling resources into use.
- There is a special opportunity for the public hospital to use its program and facilities to experiment with new ways of delivery, organizing and financing care.

Major ideas

- Expansion of the health care system needs to be brought within some reasonable “goal” set by public policy. The trends toward reducing utilization of hospitals—where care is most expensive, and where costs have been rising most rapidly—need to be encouraged.
- The discussion about the future of the health care system must move out beyond the relatively closed community of health professionals in which the issues have been debated, but not resolved, up to this point. It is a basic question about the allocation of resources—between health care and education and all the other major public functions—and as such general policymaking institutions like the Minnesota Legislature and the Metropolitan Council should be involved.
- The hospital system should be the key focus of public action. Overall, the number of hospital beds in the Twin Cities should be reduced by 1,500 to 3,500 beds.

This would serve to raise occupancy levels and to create pressure to restrain rather than expand utilization.

- This reduction should be carried out by the hospital community itself. The public sector must set overall policy direction about the size and structure of the hospital system, but unless the private sector fails to act, the government should not close beds, or hospitals, by public authority.
- The Twin Cities should move aggressively to fundamental change in how health care delivery is organized and financed by encouraging the development of plans in which doctors and hospitals have built-in incentive not only to give high-quality care but also to be careful about their costs.

Conclusions

- The “problem” in health care costs today is market failure.
- Regulatory policy has not been effective in controlling health care costs. What is needed is a fundamentally different combination of competition and regulation.
- The time has come to adopt competitive means to achieve regulatory ends.

Recommendations

- In order to enhance consumer cost consciousness and introduce true price competition, all health care providers should release price and quality information.
- Consumers should be given a real choice between additional income and additional health insurance.
- Employers should offer employees a choice among several health insurance plans with varying levels of coverage to encourage consumers to buy only the insurance they need.

- Consumers should be informed, in advance, of how much employers and insurers will pay for a given medical condition. In order to contain costs and encourage competition, employers and insurers should set limits on reimbursement and offer incentives to use low-cost providers.
- Both public and private employers should adhere to a “choices” strategy. But it is particularly important that the public sector do so now, to set an example and contain costs.
- To provide for ease of market entry, certificate of need for hospitals should be eliminated.
- Some public body with an interest in regional health care cost containment ought to determine when and under what circumstances tax-exempt financing for new construction should be granted.

- Financial incentives encourage hospitals and others to cross-subsidize low margin services with profits from higher margin services, contributing to a lack of transparency in medical care financing.

Recommendations

Changes to establish market and regularly reform in the medical care market must be approached in stages.

Stage 1 Information: developing a consumer voice

The state should establish the Minnesota Medical Information Authority (MMIA) to act as a consumer voice in medical care decision making and to oversee the gathering of information to answer two fundamental questions:

- What medical services are currently available in all medical facilities?
- What is the capacity and use of existing medical facilities?

At least two-thirds of the membership of the MMIA should be consumers of medical care (as opposed to providers, insurers, or employers).

Stage 2 Decision making

- Moratorium exception decisions should be transferred to the MMIA.
- The Legislature should authorize comprehensive bidding for inpatient hospital beds to support medical services where the greatest needs have been identified.
- The MMIA should report to the Legislature and make recommendations biennially.

Stage 3 Market reform

The MMIA should explore the possibility of expanding the competitive bidding process beyond hospitals to other types of medical services and facilities.

Stage 4 Regulatory reform

Once the competitive bidding process and/or other market reforms are in place to create significant price transparency, the MMIA can assess the benefits and risks of removing the inpatient hospital bed moratorium and make recommendations to the Legislature.

Policy redux

Part 2: Health care access

Start right with Right Start: a health plan for Minnesota's uninsured (1987)

Some low-income uninsured persons are cared for by physicians and hospitals, often without charge. To offset the cost of caring for the uninsured, these providers often increase the rates charged to insurers and to patients who can pay.

However, today's competitive, cost-conscious health care system is foreclosing the opportunity to increase charges on those who can pay for care.

