

HEALTH POLICY

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PRINCIPLES FOR REFORM

As advocates of systemic health reform, the Partnership relies on the following principles:

- Provide price and quality information that is relevant and useful to patients.
- Pay for results and outcomes, not volume of procedures.
- Eliminate regulations and mandates that inhibit innovation in insurance.
- Expand and create incentives for healthy lifestyles and wellness.
- Develop and implement appropriate infrastructure for health information.

Blueprint for Health Care Reform: Aligning incentives to deliver greater value

Goal: *To ensure a functioning, responsive health care marketplace that will achieve optimal health outcomes, reduce the cost of health care, reduce the rate of future cost increases, and increase access to affordable health care for Minnesotans.*

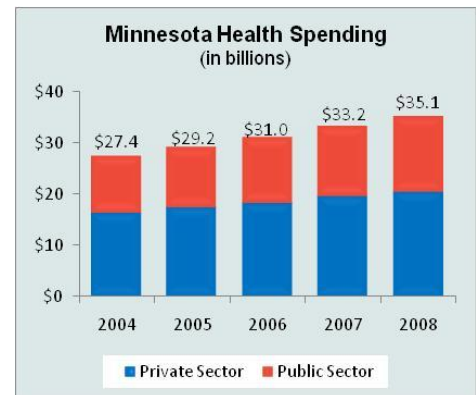
Minnesota is a national leader in health care. We have among the lowest rate of uninsured (9 percent¹), a high rate of private insurance (67 percent²), and a relatively healthy population (7th healthiest state³). As we watch other states' health care reform efforts, they are often just beginning to catch up to Minnesota. And while the Patient Protection and Affordable Care Act (PPACA) signed by President Obama makes progress on some fronts, Minnesota is still ahead nationally in terms of bending the cost curve.

However, our health care system in Minnesota and the United States is far from healthy. A RAND study found that only 50 percent of patients, both children and adults, received recommended care regardless of socioeconomic status. The Institute of Medicine estimates that 50,000 to 100,000 people nationally die every year due to medical mistakes in hospitals.

Disincentives for improvement

A McKinsey Global Institute report released in January 2007 points to the lack of incentives for patients and consumers to be value-conscious in their demand decisions as one of the main reasons for the high health care cost in the United States. Consumers remain divorced from the cost of health benefits and health care. Meanwhile, health plan and health care services are provided and priced in ways that are unintelligible, preventing value-conscious consumers from accessing useful cost and quality comparisons.

In addition to the wrong incentives for consumers, there are perverse incentives for providers. Our system rewards quantity of services over quality



Total health spending in Minnesota from \$27.4 billion in 2004 to \$35.1 billion in 2008, a 28% increase over five years. Public-sector spending (Medicare, Medical Assistance and other programs) increased 32% compared to a 25% increase in private-sector spending.

¹ Kaiser Family Foundation, State Health Facts 2009 – Insurance coverage of total population

² 2010 MDH Health Economics Program – Minnesota Health Care Markets Chartbook

³ According to 2010 America's Health Rankings

of care with economic disincentives to improve care and little accountability for results. Avoidable admissions generate revenue for doctors and hospitals. Complications require additional care generating additional provider income.

Under the current system, providers who invest in improvements in care often face economic challenges. There are many examples of providers in Minnesota and across the country who have implemented innovative care delivery initiatives which improved quality and lowered cost, only to be penalized financially because their revenue is based on service volume, not quality outcomes.

Cost pressures eroding coverage, straining budgets

Cost of health services and insurance coverage are continuing to grow faster than inflation, making our current health care system unsustainable for employers, individuals and public safety net programs. While employers continue to be the major source of health insurance for Minnesotans, double-digit premium increases and higher cost-sharing with employees are causing a decline in employer-based coverage. Employer-sponsored insurance dropped from 68.4 percent in 2001 to 58 percent in 2009⁴. That figure likely declined further during the recession, while adding more people to state public insurance programs, including Medicaid and MinnesotaCare.

While Minnesota's public-sector programs are facing the same cost pressures as the private-sector, the impact on public-sector programs is magnified by increasing enrollment. Minnesota should maximize federal matching funds for public programs to enhance our ability to cover individuals who might otherwise further the cost-shift of public programs to the private sector.

