

LISTENING TO MINNESOTANS: TRANSFORMING
MINNESOTA'S HEALTH CARE SYSTEM



Report of the
Minnesota Citizens Forum
on Health Care Costs

FEBRUARY 23, 2004

LISTENING TO MINNESOTANS: TRANSFORMING MINNESOTA'S HEALTH CARE SYSTEM

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Minnesota Citizens Forum on Health Care Costs

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*Al Fallenstein was tragically taken from us in an automobile accident in December.
He remains with us in spirit.

STAFF ACKNOWLEDGEMENTS

Michael Scandrett served as the staff director, with assistance from Mona Peterson Rosow of Hallelund Health Consulting, but many others made important contributions, including Scott Leitz and Julie Sonier of the Minnesota Department of Health, Barbara Vaughan and Sheila Moroney of the National Institute of Health Policy, and Susan Heegaard of Governor Tim Pawlenty's office. Thanks to Mary Jo O'Brien for her substantial contributions and assistance in working with the Governor's office. Thanks also to Jill Caruth and Kate Schlauch who did a lot of heavy lifting to provide administrative support and to Bonny Belgum and Bekah Orr for their research support. Many others contributed as well, most without compensation.



MINNESOTA CITIZENS FORUM ON HEALTH CARE COSTS
220 South Sixth Street, 600 Pillsbury Center South
Minneapolis, Minnesota 55402

February 23, 2004

Dear Governor Pawlenty:

On behalf of the Leadership Panel members of the Minnesota Citizens Forum on Health Care Costs and the many Minnesotans who have shared their ideas, concerns and values through our Minnesota Dialogues process, I am pleased to submit to you this report, "Listening to Minnesotans: Transforming Minnesota's Health Care System."

The report reflects not only an enormous amount of work by all those involved, but a deep-seated desire by many Minnesotans to work together to create a better system of health care. The findings and conclusions in this report are a consensus not just of the Leadership Panel, but of Minnesotans from across our state.

I submit this report with some personal observations:

First, Minnesota is in the enviable position of being able to build on some enormous strengths in our health care system. Our state's uninsured rate of 5.4 percent is one of the lowest in the nation. Minnesotans consistently have ranked among the healthiest people in the country. Dramatic and immediate change is needed, but we start our journey in far better shape than many other states.

Second, many of the recommendations in this report call for partnerships – between government and employers, between purchasers and payers, between providers and consumers and on and on. Collaboration is a great Minnesota tradition. We can look at many of the strengths of our health system and see at their beginning an innovative partnership. How much more of a challenge would we face today if employers, government, payers and providers hadn't worked together in the late 1980s and early 1990s to make it easier and more affordable for small business to obtain health coverage for their workers or to create MinnesotaCare?

Third, the report cites many barriers to an affordable, accessible health system. One barrier is not mentioned, however, even though it may be the largest of them all. Too often, important reforms are stymied by the barrier of false choices. We pit individual privacy against the need to collect data about public health, even though we can do both. Tort reform is constructed as a choice between safeguards on an error-prone system and the ability of providers to practice cost-effective, evidence-based medicine. We demand controls over rising health insurance premiums, yet reward political intervention in mandating benefits and treatments. Certainly, there will be difficult trade-offs and challenging choices as we take on the task of reforming the

health system. But we are in this together. We need to frame choices in ways that reflect the common good.

Fourth, some will take the easy way out and dismiss the recommendations in this report by saying they are nothing new. In one sense, they are right. There is no one magic answer. We have known for years that greater consumer involvement in health care purchasing decisions, universal coverage and many of the other recommendations are essential to reforming the health system. As is so often the case in life, we know the right thing to do; the difficulty is in doing it. So it is with health care.

Having said that though, this report is new on two important fronts. First, it is the most comprehensive set of recommendations ever offered for reform. It connects the actions in a cohesive and clear action plan. Second, the recommendations are borne of public involvement. The recommendations aren't the work of those with a special-interest agenda to pursue. They are based on the values and principles of Minnesotans.

And that gets me to my fifth and most important observation. Minnesotans are ready for change. In many ways, the people of Minnesota are ahead of policy makers on health care reform. Minnesotans need more tools (especially information) to be full partners in health care reform, but they are ready for the challenge. They know change will be difficult and will require contributions from everyone, but they also know that we no longer can just tinker around the edges.

Change will be difficult. It will require hard work, political courage and a faith in the people of Minnesota. Taking on this challenge may seem overwhelming. Ignoring this challenge will be devastating. Delay no longer is an option. The time to act is now.

With that, it is great privilege to have been part of this process and a great honor to submit this report, "Listening to Minnesotans: Transforming Minnesota's Health Care System."

Sincerely,

David Durenberger, Chair

Executive Summary

A CRISIS OF AFFORDABILITY. The average Minnesota household pays \$11,000 per year for health care in taxes, premiums, and out-of-pocket costs for themselves and others. If health care costs continue to grow at the current rate, the cost per household will reach \$22,000 by the year 2010. Without a change, our health care system will be priced out of reach of most Minnesotans. Businesses are also being hit hard by the increasing health care costs. In the past four years, insurance premiums have grown 3½ times faster than the state's economy and workers' wages. As health care costs continue to grow, employers have less money to spend on wage increases and other benefits for employees. Rising health care costs are also breaking the back of state and local governments. The relentless rise in health care costs has forced the Minnesota Legislature to divert millions of dollars away from education, roads, and the environment. Based on a three percent growth rate each year in the state's total health care spending and no reduction in the monthly cost of the average enrollee, by the year 2007, lawmakers will be faced with a decision of whether to cut another 104,000 low income Minnesotans from government health care programs.

PEOPLE PAY FOR HEALTH CARE. In our current financing system, people are in the dark about health care costs and excluded from most decisions about coverage and financing. Most Minnesota households pay less than a third of the cost of health care directly out of their own pockets. The rest is paid by employers and government in ways that are hidden from view. Even this money is actually coming out of people's pockets, they just don't realize it. Government uses our tax dollars for government programs and for health insurance for public employees. Employers pay their share of the health insurance premium using employee benefit dollars that might otherwise be paid to workers in additional wages or other benefits. Businesses build the cost of their share of health care premiums into the price of goods and services we purchase every day. Ultimately, people, not government or insurance companies, pay for everything and they should be fully informed and involved in decisions affecting their pocketbooks.

SERVING THE PEOPLE. Past efforts to keep health care affordable – from government price controls to managed care – have had at best only temporary success because they did not have public support. People felt the changes were forced on them by outside forces in a health care system they did not trust. To have lasting success, control of the health care system must be given back to the people who use and pay for it. Minnesota has earned a national reputation for leadership and innovation in health care. That success has always come from the ability to listen to citizens and to trust their collective judgment. The starting point must be the shared community values of Minnesotans and the goal must be a health care system where the individual is in control of his or her own care and coverage.

LISTENING TO PEOPLE. At the request of Governor Tim Pawlenty, the Minnesota Citizens Forum on Health Care Costs (Minnesota Citizens Forum) spent November and December, 2003 listening to Minnesotans. Town hall meetings and informal listening sessions were held across the state. An online survey was developed to solicit information from those who were not able to attend the town hall meetings. Ideas sent

by Minnesotans through the mail and the Internet were read. Surveys and other research on public opinion in Minnesota were studied. The Minnesota Citizens Forum worked with the Minnesota Board on Aging and the Minnesota Governor's Council on Developmental Disabilities to conduct a survey of a representative sample of 800 Minnesotans. In the end, a surprising amount of agreement was found about what Minnesotans expect from the health care system and what they think should be done about rising costs. Our first report, "*Listening to Minnesotans: the First Step towards Building a Better Health Care System,*" describes the results of the dialogue with Minnesotans in detail.

