April 18, 2008

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Legislative authors – Sen. Linda Berglin (SF3099) and Rep. Tom Huntley (HF3391) – and Governor Pawlenty are on the same page in many respects of the reform efforts because of the work of the Transformation Task Force, and passing comprehensive reform is a real possibility. We urge these leaders to keep working on a comprehensive solution this session.

Competition in the medical care market should no longer be focused on insurance companies and employers, who act as proxies for medical care delivery. The fundamental change that health care reforms must achieve is true provider competition to deliver the best care for the maximum health of the population served.

Here are the three things that we think must occur for meaningful reform.

- The development of an information system that supports decisions based on value
- Payment reform based on "total cost of care"
- Governance structures that set the ground rules for a functional market, but don't over-regulate

If you have any questions about the Citizens League positions in light of current proposals, feel free to contact me.

Sincerely,

Bob DeBoer
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Is it time for the Big Fix?

Health Care Transformation Task Force offers a plan for comprehensive reform

by Maureen K. Reed, M.D.

Do Minnesotans dare hope that the time for comprehensive health care reform has arrived? The governor's Health Care Transformation Task Force concludes that the answer is "yes." The time is now.

When the Minnesota Legislature created the Health Care Transformation Task Force in 2007, it boldly demanded that the conundrum of cost, coverage, and quality be resolved. To its credit, the Legislature established goals for our state that no other state has dared imagine, let alone seriously consider. It asked the task force to come up with a proposal to reduce health care costs by 20 percent, to provide all Minnesotans with health insurance, and to improve the quality of health and health care in the state–all by 2011.

The Legislature asked the task force to come up with a proposal to reduce health care costs by 20 percent, to provide all Minnesotans with health insurance, and to improve the quality of health and health care in the state—all by 2011.

Aggressive? Undeniably. Unreasonable? Hardly. Certainly not in the minds of families and businesses teetering on the brink of collapse because of our collective inability to resolve these issues.

After seven months of difficult but rarely contentious discussion, the task force delivered its comprehensive recommendations to Governor Tim Pawlenty in February. In brief, the report calls for five actions:

1. Take a meat ax to the health behaviors that are killing us.
2. Redesign the care delivery system to deliver the best care. Publish the results.
3. Change payment to reward the best care and to control costs.
4. Melt administrative expenses under a bright light.
5. Deliver basic health insurance to all Minnesotans at an affordable price.

The report makes clear that all five actions are necessary–and must occur simultaneously. Health care reform is not a giant game of "pick-up sticks" in which players try to extract one stick at a time, hoping that the haphazard heap miraculously remains intact. Instead, health care reform is a carefully organized rearrangement and rebuilding of the structure itself. The Legislature is considering the task force recommendations in companion bills, Senate File 3099 and House File 3391.

Recommendation No. 1: Health

It is no accident that the first task force recommendation addresses population health. Tobacco remains Minnesota's number one killer–by far. Obesity threatens our health and our budgets. Binge drinking and illicit drugs exact a painful societal toll. The report calls for the adoption of specific and aggressive health goals: Slash tobacco use by 50 percent. Increase to 50 percent the number of Minnesotans with a healthy weight. Decrease binge drinking in adults and children. These menaces require both population-wide and individual approaches.

On the "population" side of the ledger, the task force adopted the recommendations of the Minnesota Comprehensive Statewide Health Improvement Plan.

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This plan recommends those tobacco-control actions that are known to work and those especially effective in children: increasing tobacco health impact fees, funding mass media campaigns, and enforcing access laws. Furthermore, it sets statewide standards for healthy activity and eating, and it asks schools, communities, and workplaces to play their indispensable and unique roles in advancing these initiatives.

On the "individual" side, the task force recommends confidential health risk assessments, differential premiums for people who are tobacco-free and maintain a healthy weight, and requirements for health insurance to cover effective preventive services with little or no cost sharing.

With appropriate funding of the Comprehensive Statewide Health Improvement Plan, task force members believe these goals are attainable. In a recession, a $57 million annual price tag might seem challenging—until one calculates the net savings. Aside from health itself, the most impressive consequence of tackling population health is the massive return on investment in later years as savings from healthy behaviors compound. As Table 1 indicates, $1.3 billion annual net savings in 2011 mount to nearly $3.3 billion annual net savings by 2015.