Individuals without employer-sponsored coverage can purchase coverage through the individual insurance market. However, current law allows underwriting, which means individuals with high claims histories pay higher premiums or can be rejected outright. The Minnesota Comprehensive Health Association (MCHA) is the state's safety net program for this high-risk population. Because MCHA is funded through insurance premiums, it further drives up costs for employers and individuals.

The federal PPACA is enacting systemic reforms that will impact all avenues to obtain health coverage. This includes individual and employer mandates for insurance coverage in 2014 and creation of health insurance exchanges with subsidies available to certain individuals. Minnesota has the option of creating our own exchange, but if we do not, the federal government will establish an exchange for Minnesota.

PRINCIPLES FOR COMPREHENSIVE REFORM

Our current health care coverage and delivery system is unsustainable. To create a sustainable system that provides higher quality care at lower cost, the Minnesota Business Partnership advocates comprehensive reforms that engage consumers, align purchasers, and reorient providers and insurers to find and deliver market-driven efficiencies and permanent health care savings.

Principle 1: Provide price and quality information that is relevant and useful to patients.

Neither pricing in health care nor comparable quality measurements are always transparent or meaningful to patients or purchasers of health coverage such as employers. Providers' prices are primarily for individual units of service and frequently do not take into account the full episode of care. Although the

⁴ Kaiser Family Foundation, State Health Facts 2009 – Insurance coverage of total population

market is shifting to other payment methodologies such as gain-sharing and total cost of care performance, payments to each provider are still negotiated and lack transparency for consumer use. The actual price paid for a service is often not provided to the patient until long after the care is provided. Meanwhile quality measurements are beginning to be used for benchmarking providers; however, these tools are rarely used by consumers in determining which provider to use.

Recommendations

In order to help people – individuals seeking care and purchasers of health coverage – make value-based decisions for health care, the Partnership advocates reforms that will engage consumers by providing understandable information. Minnesota’s 2008 health care reform legislation, which the Partnership actively supported, initiated efforts to advance transparent pricing of health care services. The legislation established eight initial baskets of care: asthma, diabetes, pre-diabetes, back pain, obstetric care, preventive care kids and adults, and knee replacement. These baskets also include common quality measures reported and Minnesota Department of Health will publish comparative information on the baskets available. In addition, payers and providers are jointly working to develop additional episode-based or basket-based payments. In conjunction with these and other existing efforts, the Partnership recommends the following:

- Measure providers and care systems on their ability to keep patients healthy and avoid unnecessary services and costs. Use existing community, state and federal resources, such as the Institute for Clinical Systems Improvement (ICS), to define common expectations and measurements for health plans and providers.
- Pursue quality reporting by health plans using a common tool to give purchasers access to uniform, comparable quality and cost information on health plans to facilitate purchasing on value.
- Create and make available to consumers quality comparisons, consistent with the benefit packages to enable consumers to make decisions based on cost and quality.
- Create and make available to consumers measures for patient satisfaction as well as patient accountability.
- Pursue provider reporting on quality using process measures and outcomes measures, instead of claims data, where appropriate.
- Define common service ranges for comparable services (i.e. maternity care, joint replacement, etc.).
- Define a general time period for packages of care, health care home services or global payment arrangements.
- Set and publish prices for services, including unit, packaged/bundled, and global payment, or “total cost of care.”
- Couple appropriate application of evidence-based care with an individual provider price for a service.

Principle 2: Pay for results and outcomes, not volume of procedures.

Typically, our health care system does not reward services outside the traditional office visit setting such as education and follow-up. Yet, almost 80 percent of health care costs are used by patients with chronic illness, and optimal management of chronic illness requires provider-patient interactions. Meanwhile, repeated episodes of care, infections and adverse outcomes caused by system failures and the practice of “defensive medicine” result in additional payments to providers. In addition, capacity for high-margin,

preference-sensitive services such as imaging and procedures, is skyrocketing, driving up utilization and overall cost to the system. The result is an unsustainable cycle of investments that drives up cost while failing to direct resources to where they would be used more efficiently and effectively.