In addition to talking with the public, we also sought the ideas and advice of experts and leaders from health care, business and government. We were impressed. Most major business and health care trade associations submitted detailed proposals for improving health care. We found that they, like the general public, agree about more things than they disagree about. They know major changes are needed and are ready and willing to work together. Our recommendations are built on the large expanse of common ground that exists among Minnesota citizens and leaders from health care, business and government.

MAJOR CHANGE IS NEEDED. There is a big gap between what people want and what the current system delivers. Many Minnesotans said we will not be able to fix the health care system without making major changes. Isolated, band-aid approaches will not have a lasting effect. They may even have the unintended effect of increasing health care costs further. Minnesotans are ready for change and are willing to do their part.

WE ARE ALL IN THIS TOGETHER. Few of us can afford to pay the costs of a serious illness without insurance. We use a health insurance model to share the risk with others. In any given year, 20 percent of us will use no health care services while one percent will consume 27 percent of all health care dollars. By sharing the risk through insurance, we can afford health care when we need it. We count on the system to balance individual needs with the needs of others. The Minnesota Citizens Forum discovered Minnesotans understand this concept and embrace it, but they have lost faith in the system's ability to do this fairly. They lack trust because they are left in the dark and do not have a say in important decisions. Restoring trust in the system is the key to making sustainable improvements Minnesotans can support.

BUILDING ON EXISTING EFFORTS. We were very impressed with the commitment and leadership shown by Minnesota's health care community, business community and public officials. Minnesota is a hotbed of nationally recognized leadership and innovation in health care. Our health care system has a strong climate of creativity, collaboration and commitment. Activities are already underway that take us halfway to our vision of how Minnesota's health care system should work. Our goal is to build on these existing efforts rather than create new ones. We want to foster an environment that encourages collaboration among existing efforts, eliminates redundancies and capitalizes on the ability to create successful new models for health care delivery.

CHARGED WORDS. Because the health care reform discussion is so politically charged, some words have become associated with a particular political or philosophical agenda or mean different things to different people. We tried to avoid loaded terms such

as “universal coverage,” “free market system,” “consumer-driven health care,” “evidence-based medicine,” “personal responsibility” and “single-payer health care system.” When we used these terms, we tried to explain what we meant. For example, when we use the term “health care” in this report, we are using it in its broadest sense – to include mental health, dental health, and long-term care – even though we have not developed specific recommendations in these areas.

COMPETITION IN A WELL-FUNCTIONING HEALTH CARE SYSTEM. The polarized, political debate between a “single-payer” system (a universal, government-financed health insurance plan that covers everyone) and a “free market” health care system (where government plays a minimal role in regulating or managing health care) continues. In the mean time, nothing changes and we slip deeper into the health care cost crisis. The Minnesota Citizens Forum looked to Minnesotans for the answer. We found that almost all Minnesotans agree on two fundamental principles: (1) they want a responsive system where everyone gets the health care they need, and (2) they want a privately-based health care system that offers as much choice as possible. Our recommendations will lead to a uniquely Minnesotan universal health care system that promotes healthy private sector competition while assuring the overall system serves the best interests of all Minnesotans.

A VISION FOR THE FUTURE. We believe Minnesotans deserve a health care system that delivers better health and equitable to safe, high quality treatment at an affordable price. Everyone must do their part to realize the vision, including individuals, communities, those who work in the system and those who finance it. Some of these changes can be implemented immediately; many of the changes will require years of work and will succeed only if there is steady leadership from committed individuals.

GENERAL RECOMMENDATIONS

The current health system is very complex, but it is simple to describe what needs to change. We can drive a car without knowing exactly how the engine works. The following recommendations require major changes, but by working together and building on existing efforts already underway, the job will get done. For each recommendation, we have identified actions that should be taken to implement the recommendation. Time is essential, we must act now.

1. **PUT MINNESOTANS IN THE DRIVER’S SEAT.** Minnesotans should make the decisions about health care, both individually and collectively. This is a paradigm shift from the current system where many of the most important decisions are made by employers, health plans, health care professionals and government. Minnesotans need to define what the health care system should do as opposed to the system defining itself. There also needs to be a collective discussion on how to fund the system and what affordability means. Employers, HMOs, and health insurance companies should play a supportive role, but not the lead role. This means we will have to rethink what the marketplace should look like.
 - a. Give individuals more choices and control of their health care treatment, with incentives for choosing higher quality, lower cost providers; however, consumer-centered health care should

not create financial barriers that prevent people from getting preventive care and cost-effective services.

- b. Give individuals the opportunity to choose from a full array of health plan choices ranging from low-cost to high-cost, while preserving the basic concept of insurance which uses money from the currently healthy to subsidize the currently sick.
 - c. Make sure individuals with a chronic disease or disability can afford to receive the care they need to avoid preventable complications of disease.
 - d. Establish a permanent process for a continuing dialogue with the public and for conducting research on Minnesotans needs, values and preferences.
2. FULLY DISCLOSE COSTS AND QUALITY. Minnesotans should be fully informed about health care costs and quality and able to compare the price and quality of health care providers and health plans in order to make informed decisions. This will be eye-opening for the public. Most people have no idea how much variation exists in quality and price. As members of a community, they should know where the money goes, how it is used, who profits from it, and what quality and outcomes they are getting for their money.
- a. Give Minnesotans detailed information on prices costs and financing in the current system.
 - b. Create a health care information web site with comprehensive information about health care costs and quality in Minnesota (see recommendation 3 on quality).
 - c. Implement a public awareness campaign to increase the public's knowledge of the costs of health care.
3. REDUCE COSTS THROUGH BETTER QUALITY. During the dialogue with Minnesotans, many examples were given of how health care dollars are often wasted on ineffective treatments, mistakes and poor quality care. By some estimates, 30 to 40 percent of health care dollars are spent on ineffective and unnecessary care. Health care costs can be reduced by improving quality of care and eliminating health disparities.
- a. Change payment systems to reward better quality and effectiveness.
 - b. Standardize methods of measuring and reporting quality.
 - c. Give Minnesotans quality information about health plans and health care providers.
 - d. Bring together existing quality initiatives in a state forum to coordinate existing quality improvement efforts and develop a

statewide quality plan that will achieve specific quality improvement goals.

- e. Test new improvements in care for persons with chronic disease and disability.
 - f. Define “quality” to include cultural competence and no disparities in health status, access and quality.
4. CHANGE INCENTIVES TO ENCOURAGE HEALTH. The current system does not reward individuals for healthy lifestyles, nor does it reward health care providers for improving a patient’s health. The broader environment, too, does not encourage good health. Super-sized, caloric, high-fat fast food has replaced home-cooked meals. Poor diet, lack of exercise, high stress lifestyles, and smoking result in higher rates of obesity, heart disease, cancer and mental illness. Incentives in the health care system should be changed to produce better health and outcomes, and together we should seek to create healthier communities.
- a. Change payment systems across the entire health care system so that incentives produce better health.
 - b. Reward people who maintain good health with discounts on health care, lower premiums, or other benefits.
 - c. Encourage employers and communities to provide programs and incentives to influence individuals to adopt healthier behaviors.
 - d. Strengthen the state’s efforts to reduce tobacco use, with a special focus on youth smoking.
 - e. Add a \$1.00 per pack user fee on cigarettes to reduce smoking rates and raise revenue for state efforts to reduce smoking, improve health and provide access to uninsured Minnesotans.
 - f. Launch an aggressive campaign to reduce obesity, especially among children.
 - g. Strengthen the public health system through community partnerships and adequate funding.
5. ASSURE UNIVERSAL PARTICIPATION IN THE HEALTH CARE SYSTEM. Minnesotans are strongly in support of a health care system where everyone has access to needed health care. Access to health care may be limited by financial, geographic, linguistic or cultural barriers. These barriers result in poorer health, lack of preventive care and delays in needed treatment, all of which add cost to the system. We must work together to eliminate barriers so that everyone has health care coverage and is able to get the services they need. However, a universal system is not just about access and coverage, it is also about meaningful participation by individuals so we have a health care system

in which everyone receives needed health care, including preventive care, at a cost they can afford and everyone contributes to better health. We share the financial risk of medical expenses through insurance so that we can afford health care when we need it. If everyone is not paying in, especially when healthy, we run the risk that others will not receive care when they need it.