Little evidence exists in Minnesota that people are being denied needed medical care. However, there is evidence to show that the uninsured defer medical care until they are sicker, and the consequences and costs of their illness are much higher than if they had they sought care earlier.

As a result of the postponement of care, and of less visible cost-shifting and more visible patient-shifting, the general public will continue to pay the cost of care for the uninsured through higher insurance premiums or higher taxes.

Minnesota should act now to ensure access to affordable, cost-conscious health insurance for the low-income uninsured.

Recommendations

- The state should create a voluntary health insurance plan for the uninsured. Participants should pay a portion of the premium based on their ability to pay. Providers should be selected competitively from managed health care systems that meet quality and cost standards. More than one provider should be available for participant choices.
- To maximize the amount of federal dollars available, the Legislature should exercise its option under federal law to expand Medicaid coverage and increase income eligibility limits for the AFDC population to the maximum allowed.
- The state should reform current welfare medical assistance programs as it gains experience from the competitive health insurance plan.
- Employers should be given incentives to provide health insurance as a benefit of employment. Federal law should be amended to allow states to develop tax incentives for businesses that provide health insurance.
- The public should not rely on provider charity care as a major source of health care for the uninsured.

Access, not more mandates: a new focus for Minnesota health policy (1989)

Through the use of mandates the state requires that health plans issued or renewed in Minnesota include specific treatments, services, or levels of coverage.

Experience has shown that mandates fail to achieve their intended purposes: broadening access to health care services, spreading the financial risk of health care coverage, and defining the level of coverage that is in the public interest. In addition, mandates are inequitable because they are not applied uniformly to all types of health plans—and state requirements differ for group and individual policies. Furthermore, mandates may add to overall health insurance costs and inadvertently lead to fewer people with health care coverage.

Minnesota does not systematically apply a comprehensive, objective process to determine whether a benefit should be

mandated. Without such a systematic review process the potential adverse effects of mandates remain unchecked.

The state's health policy priority ought to be providing access to health care coverage for those without insurance.

Recommendations

The Minnesota Legislature should:

- Declare a moratorium on enacting new mandated benefits.
- Direct any new public or private expenditures initiated by the state for health care in Minnesota to address the basic health care insurance needs of uninsured Minnesotans.
- Evaluate existing mandated health benefits and reauthorize only those that meet specific public policy criteria.

Health care access for all Minnesotans (1992)

Insuring basic health care benefits for all Minnesotans at a reasonable price should be an important state policy goal. Residents have not only a right to basic coverage, but also a responsibility to obtain coverage if it is within their financial capability.

At the same time that we extend access to health care, it is equally critical that we begin to hold down the soaring increases in the cost of medical services. Affordability is a significant and growing barrier to access. Universal access to meaningful benefits will be little more than an empty promise until the state changes a system that allows physician and hospital costs to rise unchecked, mainly because it provides few incentives for quality care at affordable prices.

As Minnesota seeks to improve access, we must at the same time enact effective cost-containment and quality provisions. If costs continue to rise at past rates, we will find it increasingly

difficult to afford adequate care for a much higher proportion of the population.

Recommendations

Minnesota should require that every resident have a specified minimum amount of health insurance protection.

- Most Minnesotans would continue to be covered through employers.
- The Legislature should create a state-sponsored "Minnesota Basic Care" benefit plan for people under age 65 whose incomes disqualify them for Medicaid.
- Those people not otherwise covered and not eligible for the state-subsidized plan would be required to secure health care coverage.
- Every Minnesota resident would be required to supply "proof of coverage."

PERSPECTIVES

Expanding Minnesota's Conversation



A health care system that keeps us healthy

How we can make health care more affordable and secure

By Holly Rodin

Making health care more affordable and secure must be the primary goal of health care reform. When we think about the question of affordability, we have to ask first whether families will be protected from medical debt. Comprehensive health care reform must eliminate the need for families to hold fundraisers for cancer treatments or to pay for care after a traumatic accident.

If we begin by designing a system that makes people healthy, we have a place to start talking.