Recommendation No. 2: Health care

The Transformation Task Force is convinced that Minnesota already has many of the building blocks necessary to dramatically improve our health care. Care improvement coalitions, evidence-based care guidelines, electronic medical records, and public reporting of care outcomes are hallmarks of Minnesota's cutting-edge health care landscape. Yet consistently excellent, high-value outcomes elude us.

Expanding evidence-based care, establishing minimum care standards, increasing private financial investment in these innovations, and requiring electronic medical records as a condition of payment are just some of the task force recommendations. Because fundamental care redesign is incomplete without substantially greater patient involvement in care decisions, the task force calls for this as well.

If collaboration has its virtues, so does competition. Significantly expanding the breadth and depth of comparative outcomes reporting is a core feature of the task force recommendations. Meaningful information on care and cost across a multitude of services should be so readily available that consumers can quickly compare the performance of providers and act accordingly.

Recommendation No. 3: Health care payment

There are few things more toxic to care and cost improvement than the way we currently pay for health care services. Payment is based almost exclusively on volume—the more services delivered, the greater the payment. There is no significant financial incentive for keeping people healthy, coordinating their care, or producing better health outcomes. A health care reform proposal is credible only if it delivers an antitoxin that neutralizes poisonous incentives.

The task force proposal squarely confronts this challenge. It rewards those providers who deliver great care at lower cost. It also aligns patient incentives with high-value care. In the report, this new payment method is called Level 3.

In brief, this is how Level 3 works. Let's say I'm a doctor or administrator in ABC Medical Group. I know my group's cost structure and capabilities. I also know the performance, capabilities, and cost of the hospitals and specialists to whom I refer. (This wider group of providers is the "care system" in which I practice.) My knowledge of this care system allows me to determine what it will cost to deliver all the health services that a standardized group of patients will require in a given period. Having calculated this cost, I can now decide the price my care system will charge for delivering these comprehensive services to this standardized group of patients.

My care system brings our price forward, and this price becomes public information. If the cost for delivering all necessary care turns out to be less than my care system's price, we will realize financial rewards. If the cost is ultimately more than the price, we will not be allowed to charge for the overage.

My care system is only responsible for the conditions and the care that are under our control and influence. The insurance risk of underlying health conditions, socioeconomic status, and ethnic background of the patients is adjusted out and is not our responsibility.

What are the consequences of this new payment method? First, because every care system makes its price public, every purchaser can now easily compare prices. Cost competition ensues. The care system with low capital costs and administrative

Table 1: Potential Health Care Cost Savings

	2011		2015	
	$ millions	% of total spending	$ millions	% of total spending
Base: Projected Spending	$43,933.8		$57,400.0	
Potential cost savings:				
Payment reform	$4,393.4	10.0%	$5,740.0	10.0%
Prevention and health improvement:				
Overweight/obesity	$332.0	0.8%	$1,236.3	2.2%
Smoking	$841.9	1.9%	$1,684.3	2.9%
Alcohol and drugs	$189.6	0.4%	$417.8	0.7%
Cost of interventions*	($57.1)	(0.1%)	($57.1)	(0.1%)
	$1,306.4	3.0%	$3,281.3	5.7%
Patient shared decision making	$43.9	0.1%	$57.4	0.1%
Technology assessment	$439.3	1.0%	$746.2	1.3%
Administrative efficiency	$878.7	2.0%	$2,468.2	4.3%
Subtotal: cost savings	**$7,061.7**	**16.1%**	**$12,293.1**	**21.4%**
Net cost to cover uninsured**	($866.0)	(2.0%)	($1,155.0)	(2.0%)
Net savings	**$6,195.7**	**14.1%**	**$11,138.1**	**19.4%**

Does not include potential additional costs borne by private and public insurance

**System-wide increase in cost due to increased use of health care services. See Appendix B for information on potential cost to state government.*

expenses has a distinct advantage. The all-too-obvious current temptation to build unnecessary capacity disappears.

Second, in this new world there are no contentious, expensive, time-consuming negotiations between providers and health plans. Administrative costs are therefore further reduced.