- a. Set a goal of “universal participation” in the health care system, which is broader than just universal access or coverage.
 - b. Continue the state’s commitment to the goal of health coverage for all Minnesotans, with a priority for covering children.
 - c. Give uninsured Minnesotans access to affordable basic preventive care and other cost-effective services that will improve their health and reduce the need for more costly treatment.
 - d. Require participation in the health care system by uninsured Minnesotans who can afford to buy health coverage but choose not to.
 - e. Change the current system of financing uncompensated care for the uninsured to eliminate cost-shifting and spread the burden more equitably.
 - f. Eliminate non-economic barriers to access for needed health care services.
 - g. Reform the insurance market and promote purchasing pools to create better opportunities for individuals and small businesses.
6. **SUPPORT NEW MODELS FOR HEALTH CARE EDUCATION.** Minnesota is facing a growing shortage of health care workers even in areas typically not affected by worker shortages. The existing workforce cannot keep up with current demand, nor is it adequately prepared for the rapid changes that are taking place in our state’s demographic makeup and the revolution of medical technology treatment. Support new models for health care education to meet Minnesota’s changing health care needs.
7. **REDUCE THE COST OF OVERHEAD AND ADMINISTRATION.** The complexity, duplication, and lack of accountability in the current system results in unnecessary costs for overhead and administration. Significant savings can be achieved by streamlining and standardizing administrative procedures and government regulations. New electronic technology offers an opportunity for further savings.
- a. Establish uniform health care industry standards for electronic billing, electronic medical records, reports and other administrative procedures.

- b. Use health care industry partnerships to facilitate the rapid adoption of new electronic technologies that will improve efficiency and service and reduce administrative costs.
- c. Adopt a new approach to state health care regulation.
- d. Reform health care taxes.

HOW TO GET THERE

A major effort is needed to make the transformational changes recommended above. The good news is that much agreement exists about the direction we need to go; everyone seems ready to do their part, and leaders are stepping forward to spearhead the effort. These three ingredients – vision, commitment and leadership – will get us to our goal. We suggest the following specific steps to get started, but all should be done in a way that is open to the public and maximizes participation of Minnesotans to assure that the changes truly serve the needs of Minnesotans.

- 8. **STATE LEADERSHIP.** The State of Minnesota will lead the way by changing the way the state carries out its role as purchaser, regulator and provider of health care services. On Friday, February 6, 2004, Governor Pawlenty announced that the State of Minnesota will develop a united state health care purchasing and regulatory strategy that will set an example for the entire state.
- 9. **BUYERS ALLIANCE.** With state leadership, consumers, employers and other buyers can be brought together to form a united buyers alliance to get the leverage needed to drive major changes in the health care delivery system. Governor Pawlenty and some of the state's largest employers and business organizations have agreed to provide leadership.
- 10. **PUBLIC/PRIVATE PARTNERSHIP.** Once consumers and buyers make it clear what is expected from their health care system, the health care industry will respond. An action-oriented, public/private partnership is needed to help the health care industry retool and work together to manage a seamless transition from the old way to the new way of doing things. Private leaders from health care and business will work with Governor Pawlenty to organize this activity.
- 11. **BIPARTISAN LEGISLATIVE WORK GROUP.** While much can be accomplished through public and private collaboration without the need for legislation, the Minnesota Legislature will play an important role in changing the state's public policy to support improvements in health care. Health care leaders in the House and Senate from both parties have agreed to work together and with the Governor, in a bipartisan way, to agree on public policies and draft legislation for the 2005 legislative session.

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LISTENING TO MINNESOTANS: TRANSFORMING MINNESOTA'S HEALTH CARE SYSTEM

Report of the Minnesota Citizens Forum on Health Care Costs

Introduction

In September 2003, Governor Tim Pawlenty announced the formation of the Minnesota Citizens Forum on Health Care Costs (Minnesota Citizens Forum.) Under the leadership of former U.S. Senator David Durenberger, an 18-member Leadership Panel comprised of respected citizen leaders was convened to lead a statewide, public discussion on how to keep health care affordable. Their charge was

To engage Minnesotans in a public dialogue about the causes and consequences of rising health care costs, and possible solutions, and to recommend both short and long-term actions for controlling costs that are grounded in community values.

The Leadership Panel sought to develop a set of recommendations for changing the way health care is delivered in Minnesota, a plan based on Minnesotan community values. Beginning in October 2003, the Leadership Panel began meeting each month to discuss the current health care system and aspects of the system that were driving up costs. After defining the problem, the Leadership Panel began focusing on the vision for the future of Minnesota's health care system. As part of this process, the Leadership Panel formed four small groups around health, access, quality and affordability to discuss in depth the goals for Minnesota's health care system and to make recommendations on how to meet those goals. These groups presented their recommendations to the panel for approval.

Over the same period of time, the Leadership Panel went to Minnesotans, both the general public and health care experts, to learn what Minnesotans believed was the problem, the solution and the vision of Minnesota's health care system in the future. Over the course of this process, the Leadership Panel received input from:

- Twelve town hall meetings, including 4 meetings with special invitations extended to the Latino, American Indian, African American, and Asian American communities - over 500 people participated in the town hall meeting process.
- 800 randomized participants in a telephone survey.
- 108 respondents to an online survey.
- 94 proposals from both individuals and stakeholder organizations.
- 158 individual emails and letters.
- Numerous listening sessions with local chambers, trade associations, business groups, health educators and others.

Based on this information and their discussions, the Leadership Panel developed recommendations that are contained in this report, the second report issued by the Leadership Panel. The first report, "*Listening to Minnesotans: the First Step towards Building a Better Health Care System,*" describes the results of our dialogue with Minnesotans. This report uses what was learned through our conversations with Minnesotans to recommend changes to Minnesota's health care system that will keep health care accessible and affordable, using methods that the public will consider fair and reasonable.

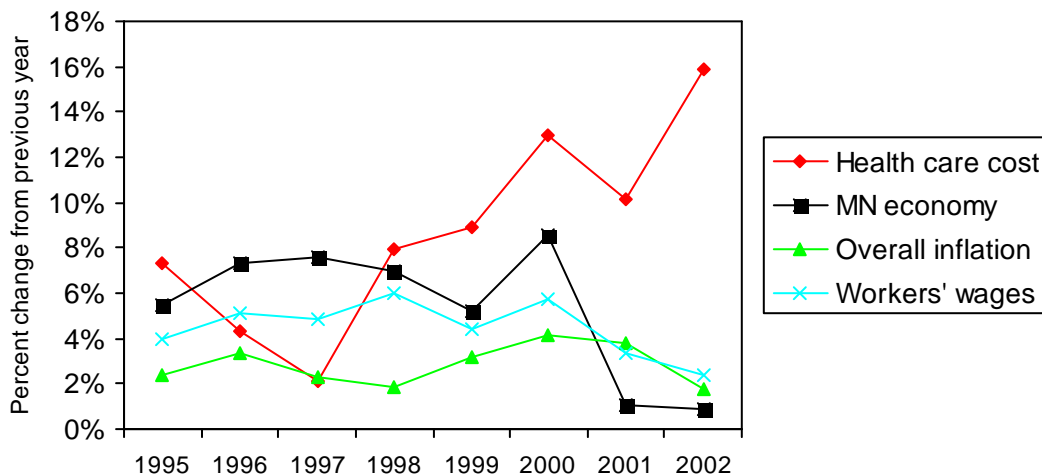
Chapter One

MINNESOTA'S HEALTH CARE CRISIS

The rising cost of health care is a serious threat to Minnesota's business climate, the state budget and citizens' well-being and standard of living. In 2001 alone, \$21.6 billion was spent on health care (over 11 percent of Minnesota's economy), and the costs are rising faster than economic growth, personal income and general inflation. In the past four years:

- Medical costs for insured Minnesotans have grown by 57 percent.
- The cost of health insurance has grown 3½ times faster than the state's economy and workers' wages.
- The cost of health insurance has grown over 4 times faster than the rate of inflation.