Most of the health care reform proposals currently under consideration try first to accommodate the sectors of the health care industry that drive health care costs: the insurance companies which insure only the healthy and deny as many claims as possible; the hospitals and clinics that are engaging in a medical arms race to buy the newest and most expensive medical technology; and the providers who are caught in a payment system that rewards the number and complexity of procedures done, but does not pay for time spent monitoring and supporting patients as they try to get healthy after their hospitalizations. These sectors of the health care system have failed us. Instead of working with us to produce healthier communities, they have constructed and now defend a system that spends more than any other industrialized country in the world for health outcomes that are not as good as most of those other countries.

We have to turn this debate on its head. Let's focus first on what kind of health care system would produce healthy people, and what institutions would best deliver that care. Right now, just 10 percent of the population consumes 64 percent of health care dollars. We need a system that works to

prevent the other 90 percent from becoming sick and helps the remaining 10 percent manage their illness. We need a health care system where everyone is covered, where preventive care and managing chronic disease are priorities, where a network of primary care doctors and nurses focus on keeping people healthy rather than just delivering "sick" care, and where there is a realization that personal responsibility alone cannot protect us from getting sick.

Once we address the need for preventive care and chronic disease care we can make decisions as a community about just how extensive an acute care system needs to be to meet our needs. Right now, those decisions are made by providers, the very decision makers who have created this medical "arms race." In Maple Grove, three new medical facilities are set to open in 2007, and the new hospital is set to open in 2009. These developments and other new medical services will mean that in a community of 60,000 people, there will be five urgent centers, two emergency rooms, two substantial out-patient centers, at least five clinics, and a 100-bed acute care hospital. More than enough to meet the health care needs in the area.

A health care system that finds a way to correct the current problems of underuse, misuse, and overuse will be one that can control the cost of health care, and improve our health at the same time.

Now what about our concern over the security of our health care coverage? Every time we switch employers we worry whether the new employer offers health insurance, whether it meets the needs of our families, and what it costs. People have good reason to feel insecure. Fewer employers offer insurance now than seven years ago and fewer employees are purchasing coverage due to increased

costs. More working Americans and their families are uninsured.

We need to move away from a health care system that is tied to employment to one that ensures all Americans have insurance coverage that cannot be lost or taken away. A system where insurance companies can no longer pick and choose who to cover; where the cost of insurance products doesn't vary based on age, health conditions, geography, or type of employment; a system that maintains the advantages that the employer-based system provides: large pools of people who share the risk.

We all want affordability and security in our health care system. And if we begin by designing a system that makes people healthy, we have a place to start talking about comprehensive health care reform. At a time when an in-patient hospital stay would cause serious financial hardship for almost 80 percent of the population, this is not a small problem to solve. But let's begin the discussion by focusing on what we really need from a health care system first, not by focusing solely on the very institutions that have helped to create and sustain the crisis we currently face. ●

Holly Rodin, Ph.D. is a senior field researcher for the Service Employees International Union (SEIU). SEIU unites 28,000 members in Minnesota, including 14,000 health care workers.





Better, not just more, health care

Four cornerstone principles can ensure we all receive optimal care

by Carolyn Pare

Broken. Falling apart. Too expensive. About to go over the edge. These are just a sample of the terms top experts use to describe our current health care system. Health care today is defined by its high costs and poor outcomes. While we agree there is a need for fundamental change, champions of reform seem to tout narrow solutions, such as tax law modifications or expanding access to health care, as the only legitimate approaches to reshaping a very complex delivery and payment system.

The flurry of proposals intended to increase access to health care for targeted population groups should prompt community leaders to ask some brutally honest policy questions:

Is it wise to expand access to a health care system that is not accountable for consistent and high performance?

Should there be a quality improvement/access quid pro quo for any access expansion efforts? (Before approving hospital expansions, should we make sure that the provider can easily share patient records with others electronically?)

What medical conditions and diseases should we prioritize to achieve the best overall health outcomes in exchange for additional public spending or private investment?

Tying quality to access

The evidence for tying quality improvement to strategies for expanding access to health care is clear and convincing.