Third, the provider must maximize care outcomes. Remember recommendation No. 2? Every individual and institutional purchaser has full access to comparative information on care outcomes. Because the only way to achieve great care outcomes is to provide timely, coordinated, patient-centered care, every care system must do just that. Becoming a "medical home" for patients with complex, chronic conditions may be one approach that care systems employ.

While recommendation No. 3 speaks primarily to provider payment, this recommendation also ensures consumer engagement. Giving consumers information is one engagement tool. Another is allowing consumers to financially reap the benefits of choosing a high-quality, low-cost provider. While patients may choose to get care in a more expensive care system, they will pay more for choosing this option.

An important challenge of any new payment method is for a critical mass of purchasers to adopt it. Medicare will likely not accept this new method, so energetic adoption by other purchasers is necessary. Given the expected cost reductions of a payment method that re-aligns incentives, Minnesota's public and private purchasers will be encouraged to jump on the train.

Although the Level 3 payment method is not completely new, many details must be worked out in advance of the recommended 2012 implementation date. For the interim, the task force creates two temporary payment methods which may be used as a bridge to 2012. Neither is a destination. The first (Level 1) is an important tweak to the current system. It ties the fee-for-service payment to achievement of certain quality outcomes. The second (Level 2) goes a step further. In addition to requiring quality outcomes, it creates a fee-for-service payment for those providers who proactively identify and coordinate the chronic care needs of their patients and who effectively involve those patients in their own care.

Recommendation No. 4: Health care costs

The health measures of recommendation No. 1, the data transparency and quality improvement of recommendation No. 2, and the payment reform of recommendation No. 3 substantially reduce health costs. But achieving the 20 percent cost reduction that the Legislature envisioned requires additional actions. Therefore the task force calls for educating consumers, streamlining governmental regulation, eliminating health plan activities unnecessary in the reformed system, and visible public reporting of administrative costs. Because health care costs are fueled in part by the rapid spread of new therapies whose effectiveness is unknown, the task force also recommends assessment of the comparative effectiveness of new therapies. Health insurance should not pay for new therapies that are not known to be better than current treatments.

> Health care reform is not a giant game of "pick-up sticks" in which players try to extract one stick at a time, hoping that the haphazard heap miraculously remains intact.

Recommendation No. 5: Health insurance

A newly created "health insurance exchange" oversees sweeping insurance reform. This reform includes merging the individual and small group markets, guaranteed issue of insurance regardless of health status, and premium differentials based only on age, geography, and health behaviors. A "risk equalization" mechanism guards against risk avoidance by insurers. And to promote fairness, the task force calls for most employers to offer Section 125 plans that allow employees to purchase insurance with pre-tax dollars.

The task force agrees that people making less than 300 percent of the federal poverty guideline should not be expected to spend more than 7 percent of their income on health care. Under this proposal, people at lower incomes receive subsidies to allow them to purchase affordable basic health insurance. Furthermore, all citizens will be mandated to purchase a basic, standardized insurance package. This standardized benefits package includes those services known to be effective and of significant value.

Because the cost of subsidizing care is hefty (see table), the need for effective cost control mechanisms is obvious.

Conclusion

Under the best current estimates, this proposal delivers truly impressive net savings. Table 1 estimates that when this proposal is aggressively and fully enacted, the cost of health care is reduced 14 percent by 2011. The Legislature's goal of 20 percent cost savings is nearly achieved by 2015. The task force believes that this holistic proposal has an excellent chance of delivering what Minnesota requires. The task force is also convinced that extracting and implementing only some of the recommendations may cause the tottering pyramid of pick-up sticks to collapse.

A proposal this comprehensive will certainly invite scrutiny. And well it should. Several health care reform proposals are currently circulating at the Capitol. Citizens should judge each proposal based on its ability to meet the aggressive and necessary goals that the Legislature established in 2007. Any proposal that cannot simultaneously improve health and health care, cut costs by 20 percent, and cover all Minnesotans should be rejected.