Diagram 1: Key Minnesota Health Care Cost and Economic Indicators



SOURCE: Minnesota Department of Health, Health Economics Program (HEP)

* Note- Health care cost is Minnesota privately insured spending on health care services per person; MN economy is gross state product; overall inflation is consumer price index for the Twin Cities area; workers' wages is the average weekly wages for Minnesota workers.

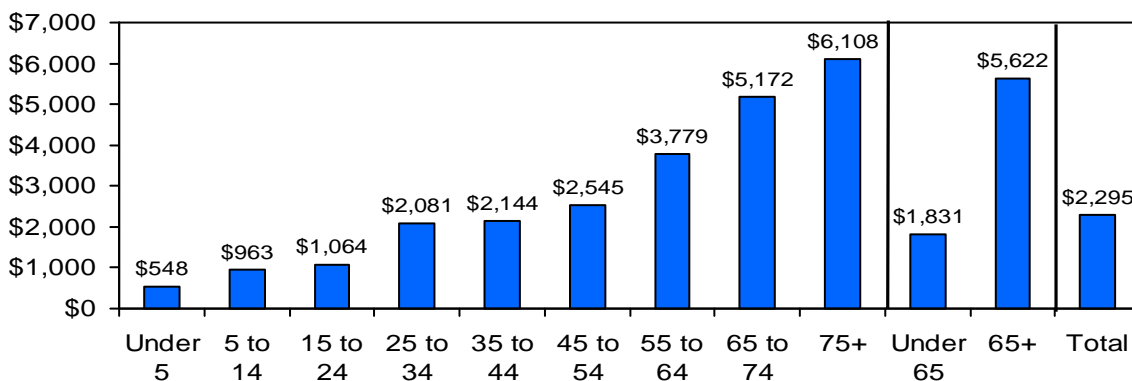
A CRISIS OF AFFORDABILITY. The average Minnesota household pays about \$11,000 per year in premiums, out-of-pocket costs and taxes for health care for themselves and others. A person working full-time at minimum wage does not make enough to pay the monthly premium for a typical family health insurance policy. If costs continue to grow at the current rate, the cost per household will reach \$22,000 by the year 2010. Without a change, our health care system will be priced out of the reach of most Minnesotans. Businesses are also being hit hard by the increasing health care costs. As health care costs grow, employers have less money to spend on wage increases and other benefits for employees. Rising health care costs are also breaking the back of state and local governments. Based on a three percent growth rate each year for the

state's total health care spending and no reduction in the monthly cost of the average enrollee, by the year 2007, lawmakers will be faced with a decision of whether to cut another 104,000 low income Minnesotans from government health care programs.

AN AGING POPULATION. The changing demographics of the state will further compound the problem. The age distribution in Minnesota is changing as the baby boomers age with a 70 percent projected growth of the sixty-plus age group by 2020. On average, as people age, their need and use of health care services increases. Because of this projected change in demographics, hospitalizations and use of physician services are likely to increase substantially. In 2001, Minnesota hospitals provided 2.5 million days of inpatient care (approximately 57 percent capacity); it is predicted that by 2030 this could rise as high as 3.9 million (approximately 91 percent of current capacity.) This growth will place strains on the health care system not only in terms of costs and services, but also in terms of workers.

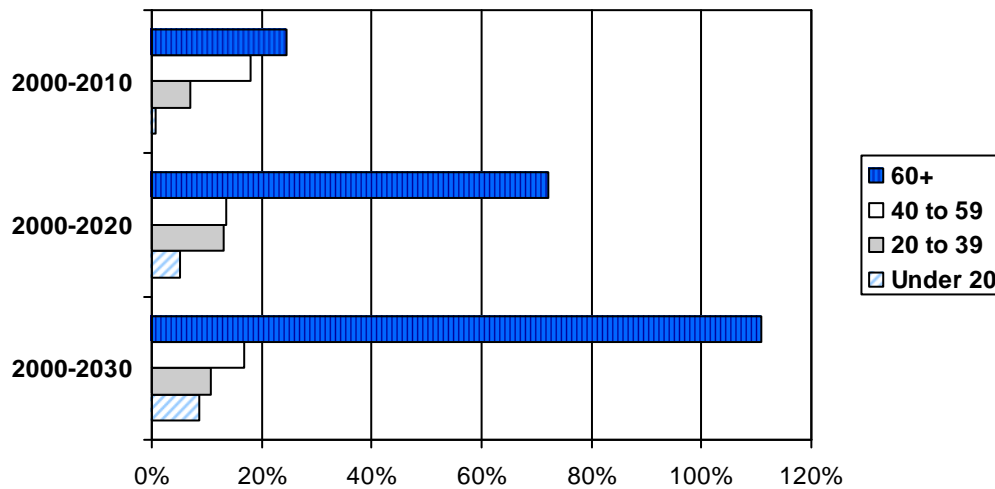
Diagram 2: Variation in Health Care Spending by Age

Per Capita U.S. Health Care Spending by Age, 2000



SOURCE: Agency for Health Care Research and Quality, Medical Expenditure Panel Survey, data for per capita spending by age group in the Midwest, inflated from 1999 to 2000.

Diagram 3: Projected Minnesota Population Growth, by Age Group



SOURCE: Minnesota State Demographic Center

PEOPLE PAY FOR HEALTH CARE. The complexity of the health care system similarly compounds the health care costs crisis. People, not government or insurance companies, pay for health care. Even though everything comes out of their pockets, individuals are in the dark about health care costs and excluded from most decisions about coverage and financing. Most Minnesota households pay less than a third of the cost of health care directly out of their own pockets. The rest is paid by employers and government in ways that are hidden from view. Even this money is actually coming out of people's pockets, they just don't realize it. Government uses tax dollars for government programs and public employees' health insurance. Employers pay their share of health insurance premiums using employee benefit dollars that might otherwise be paid to workers in additional wages or other benefits. Businesses build the cost of their share of health care premiums into the price of goods and services purchased every day. For example, Ford Motor Company adds \$700 to the price of every car to cover the cost of its employees' health care premiums. Because health care decisions are being made by people who do not pay for those services, there is no connection between those who pay for the services (the individual) and those who buy the services (the government or employer.) Leaving individuals out of decisions regarding health care results in higher costs for everyone because individuals have no idea how much things cost and therefore no incentive to choose cost-effective services.

WE MUST ACT NOW! Minnesota's health care system has to change. We have two options. We can either passively let the health care system change based on current pressures and take our chances that we will end up with a better health care system, or we can act now as a community to plan and control health care system changes so that our future health care system will meet our needs and be consistent with our community values. We believe Minnesotans are ready to learn from the past, define the problems and solutions, adopt a uniquely Minnesotan vision for the future and come together to make major changes to the health care system. With these steps, we believe our health care crisis will be averted.

How We Paid for Health Care in 2001 in Minnesota*

SOURCE: MDH Health Economics Program 12-15-03

Method of Payment	Average Per Household ²	% of Household Income ³	GSP \$ ¹	GSP % ¹
Indirect				
Medicare Payroll Taxes ⁴	\$1,416	2.19%	\$2,723,720,690	1.45%
Other Fed, State, Local Taxes ⁵	\$4,791	7.40%	\$9,215,097,294	4.90%
Reduced Wages ⁶	\$1,311	2.02%	\$2,521,054,293	1.34%
Other ⁷	\$236	0.36%	\$454,506,112	0.24%
Direct				
Private Health Insurance Premiums ⁸	\$1,455	2.25%	\$2,798,608,973	1.49%
OOP Payments ⁹	\$1,781	2.75%	\$3,425,394,000	1.82%
Public Program Premiums ¹⁰	\$211	0.33%	\$405,564,638	0.22%
Total	\$11,200	17.30%	\$21,543,946,000	11.46%

SOURCES AND

NOTES:

1. GSP \$ and % based on MDH HEP "2001 Minnesota Health Care Spending" Sept. 2003 and 2001 Minnesota Gross State Product from the Bureau of Economic Analysis (BEA).