A 2004 Rand Corporation study revealed that even individuals with the best coverage receive recommended care, on average, only 55 percent of the time. Providers are still paid by insurers for episodes of care rather than to ensure that patients are healthy. In other words, consumers are paying for “access” to health services, but not they’re necessarily receiving effective, high-quality treatments.

In our current care context, costs continue to rise far in excess of inflation and care is too often focused toward acute, episodic illnesses—not on the chronic diseases that now consume so much of our total health resources. In addition, the competition that does occur among health plans, providers, and payers often does not identify or reward the best preventive, diagnostic, and treatment strategies.

A recent Minnesota Department of Health report sheds light on why cost containment and quality improvement are so challenging in our state. This study on hospital facility construction concludes that too many decisions to build medical facilities are based on what brings in the most money for hospitals and doctors rather than what’s best for patients. The report also shows that areas with more health resources or access to care do not always experience better outcomes. While it’s clear the existing 20-year moratorium on new hospital beds has had a negative impact on some growing Twin Cities communities, this report demonstrates that health care systems and state leaders need to be more thoughtful in their investment and authorization strategies.

We believe Minnesota could make a great leap forward in providing better care and greater access if more public programs and private initiatives include four health quality cornerstone principles. These principles have been adopted by the Buyers Health Care Action Group (BHCAG) along with our state, business, and union partners of the Smart Buy Alliance. The four principles are:

- **Adopt uniform measures of quality and results.** Uniform quality measures give purchasers, large and small, a clear comparison of how health plans and providers stack up against one another. They send a unified message to the marketplace, and relieve providers of the need to respond to multiple demands from many different purchasers.
- **Reward “best in class” providers of care.** Rewarding good care should be a key feature in any new program. Governor Tim Pawlenty’s QCare program, which directs all state agencies to use performance-based payment standards, and Bridges to Excellence, an employer-led initiative that pays doctors cash bonuses for optimal care of diseases such as diabetes, are both good examples of programs that reward providers for keeping patients healthy and

eliminate the ineffective focus on episodes of care.

- **Empower consumers with easy access to comparative information.** Consumers need quality and price information to make “value” decisions about the health care services they receive. MN Community Measurement gives consumers a tool to help them assess the quality of care provided by clinics in a number of key categories. This Web-based report, which uses an easy to understand three-star system to rate providers on their treatment, is a good template for the type of price and quality information tools needed for our Internet-savvy society.
- **Require providers to use the latest information technology to improve administrative efficiency, quality, and patient safety.** Through the Minnesota e-Health Initiative, leaders of stakeholder groups representing consumers, employers, hospitals, doctors and others are currently developing the framework and interoperable information technology standards to give consumers portable electronic medical records and to quickly transmit patient data between competing health systems. Health care will never catch up to other industries until leaders can agree on interoperable standards.

No one should question individuals and organizations for their passion to increase access to health care. With our abundant national wealth, it is an embarrassment that so many Americans go without needed care. Not only do our citizens deserve access to care, they deserve access to the best care. Today, those with or without health care access have little better than a 50/50 chance of getting good care. We shouldn’t have to gamble on receiving high-quality care when we enter the doctor’s office. Instead, we should work hard to embrace the four health quality cornerstones to ensure that measures and rewards are in place for optimal care. ●

Carolyn E. Pare is the Chief Executive Officer of the Buyer’s Health Care Action Group, a coalition of more than 30 public and private employers dedicated to health care market reform. For more information, visit the website at www.bhcag.com.



What I learned on my journey through the health care maze

Transitioning from one job to another, one health insurer to another, was anything but seamless

by Ann Kirby McGill

In January the Citizens League policy blog asked readers to share their experiences with the health care system. As a woman, mother, daughter, and employee I've had plenty. They've been mostly good; they could be better.

My recent experiences have me thinking that health care portability is worth serious consideration. And if portability isn't a viable solution then, at the very least, insurers, primary and secondary providers, and employers need to explore how they can work better together to help consumers make transitions more efficiently.