The task force has demonstrated that there is indeed a way to resolve the cost-quality-coverage conundrum. Yes. The time has arrived. ●

Maureen K. Reed, M.D., F.A.C.P., is a board-certified internist and an independent consultant engaged in state health policy and a member of the Citizens League. She was formerly the Medical Director for HealthPartners Health Plan, a Regent of the University of Minnesota, and the Independence Party's 2006 candidate for lieutenant governor.



Citizens League's history on health care policy shares much with current reform efforts

by Linda Stone, Bright Dornblaser, and Bob DeBoer

Following the report of the Citizens League's medical facilities study committee in 2006, the Citizens League proposed legislation calling for the creation of a consumer council to chart a path toward the development of a functional market in medical care. In 2007 we participated in the governor's Health Care Transformation Task Force (see related article on page 1).

State lawmakers are now considering the recommendations of the Transformation Task Force, and, early this year, the Citizens League met to discuss how best to advance our policy on health care. As part of that effort we decided to look back at where we have come from. Over the past quarter-century, the Citizens League has produced four study committee reports and one statement on health care.

Earlier Citizens League work and the Transformation Task Force both conclude that unsustainable growth in the cost of health care is the result of market failure and ineffective regulatory policy.

There are clear areas of congruence between the 2006 medical facilities study committee and the Transformation Task Force recommendations, especially in two areas:

- **Information**—information is necessary to support a functional market in medical care. Without informed consumers, we cannot realize the benefits of lower cost and better value that supply and demand typically provide in a competitive market.
- **Governance**—government, nonprofit organizations, private institutions, and citizens must work together to govern major changes in health care. We cannot rely solely on a regulatory approach and a dysfunctional market. The Citizens League seeks to take this concept even further, defining "governing" as something that can occur anywhere and anytime an individual has authority to make decisions. We all have some decision-making authority in our families, communities, religious organizations, and businesses.

When there is an opportunity to advance existing policy positions at the Citizens League, we put a notice in our free email newsletter. Subscribers meet to discuss how current developments and Citizens League policy intersect. We call these policy advancement groups. The policy advancement group's recent discussion of these areas of congruence led to an important agreement: the need to evaluate Citizens League work from before 2006 to determine its relevance to the Transformation Task Force report. Three Citizens League health care reports and a statement, produced between 1981 and 1992 and summarized here, provided a fertile ground for comparison and analysis.

Paying attention to the differences in price (1981)

One fundamental conclusion of this report was that the health care industry was not operating as a rational market. The report recommended controlling health care costs by reforming the market—focusing on the demand side—rather than attempting to regulate supply. It advocated encouraging true competition by making provider prices readily available to the public and revising the system's incentives to reward efficiency rather than consumption.

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

The Citizens League recognized the lack of available health care coverage for low-income Minnesotans whose incomes were too high to qualify for public assistance and those workers whose employers did not offer health insurance. We recommended that the state create a voluntary health insurance plan for the uninsured earning up to 200 percent of the federal poverty level and based on ability to pay. We recommended that eligibility be phased in starting with children, pregnant women and persons leaving AFDC. Subsequently, the Minnesota Legislature enacted the Children's Health Plan; Minnesota Care was created five years later.

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

The Citizens League questioned the value and equity of Minnesota's large number of mandated insurance benefits. We stated that the state's health care priority should be universal access to a basic level of care. We recommended a moratorium on new mandates pending a legislative review and a critical evaluation of existing mandates.

Health care access for all Minnesotans (1992)

This statement was issued in February 1992, three months before the creation of Minnesota Care. The top conclusion based on our existing body of work was that basic health care benefits should be available to all Minnesotans at a reasonable price, and that all residents not only have a right to basic coverage, but a responsibility to obtain it if it is within their financial capability. Based on work from 1987, the statement outlined the Minnesota Basic Care Plan and the Major Medical Care Plan and called for financing the proposal from the state's income tax so that all citizens shared in the responsibility of providing it, based on ability to pay.

The Citizens League called for cost and quality control and said that "Minnesota cannot afford simply to extend access to the current system with the uncontrolled and rapidly rising costs it produces." We also stated that "universal coverage, however, need not and should not mean a single-payer, government-dominated system" and that "variety and true competition—a mixed system with multiple payers and providers—is the most promising path to quality medical care at reasonable prices."