2. Population and household estimates for 2001 are from the U.S. Census and MN State Demographer/MN Administration Department.

3. Average Minnesota Household Income is based on data from the 2002 American Community Survey plus employer provided health benefits.

4. Includes employee and employer paid. Data sources used in deriving estimate: CMS, BEA, LAUS and CEW data sets, and the 2001 MN Health Access Survey.

5. Taxes for government health care spending, plus general taxes to compensate for tax subsidies for health related income. Estimate is a residual. 2002 ACS used to break out by age.

6. Employer contributions for health insurance, less tax subsidies. Data used in deriving estimate: MN 2001 Health Plan Financial and Statistical Report, MDH HEP "2001 Minnesota Distribution of Insurance Coverage" Sept. 2003, 2001 MN Health Access Survey, KFF and HRET "Employer Health Benefits, 2001", MN Dept. of Revenue "State of Minnesota Tax Expenditure Budget" Feb. 2002, Mark Pauly "Administering Social Problems Through the Tax System: Tax Implications of Health Benefits" Presented at June 2003 IRS Research Conference.

7. Non-patient revenue for the health care industry, including donations, interest income, hospital parking, gift shops, etc. Data Source: 2001 Audited Financial Statements of Health Facilities.

8. Includes employee contributions to private group plans, individual policy premiums, and Medigap and M+C premiums. Data used in deriving estimate: MN 2001 Health Plan Financial and Statistical Report, MDH HEP "2001 Minnesota Distribution of Insurance Coverage" Sept. 2003, 2001 MN Health Access Survey, KFF and HRET "Employer Health Benefits, 2001", MN Dept. of Commerce Med. Supp. rates, MDH HEP "The Structure of Cost Sharing and Benefit Levels in Minnesota's Small Group and Individual Insurance Markets" Oct. 2003.

9. Data Sources: MDH HEP "2001 Minnesota Health Care Spending" Sept. 2003, Medical Expenditure Panel Survey (MEPS) used to break out OOP by age.

*These figures do not count that portion of the price of every product and service we buy that represents the cost of health benefits provided to workers who brought the product or service to us.

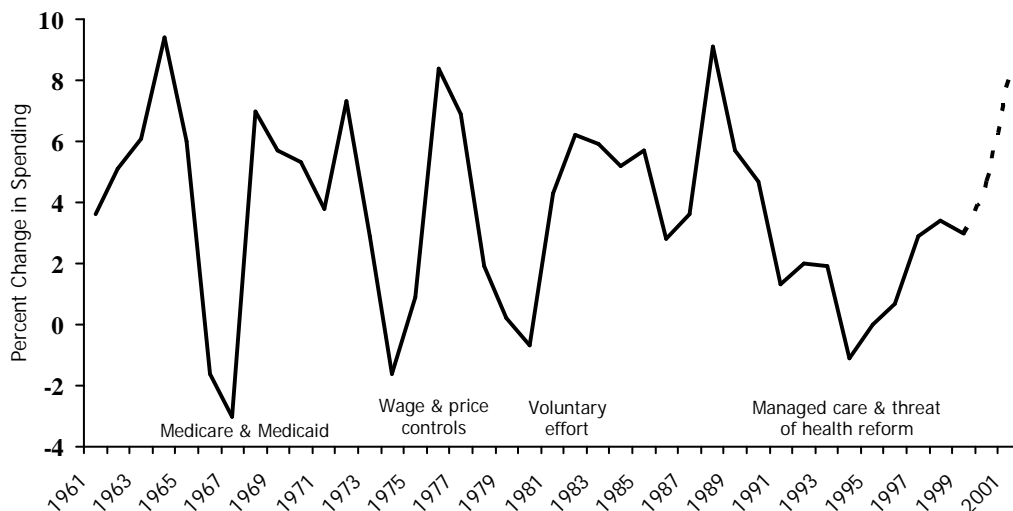
Chapter Two

LESSONS FROM THE PAST

These problems are not new. We have been struggling to find a solution to rising health care costs for a long time. As the diagram below shows, past efforts to reform the health care system provided temporary relief, but did not produce lasting results. Each time we thought we had solved the problem, the costs eventually started to rise again. Minnesota's comprehensive health care reform initiative of the early 1990's included a cost containment plan, but it was repealed in 1994, before it was implemented and costs began to rise soon afterwards. Lessons to be learned from these past experiences will increase our chances of having lasting success in our new efforts.

Diagram 4: The Sad History of Health Care Cost Containment as Told in One Chart

Annual Change in Private Health Spending Per Capita (Adjusted for Inflation), 1961-2001



SOURCE: "The Sad History of Health Care Cost Containment As Told in One Chart," *Health Affairs*, January 2002, Altman and Levitt.

Notes: Private health expenditures per capita 1960-99 are from the Centers for Medicare and Medicaid Services (CMS). Change in private spending per capita for 2000-2001 is estimated based on average premium increases for employer-sponsored coverage from Kaiser/HRET Survey of Employer-Sponsored Health Benefits (www.kff.org). Real change in spending is calculated using the Consumer Price Index (CPI-U) all items, average annual change for 1961-2000 and July to July change for 2001. This analysis was inspired by an analysis done by Jeff Merrill and Richard Wassermann more than 15 years ago. See J.C. Merrill and R. J. Wassermann, "Growth in National Expenditures: Additional Analyses," *Health Affairs* (Winter 1985): 91-98.

THERE IS NO SILVER BULLET. Past efforts attempted to find a single solution that would solve all the problems, forever. But there is no silver bullet. We need a comprehensive effort and a way to continuously work together to make adjustments and changes as the health care environment changes. Health care "reform" must be a continuous activity and must utilize many different tools.

SERVING THE PEOPLE. From government price controls to managed care, past efforts to keep health care affordable have had at best only temporary success because they did not have sustained public support. Many people felt the changes were forced by outside forces in a health care system they did not trust. We have a health care system in which the customer is not necessarily the individual, but instead it is the employer, the physician or the health plan. The person who ultimately needs services is the individual. It is the individual, therefore, who has the greatest control over his or her health and the amount of money that he or she will ultimately spend in services. We need a health care system that listens to the individual and is patient-centered. To have lasting success, control of the health care system must be given back to the people who use and pay for it.

Chapter Three

COMMUNITY VALUES: A MINNESOTA DIALOGUE

Minnesota has earned a national reputation for public and private policy innovation, especially in health and human services. That success has always come from our ability to listen to our citizens and trust their collective judgment. The starting point must be the shared community values of Minnesotans and the goal must be the best interests of the people who use the health care system and who ultimately pay for it directly and indirectly.

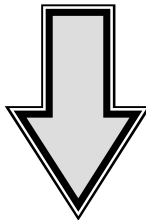
LISTENING TO PEOPLE. With this objective in mind, the Minnesota Citizens Forum spent November and December 2003, listening to Minnesotans. We asked Minnesotans what the problems are, how their lives are being affected and where they think changes should begin. Town hall meetings and informal listening sessions were held across the state. An online survey was developed to solicit information from those who were not able to attend the town hall meetings. Ideas sent by Minnesotans through the mail and the Internet were read. The Minnesota Citizens Forum worked with the Minnesota Board on Aging and the Minnesota Governor's Council on Developmental Disabilities to conduct a telephone survey of a representative sample of 800 Minnesotans. In the end, a surprising amount of agreement among Minnesotans was found about what they expect and what they think should be done about rising costs.