Briefly, here's what happened to me. In early 2004, I was covered by a health plan offered through the University of Minnesota, then my employer. My husband's employer, the Saint Paul School District, used the same provider, but dependent coverage was much better under my plan so we put our son on mine. Both my husband and I used the use-it-or-lose-it pre-tax reimbursement accounts offered.

I left the University to work for a newly formed consulting firm. My new employer offered a high-deductible plan with a generous contribution to a Health Savings Account through a different provider. I wasn't eligible for 90 days, so I made COBRA payments of \$500 per month for the first three months.

Under that plan, my out-of-pocket costs rose from roughly \$30 per month to \$200 per month for my coverage alone, it was significantly more to include my son. We moved him to my husband's plan. Even with that cost-saving move, our out-of-pocket expense rose nearly 1000 percent.

on productive work or engaged with my family, friends, and community.

Systems that deal with so much always-changing data seem unable to deal in real time or to correct errors once made. With each transition, the billing lagged so that my old plan was charged for services that

I spent countless (literally) hours on paperwork and clarifying telephone calls to get onto or off of plans, shift my son's coverage, manage bridge coverage, and correct data and billing errors.

The consulting firm was a great experience, but turned out to be a transitional job. Last April, I came to the Citizens League. We're covered by the same plan I had at the University. I was eligible after 90 days, so it was back to COBRA payments and reevaluating who covered our son. He came back on my plan.

It's not the shifting financial implications of these changes that frustrate me. I am grateful for the contributions our employers make to our family's health insurance. It's a real benefit. What makes me crazy is the incredible chaos and inefficiency that has defined my efforts to manage these simple transitions. I can't imagine what it would have been like if I didn't have the wherewithal to deal with the confusion.

I spent countless (literally) hours on paperwork and clarifying telephone calls to get on to or off of plans, shift my son's coverage, manage bridge coverage, and correct data and billing errors. In every instance there was someone—sometimes several someones—on the other end of those transactions—at my employers, at their benefit companies, at my husband's employer, at the health care plan I was leaving or joining, and at the financial institution managing my Health Savings Account. It seems like a lot of wasted resources. I'd much rather spend my time

should have been paid under my new plan. The same sorts of errors happened with my son's transitions—though, remember, he stayed with the same health care plan under different group contracts. For example, his middle initial is "C" but somewhere along the line it got recorded as "G", though not consistently. Try as I might, I can't get it corrected.

My frustrations are offset by what I have learned by going through this process. I have a truer sense of the real costs to insure my family's health. I think about our responsibilities—both physical and financial—differently.

The movement between a provider-based plan and a choice-based plan has given me a chance to better understand how both work. I am relieved that my provider-based system has become more flexible in letting me see the doctors I choose and that they accept many different plans.

I expect I'll stay put for awhile and won't need to navigate this maze any time soon. Hopefully by the time I do, we'll have better, more consistent information and processes between the various players so that these transitions—with portable plans or not—happen seamlessly. ●

Ann Kirby McGill is the Citizens League's deputy director.



4/19

Policy and a Pint: America's Checkbook—Overdrawn

David Walker, head of the U.S. Government Accountability Office, is on a mission: He wants Americans to face up to the dangers of the federal deficit and fiscal irresponsibility. Join the Citizens League, 89.3 The Current and special guests to talk about what's wrong, learn what we need to do to fix it, and what it means for each of us.

5:30 p.m. at Solera, 900 Hennepin Avenue, in Downtown Minneapolis.
Sponsored by Skyline Exhibits.
Go to www.citizensleague.org for more information.

Calling all youth: join the Citizens League's new action groups

Are you a young person (18 to 25) looking to get involved in your community? Do you want to do policy work that really makes a difference in our community and our state?

Join the Citizens League and other action-oriented young people in identifying a problem, learning about it, proposing a solution, and working to make that solution a reality. Build your leadership and organizing skills in the process while you contribute to the common good.

Interested? Know someone that would be? Email Annie Levenson-Falk at alevensonfalk@citizensleague.org or call 651-293-0575 x16 to get involved. And visit www.citizensleague.org/get-involved/action/ to find out more.

PERIODICALS



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