Recommendations

The Partnership advocates reforms that realign incentives within the system to deliver and reward value, not volume; drive efficiencies and cost savings through improved and coordinated care delivery; reduce the demand for costly procedures and hospitalizations; and reward providers of all sizes based on results and outcomes, not just volume of patients served and their ability to negotiate with health plans.

- Structure payment reform initiatives to reallocate current resources, not just add more money into the system. Target the savings achieved through reform to shifting from a fee-for-service system to a performance-risk system.
- Base provider contracts on superior results. Health plans should continue to pursue contracts with providers based on results and outcomes, not just discounts. Align financial incentives to reward reductions in total cost, improved quality and consumer satisfaction.
- Reimburse providers based on levels of service and global payments for full continuum of care under Accountable Care Organizations.
- Encourage providers and payers, including Medicaid and Medicare, to develop innovative, outcome-based payment structures that reflect the unique positions of providers across the state.
- Maintain strong antitrust policies in both the health plan market and health care delivery market to avoid anti-competitive pricing practices while encouraging collaboration on individual patient care.
- Make utilization data uniformly available to providers to facilitate care coordination focusing on high risk populations with multiple chronic conditions.
- Review the current license and scope of practice laws for all members of a medical team to ensure that each may practice from bottom to top of their licenses – thus delivering care more efficiently, at lower cost and with less risk of complications.
- Support public policies that will discourage and minimize medical mistakes and other avoidable events that add to the cost of care.
- Reform medical malpractice laws in order to reduce the practice of defensive medicine while ensuring adequate patient protection.
- Encourage and support health care providers who incorporate Lean Management principles and other proven business practices that will provide greater efficiencies, not only in the care they deliver, but also in the management of their business.

Principle 3: Eliminate regulations and mandates that inhibit innovation in insurance.

All too often, government regulations and mandates add to the cost of health coverage, create incentives that encourage cost shifting and cost avoidance, and discourage – even prohibit – activity that could increase efficiency, reduce overall costs and improve quality of care. For example, Minnesota has 63 mandated benefits which add to the cost of health care for those in the fully insured market, and may add to the cost of public programs depending on what essential benefit set is established by the federal government.

Recommendations

The Partnership advocates a functioning individual insurance market with tax parity that would provide employers with a choice of offering specific insurance programs for their employees to help with recruitment and retention of employees, or help employees purchase coverage in the individual market through compensation and administrative supports.

- Provide comparable insurance coverage and tax fairness for individuals by providing the same tax benefits as those covered in the group market.
- Develop a Minnesota-based Health Insurance Exchange to enhance Minnesota's individual insurance market.
- Create a commission to 1) compare Minnesota's state-mandated benefits for public and private programs to mandates in other states, and 2) review current and proposed mandates to assess the scientific evidence, medical effectiveness and impact on resource allocation and health coverage affordability.
- Eliminate regulatory requirements that discourage insurance product innovation and delivery in order to provide more options for employers, employees and individuals.

Reform the Minnesota Comprehensive Health Association (MCHA), the state high-risk pool, by supporting:

- Ensuring MCHA rates do not compete and in no case are lower than rates in the private market. Premium rate increases for MCHA enrollees should be consistent with rate increases seen in the private sector based on comparable plan design.
- A broader-based funding source for MCHA. The MCHA assessment accounted for more than 2 percent of premium for the fully insured market in 2009. The fully insured market is mainly made up of small- and medium-size employers and individuals.

Principle 4: Expand and create incentives for healthy lifestyles and wellness through insurance products, health care providers, employers, schools, etc.

According to the Centers for Disease Control and Prevention, costly chronic diseases, such as diabetes and heart disease, are among the most common and preventable of all health problems in the U.S. today. One in two adults in the US has at least one chronic disease. One in three adults is obese, as is one in five youths. Approximately one in five adults smoke. Less than a quarter report eating the recommended servings of fruits and vegetables per day or getting the recommended activity. Tobacco use, physical activity and nutrition are behaviors that can be modified by an individual to reduce the likelihood of becoming obese, suffering a stroke, or developing heart disease or arthritis.