Throughout this process, people expressed many different views and their opinions on some topics varied widely. We found some recurring themes, however, in each community we visited. After listening and reviewing existing research about Minnesotans, we took these themes and identified a list of core values about the health care system that are shared by most Minnesotans. It is this list that we used to guide our recommendations and our vision of what Minnesota's health care system should look like in the future.

Detailed information on the "Minnesota Dialogue" is contained in our earlier report *"Listening to Minnesotans: the First Step towards Building a Better Health Care System."*

Themes from our Minnesota Dialogue

- Minnesotans are concerned about health.
- Most are concerned about rising costs and access.
- Some are dissatisfied with quality and access.
- The health care system is unnecessarily complex and masks hidden costs, profits and unfair pricing, especially in the area of drug pricing.
- Individual responsibility is important.
- Access should be assured for everyone.
- People want choices, control and personalized health care.
- People want a community-based health care system, which provides care at the right time and place.
- Prevention is important.
- Government has a role.
- Minnesotans want an inclusive, universal health care system.



Desired Characteristics of a Health Care System

- Accessible to all
- Fair
- Safe, high-quality care
- Personalized
- Promotes health
- Affordable
- Rewards personal responsibility
- Understandable

LISTENING TO THE EXPERTS. In addition to talking with the public, we sought the ideas and advice of experts and leaders from health care, business and government. We were impressed. Most major business and health care trade associations submitted detailed proposals for improving health care. They, like the general public, agree about more things than they disagree about. Key themes heard most frequently were:

1. Major change is needed to preserve excellence in health care services.
2. We need better information on cost and quality of health care.
3. Our system should focus more on prevention, restoring and maintaining health.
4. We should work together to assure patients receive the best and most effective treatment.
5. We have a responsibility to reduce the disparities that exist in health status, access, quality of care and coverage.
6. No one is to blame for the problems in our current system, but everyone has a responsibility to do their part to improve it.
7. We should continue Minnesota's tradition of seeking a universal system where everyone has access and coverage.

They know that major changes are needed and are ready and willing to work together.

DOES THE CURRENT SYSTEM MEASURE UP? Based on the values that we identified during our conversations with Minnesotans, we assessed whether the current health care system meets Minnesotans' needs. With respect to each value, Minnesotans told stories about how the current system did not live up to their needs and expectations. Whether it was because the system was difficult to navigate, unaffordable, did not provide the right incentives or provide useful information, the current health care system does not meet the needs of Minnesotans.

GOAL	REALITY	IN THEIR OWN WORDS
Accessible to All	Minnesota leads the nation in health coverage and access, but many Minnesotans are left out due to financial, geographic, cultural, linguistic or informational barriers. Those who do not have access or coverage often delay treatment and forego preventive care, costing everyone more in the long run.	<i>Every person is paying for health care either by paying taxes (public programs) or by paying for benefits (private coverage) or paying prices for goods and services . . . We are already paying for universal health care, we just aren't getting it.</i> <i>"We have what you don't have" needs to be replaced by "everyone does better when everyone does better."</i>
Fair	Minnesota does well on the averages, but below the surface there are serious disparities between different patients and groups.	<i>What is the American health care system? The only answer is "it depends." It depends on if you are a Veteran or an American Indian or a poor person or an employed person. The American health system is unfair.</i>

GOAL	REALITY	IN THEIR OWN WORDS
Safe, High-Quality Care	Minnesota does well compared to the nation, but we can do a lot better. There is wide variation in quality of care, and too much care is ineffective, unnecessary or unsafe.	<i>There is no connection between cost, value and what is received.</i>
Personalized	Consumers and patients are not given sufficient choices or empowered with information and control over decisions affecting their health.	<i>Health insurance is a medical model; we do not have a consumer driven model of health care. Consumers do not control their health care destiny.</i>
Promotes Health	Our health care system focuses on treatment rather than prevention and improvement of health.	<i>We pay for acute, episodic health care. We don't pay for education or prevention.</i>
Affordable	We enjoy the nation's highest rates of coverage and access to health care services, but rising costs are creating a crisis for individuals, businesses and government. Many more Minnesotans will lose coverage.	<i>I've worked all my life and I am now between jobs. I paid for insurance all those years and where did the money go? Now I need coverage and cannot get it.</i>
Rewards Personal Responsibility	The current system does not reward individuals for living healthy and for using the health care system appropriately.	<i>Car insurance gives us a break if we take safety classes. Why can't health insurance give us a break if we take classes for prevention of health problems?</i>
Understandable	The current system is too complicated and shrouded in mystery. Even the experts do not understand everything about how the health care system works.	<i>We don't have a health care system; we have a health care mess. We would have never created the system we have today.</i>

Chapter Four

FRAMING A SOLUTION

We found it useful to choose an “architecture” to help us organize our thinking as we tried to define the problem and the possible solutions. We used four goals to define the problem and identify new directions, and four roles to assign responsibility for getting us there.

<u>GOALS</u>	<u>ROLES</u>
1. Health	1. Individuals
2. Access	2. Communities (including government)
3. Quality	3. Providers: those who deliver health care services (including doctors, hospitals, medical technology companies, etc.)
4. Affordability	4. Payers: those who finance health care (including government as a payer)

HEALTH: PREVENTION AND IMPROVEMENT INSTEAD OF SIMPLY TREATMENT

Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.

- The World Health Organization's definition of “health.”

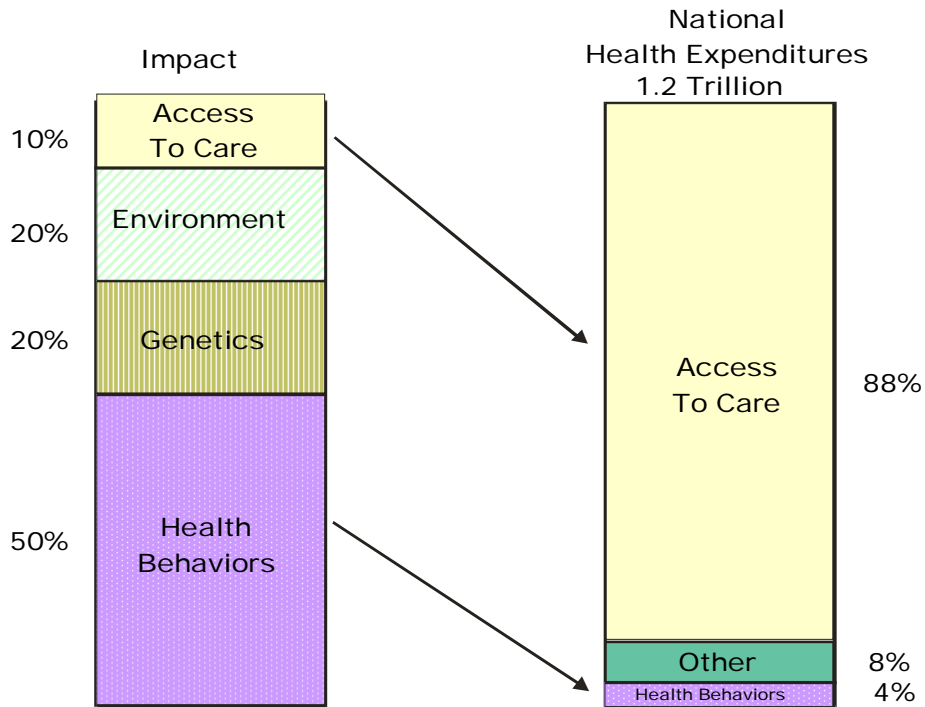
The current health care system does not promote better health, it promotes more treatment, especially of catastrophic conditions. It is like continuing to use band-aids on blisters when a pair of gloves would prevent the blisters from developing in the first place. The financing system does not support what needs to happen in order for people to be healthy. We need a shift in the thinking for everyone in the system. We should be “treating” people before they get sick when there is a chance to prevent the individual from having the illness at all.