Congruence and divergence

Many provisions of the Transformation

Task Force report are congruent with Citizens League conclusions and recommendations. In trying to determine which elements of the task force report the Citizens League supports, it is important that we look beyond the differences in the framing and scope as we evaluate the overlap between the two.

Market failure

Earlier Citizens League work and the Transformation Task Force both conclude that unsustainable growth in the cost of health care is the result of market failure and ineffective regulatory policy. Both recommend restructuring the market in a way that allows for true competition and results in high-quality health care at a sustainable cost. Both identify the need for transparent price and quality information and introduce incentives and disincentives as mechanisms for containing costs.

Price and quality information equal value

Earlier Citizens League work called for providers to set fees and consumers to make choices. The idea of a consumer guide in the early Citizens League work is replaced by the Transformation Task Force's more comprehensive approach, which recommends restructuring the market through meaningful competition. That comprehensive approach calls for prices to be based on the cost of all services related to a medical condition, not individual services. Providers are accountable for quality, the coordination of care, and the total cost of care. Consumers will be able to more accurately compare providers because there will be no cost shifting to insurers or to other payers. It will also reduce administrative costs by eliminating multiple fee schedules and negotiations between providers and payers on every contract.

Total cost of care

Total cost of care is a new concept for Minnesota cost-control legislation. The Transformation Task Force argues that competition on price and quality alone would help to reduce the costs of individual services, but it would not go far enough to reduce overuse of unnecessary medical services. Holding providers accountable for the total cost of care provides an incentive not only to reduce the unit cost of each service but also to reduce overuse.

While early Citizens League work focused primarily on the impact of providing health care consumers with better price and quality information, even then, study committee members recognized that a broader approach would be needed. In 1981, a study committee wrote:

"Comparisons that focus on the health patterns of representative populations, rather than solely on the cost effectiveness of discrete services, will permit consumers to evaluate the overall effectiveness of various providers and will provide incentives to those providers to encourage healthy lifestyles among their patients."

The Transformation Task Force has captured that broader approach with its recommendation for a total cost of care approach to pricing medical care in Minnesota.

Employers, insurers, and providers

The Citizens League has historically recognized that employers and insurance plans are central to market competition in health care. We called for employers to offer employees a choice among several insurance plans with varying levels of coverage. We wanted buyers (insurers, businesses, and government) to set reimbursement caps for various medical services and to notify consumers in advance of how much they would pay for a given medical condition.

This ideal of consumer choice led the Citizens League to oppose what is called "community rating" in earlier Citizens League health care work. We wanted the

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Government's role in Transformation Task Force recommendations

A new private, non-profit, and publicly accountable Health Care Transformation Organization (HCTO) should be established to plan, coordinate, and report on implementation of all of the recommended transformations.

- Governor and legislature appoint the HCTO board.
- HCTO designates Health Care Value Reporting Organization to report on quality, including outcomes, processes of care, and patient satisfaction.
- HCTO implements and evaluates the payment system reforms that call for pricing, transparency, pricing for "baskets" of services, and accountability for new total cost of care.
- HCTO reports progress towards containing health care cost growth and improving quality.
- HCTO makes action recommendations to governor and legislature about adjustments.

Defines affordability of health insurance coverage and provide subsidies (guidelines).

The Institute for Clinical Systems Improvement (ICSI) acts as a collaborative, non-regulatory body to review the evidence for new technologies and determine whether they should be covered by health insurance.

Nonprofit health insurance exchange with public oversight:

- Provides technical assistance to small employers in establishing and operating Section 125 plans.
- Serves as a convenient source of standardized information to consumers comparing the cost and quality of different health insurance products.
- Can purchase in or outside of the exchange as long as price is same.

Establish an independent board (contracts with ICSI) to define an essential benefit set that:

- Includes necessary, evidence based care.
- Excludes care that has been demonstrated as being ineffective.
- Covers other services that produce good outcomes at a reasonable cost.

Fiscal systems

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These principles, deployed by creative Minnesota minds focused on the fiscal system, could lead to improvements and additions to the reforms suggested here.