Recommendations

To restrain health care cost trends, the Partnership advocates the use of effective primary and preventive care that, based on strength of evidence and magnitude of net benefit, can prevent costly procedures and hospitalizations. We should promote the use and expand the availability of wellness programs in our communities. Wellness programs available through health plans, health care providers, employers, schools and many other organizations are focused on these factors.

Efforts that will support and promote effective primary and preventive care include:

- Follow accepted guidelines for preventive care endorsed by groups such as the Institute for Clinical Systems Improvement.
- Educate individuals on the availability and benefit of primary and preventive services in their existing health coverage.
- Ensure that public programs offer proven primary and preventive care coverage.
- Create and promote appropriate incentives for people to use primary and preventive services in both public and private plans.

Efforts that will support individual and community wellness:

- Measure Return on Investment (ROI) of wellness programs.
- Educate employers and other potential investors of the ROI of wellness efforts.
- Coordinate a forum for wellness best practice-sharing, mentoring, education, etc.
- Educate the public about the availability of existing wellness programs.

Principle 5: Develop and implement appropriate infrastructure for health information sharing between providers that is portable for individual patients with appropriate information.

While the health care sector is on the leading edge of advances in medical technology, the industry lags in the application of information technology (IT). Despite rapid evolution in data transmission, aggregation and storage, personal health information remains fractured. Pertinent health information is in the hands of multiple providers who have treated people at different points in their lives instead of in one secure but accessible location.

Recommendations

The Partnership recommends a health IT infrastructure where information could be easily shared to improve quality and reduce medical errors; decrease costs by improving efficiencies, reducing medical errors and coordinating care; and, improve provider/patient decision-making.

- Continue to support Minnesota's efforts on coordinated HIT implementation and development, and that policies moving forward should be consistent with both ongoing state initiatives as well as the federal HITECH act.
- Develop and implement a statewide IT protocol for sharing clinical data among providers to improve quality of care, increase patient safety and utilize our health care dollars better (i.e. not perform the same test at multiple sites).
- Provide financial incentives and support to help providers, particularly smaller, independent providers, adopt IT tools.
- Make personal health records portable and available for all Minnesotans to improve care, reduce duplicate tests and redundant data collection, and help consumers play a more active role in their care.

ROLE OF GOVERNMENT

In addition to the principles above, the Partnership has identified the following roles for government to enhance a strong, functioning marketplace for health care.

Set standards: Within this framework, the role of government should be to set standards for the health care sector – and take down barriers to cost-effective health care, allowing for market innovation to lead reform efforts consistent with our Blueprint. Appropriate state and federal regulations should be in place to protect consumers and reinforce the incentives in a functioning market-based, patient-centered system. Standards should address issues such as insurance underwriting, individual affordability, benefit coverage and provider quality.

Provide a safety net: State and federal health care programs, such as Medicare, Medicaid, MinnesotaCare and General Assistance Medical Care, play a distinct and important role as payers for a large portion of the population. These programs should be structured as part of a functioning market, and should be streamlined for maximum administrative efficiency and value to the individuals covered.

- Beneficiaries should be empowered to use providers/plans that deliver cost effective, quality care.
- Reimbursement systems and levels should include incentives for high-quality, cost-effective care without shifting cost to the private sector.
- The cost of uncompensated care should be addressed directly and transparently – not simply shifted to the private sector through higher private reimbursement rates.
- Revenue to fund public health care spending should rely on broad based, equitable sources.
- Revenue designated for health care should be used only for health care purposes.

Minnesota Impact from Federal Reform: Traditionally, the Partnership does not lobby at the federal level. However, the debate over national health care reform – with its potential impact on Partnership members and Minnesota – led the Partnership to work with members of Minnesota’s congressional delegation on the issue. As federal health care reform in the Patient Protection and Affordable Care Act (PPACA) is implemented, the Partnership will continue to work with our key congressional members and state policy leaders to ensure that Minnesota’s makes the most of opportunities provided and that our advances in health care reform are not negatively impacted.

Innovation in the Private Sector: The state should enable plans, providers and employers to create a market-based, patient-centered system and to promote healthy lifestyle choices. Rather than attempt to restrict self-insured organizations, which are governed at the federal level by ERISA, the state should look to them as valuable vehicles for innovation and flexibility in health care.