Statistics show that if individuals are treated early or even before developing a chronic disease that the cost savings over the individual's life both in terms of quality of life as well as financial dollars are significant. For example, nearly 60 percent of adult Minnesotans are overweight and almost 17 percent of adult Minnesotans are obese. In 2000, an estimated \$295 million – over 100 dollars per person – was spent treating diseases and conditions that

could have been avoided if all Minnesotans were physically active.¹ By merely encouraging people to walk 10 minutes three times a day, individuals would receive the recommended amount of physical activity to stay healthy.

The diagram below illustrates how our health care expenditures bear little relationship to the factors affecting our health.

Diagram 5: Health Status Impact versus Expenditures



SOURCES: Centers for Disease Control and Prevention, University of California at San Francisco, Institute for the Future

We need a system that gives individuals responsibility for maintaining a healthy lifestyle, while respecting each individual's right to pursue and maintain his or her own health. As a community, we need to create incentives and structures to encourage people to pursue healthier behaviors. We need to teach healthy behaviors early and reinforce the message throughout people's lives. Providers of health care should be rewarded for helping their patients adopt healthy behaviors. Payers have a role in creating incentives for providers and consumers that will encourage people to achieve their optimum health.

¹ Minnesota Department of Health Fact Sheet, *Health Care Costs of Physical Inactivity in Minnesota*. (May 15, 2002).

ACCESS: BARRIERS PREVENT ACCESS TO APPROPRIATE CARE

Access is not only about eliminating barriers; it is also about being able to get the services that you need easily.

Access means an ability to easily enter the health care system. Almost everyone in Minnesota has access to certain types of health care services, even the uninsured. When sick, any person may go to an emergency room for treatment. However, just because a person has access to these health care services does not mean that the services are provided efficiently, financed fairly or that the person is able to get all the care that they need. For a healthy life, people need some health care services even before they get sick and when sick, they need the right care, at the right time, in the right place. Our current health care system has many barriers which prevent people from getting the care that they need: informational, geographic, cultural, linguistic and financial. Each of these barriers raises the cost of health care for all of us because the barriers cause people to delay or not seek treatment until absolutely necessary. There is a need to ensure access to services in terms of coverage and financing as well as access to services in terms of eliminating geographic, social or cultural barriers.

There is not a one-size-fits-all solution to eliminating access barriers and each of us has an important responsibility. Individuals should use the system appropriately, including obtaining preventive care and seeking treatment early, and should purchase health coverage when they can afford it. Communities should provide information to help individuals use the system appropriately and provide assistance for those who need it. Providers should improve their ability to serve all communities and work within their communities to find ways to provide health care services to those that are left out. Payers have a role in making sure that the system as a whole is serving the needs of everyone the community.

QUALITY: UNACCEPTABLE VARIATION AND DUPLICATION

The purpose of the health care system is to reduce continually the consequences of illness, injury and disabling conditions, and to improve the health status and function of all people.

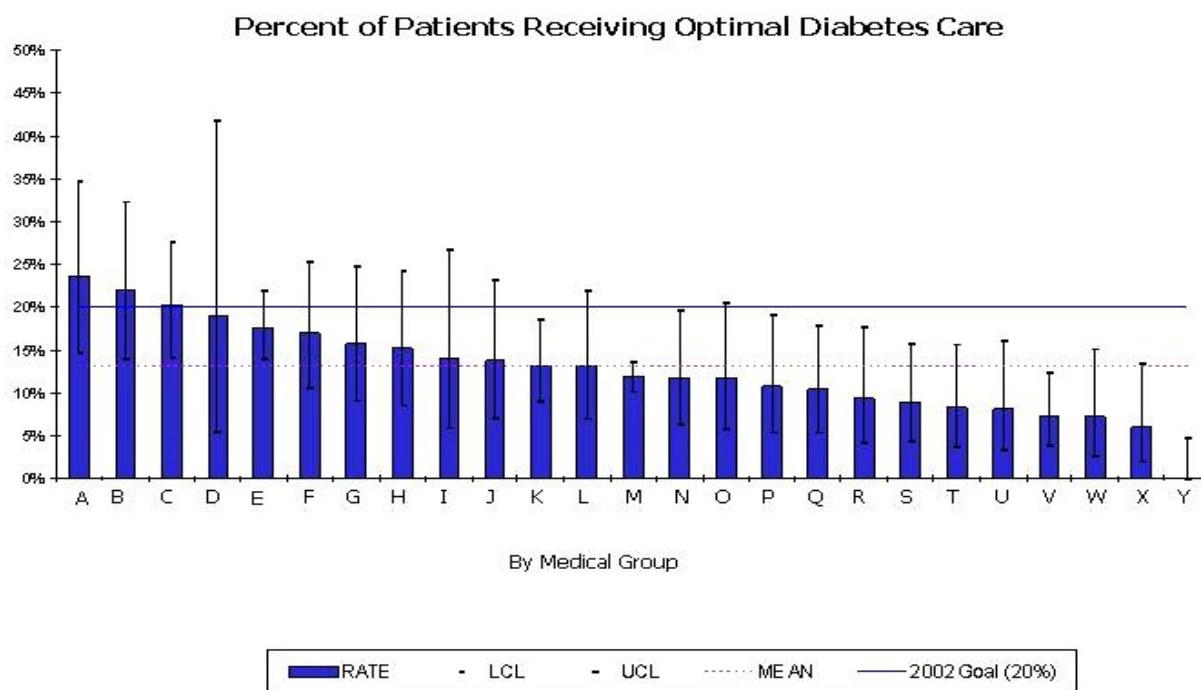
The current system focuses on volume rather than on value. The quality of treatment varies widely and many people do not receive the best quality of care, even though they generally feel satisfied with the care that they are receiving. Disparities in quality are especially acute for communities of color. On average, Americans receive the recommended medical treatment based on evidence-based guidelines only about one-half of the time.² Gaps in service delivery are found in all aspects of medical care: preventive, acute, as well as chronic. Mistakes in health care cause injuries, complications and death. Our quality improvement system is complicated at best, ineffective at worst. Minnesotan hospitals are subject to over 26 different quality measurement and patient safety projects for which they collect and disseminate information. There is no coordination between organizations or requests, which results in duplication and increased administrative costs. As a result, providers spend a lot of

² McGlynn EA, Asch SM, Adams J et al. *The quality of health care delivered to adults in the United States*, N Engl J Med 2003; 348:2635-45.

time and money producing quality reports that don't result in good quality information either for the payers or the public. Quality doesn't mean more expensive care. Providing the most effective care the first time can be less costly than continuing to provide ineffective care or waiting until a medical condition becomes more serious and more costly to treat.

The diagram below shows the wide variation that exists among Minnesota medical groups for one particular condition: diabetes. The chances a patient with diabetes will have his or her condition "optimally managed" varies six-fold depending on which medical group is chosen. In the best medical groups, which are national leaders in diabetes care, only one in four patients experience optimal disease management.

Diagram 6: Comparing Quality of Diabetes Care



SOURCE: Sample data from *Clinical Quality Report*, HealthPartners 1/1/2002-12/31/2002

We need quality information for both the individual and for the system as a whole. To achieve this goal, we need a plan that addresses both *service* quality and *technical* quality. Service quality aims to address things like satisfaction with providers, plans and insurance, while technical quality focuses on the structural measures for the health care system such as appropriateness, outcomes, process, freedom from error and elimination of waste. This plan must be based on national and Minnesota goals and incorporate medically-based criteria that health care providers measure, report and use for quality improvement programs. The Institute of Medicine's report "*Crossing the Quality Chasm*" contains six aims for the ideal health care system: safe, effective, patient-centered, efficient, equitable and timely. These six aims provide a useful framework for planning. The quality plan should be simple, straightforward and build on existing quality measurement projects already present here in Minnesota.