A generation ago, Minnesota's legislature and governors changed the state/local fiscal system dramatically, creating the "Minnesota Miracle". Now, the legislature and Governor Tim Pawlenty could renew the Minnesota Miracle by reconstructing the fiscal system, applying these principles to fit 21st century reality.

Conventional wisdom says big change is politically impossible. President Ronald Reagan, when talking about the Tax Reform Act of 1986, said: "There are three stages of reaction to a new idea like our tax proposal. The first stage is: 'It's crazy. It'll never work. Don't waste my time.' The second: 'It's possible, but it's not worth doing.' And finally: 'I've always said it was a good idea. I'm glad I thought of it.'"

I say, Minnesotans did it before, and we can do it again. ●

John P. James is an attorney with extensive experience in taxation and in creating fiscal system reform proposals and a member of the Citizens League. He was Minnesota Commissioner of Revenue from 1987-91 and has been actively involved in Minnesota fiscal system issues ever since.

Health care history

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maximum in consumer choice, but the basic idea behind insurance—before we started adjusting risk for so many variables—was that everyone would pay a similar amount for a similar amount of coverage. The total of what everyone paid needed to be enough to provide the coverage to the "community" or the rates would need to increase. This is the essence of community rating.

The Transformation Task Force proposes the framework for true competition among health care providers based on value, therefore some of the specific measures that the Citizens League called for from employers and insurers in earlier work may not apply to the task force's approach. The task force call for a modified community rating and the basis for our earlier rejection needs to be reevaluated in this new context.

Access

The task force calls for universal access to high-quality health care at a sustainable cost. Insurers who offer individual health insurance policies would be required to sell a policy to anyone, regardless of their age or health status. The Citizens League has long supported universal access to health care and produced the foundational work for the Children's Health Plan and Minnesota Care.

In its 1989 report, the Citizens League argued that access to basic health care should be available and attainable. The report recommended the legislature direct new state funds to provide health insurance to the uninsured with a plan that provided a basic set of benefits. Until such a basic health plan permitted universal access to health care, the Citizens League argued there should be no new mandates for benefits. Once access to health insurance was guaranteed, individuals should be required to enroll in a health insurance plan. Any mandated benefits should then define the level of care in the public interest, spread the financial risk, and support a basic level of required care.

Unlike this staged approach, the Transformation Task Force recommends simultaneously providing access and mandating coverage.

The role of government

The Citizens League has consistently called for government to function in a quasi-public role: to establish the rules of the health care market allowing consumers to reap the benefits of true competition.

The Citizens League called for a system of competition and regulation in 1981. The task force proposal evolves beyond this with a call for a restructured system of collaboration, coordination, and integration throughout the full cycle of health care. The task force assumes that cost controls—a more regulatory approach recommended in earlier Citizens League reports—will not be needed as it shifts basic accountability for cost and quality from employers to providers and health insurance companies.

The Transformation Task Force calls for government to decide on strategy and implement new regulation; support population health improvement programs; support and participate in community-wide processes to develop evidence-based guidelines for care; create greater price and quality transparency; and, introduce and support incentives to restructure market according to goals (see sidebar p.8).

Continued advancement

The Citizens League will continue to push for a functioning market in medical care. We believe that the measures in the Transformation Task Force report support and extend the Citizens League work, and, if implemented, the recommendations will do much of what is necessary to provide the right kind of informed medical care marketplace. The Citizens League also supports a governance structure that acknowledges the role that government must fill, but goes well beyond government in roles and responsibilities. We believe that the task force work also provides the framework to do that. It is clear that the rich health care policy history of the Citizens League provides us with the gateway to continue to contribute in developing comprehensive health care reform and the Citizens League will work toward that end.

For a more detailed comparison of the Citizens League and the Transformation Task Force health care positions, visit the Citizens League website under the "Policy Advancement" header.

The Citizens League will convene additional policy advancement meetings on health care in the coming weeks to determine more specifically the degree to which we support current reform efforts. ●

Linda Stone is a member of the Citizens League and has practiced immigration law for the last 18 years.

Bright Dornblaser is Emeritus Professor with the University of Minnesota Division of Health Policy and Management, the former director of the U's Health Care Management Program and a member of the Citizens League.

Bob DeBoer is the Citizens League's Director of Policy Development.