Ignorance is not bliss. Minnesotans have been left in the dark for too long. As individuals, they should be able to compare the quality of health care providers and health plans in order to make informed decisions. As a community, we should be able to demand high quality services, provide education and financial supports to achieve the quality we desire, and be able to hold providers accountable when services are not delivered with the quality we deserve. Providers need to work with each other to create a health care system that focuses on quality and rewards providers with the best quality. Payers should work with providers to develop financial incentives and payment structures that support quality care and better health.

AFFORDABILITY: PEOPLE PAY FOR HEALTH CARE

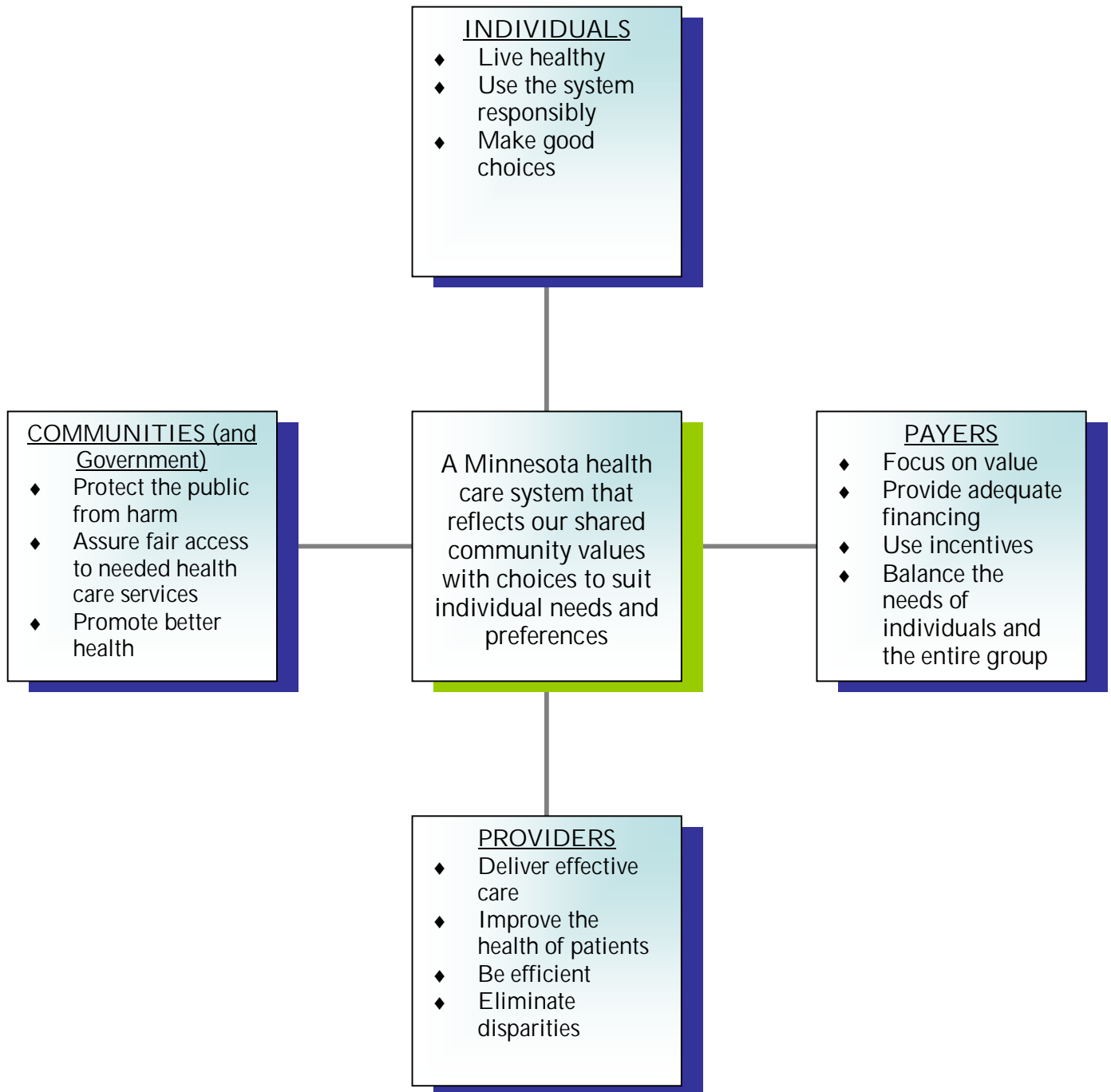
What constitutes "affordable" health care is relative, it is defined as what I can afford to pay and what I can purchase with that amount. However, we have no idea how much services and products actually cost or where the money paid into the system goes.

Minnesota is not different from the rest of the nation in the issues confronting our health care system. We have a cost spiral that is currently unsustainable for many individuals and businesses, and will be unsustainable for all of us in the long-term. Too many Minnesotans are losing access to affordable health care. People are paying for health care through their premiums, co-payments and deductibles, as well as their taxes, the prices they pay for products and services and the dollars that their employers pay for their health coverage in lieu of paying higher wages or other benefits. Because of the complexity of the health care system, with hidden cost-shifting, multiple payment methods and variations in price for the same health care product or service, we don't know what anyone *really* pays for health care and we don't know where the money goes. Ultimately, people pay for everything and they should be fully informed and involved in decisions affecting their pocketbooks.

To implement changes in the health care system to make it affordable, we need to understand how the current system works and how it is financed. Different levels of coverage and access are inevitable and so we need to offer a full range of choices beginning with affordable basic care, then let people make their own decisions. At a minimum, we believe that we must have a health care system with universal participation in a basic benefit package that offers affordable first dollar coverage of preventive services and necessary services for chronic conditions with numerous options for the purchase of the remaining services. In order to do this, however, we need to know what services and products really cost, how prices are set and where the dollars flow. Once we understand the current system, we can decide how it should be changed. It is at that point that we can determine how health care dollars can be used to produce better health and better treatment.

In this process each of us has an important responsibility. Payers, in both the private and public sector, need to work together to provide comprehensive information on costs for both the individual and the system as a whole. Providers need to work with payers to define how much health care services and products really cost. Communities throughout Minnesota should have discussions about what costs are reasonable and what responsibility people and the community have in keeping health care affordable. Once the information is available, individuals have a responsibility to learn more about their health care, what services cost and whether their beliefs about what constitutes "affordable" health care are reasonable.

HEALTH SYSTEM ROLES AND RESPONSIBILITY



Case Study: Obesity and Diabetes

We cannot keep health care affordable without addressing the other three goals: health, access and quality. The factors underlying obesity and diabetes present a great example of this concept.

Health: Poor health habits of Minnesotans have resulted in a rapid rise in obesity, a major contributing factor to diabetes, which costs Minnesotans \$2 billion per year. Improving the overall *health* of Minnesotans will reduce the need for costly treatment later on.

Access: Diabetes caused by obesity can be effectively managed only if patients have *access* to testing supplies, monitoring and other health care support that they need to manage their illness and prevent deterioration of their health and expensive complications.

Quality: The odds are not very good that diabetic patients in Minnesota will receive optimal care to keep the disease under control. In the best clinics in Minnesota, which are among the best in the nation, only one in four patients with diabetes is receiving optimal care. *Quality* of care is a responsibility of both the provider and the patient. If done well, patients will be healthier and costs will be greatly reduced.

Health, access, quality and affordability are the shared responsibility of individuals, communities, government, health care providers and employers and health plans that finance health care.

Chapter Five

PLANNING TO GET FROM HERE TO THERE

We cannot demolish our current system and build something new from scratch. We can't afford disrupting the current system while people are still receiving the care that they need. The "Harry and Louise" ad campaign of the Clinton health care reform era taught us that people are fearful of attempts to entirely replace the current health care system with an entirely new system. We need a vision for what the health care system should look like in the future, but we must carefully plan the steps that will get us from here to there.

MAJOR CHANGE IS NEEDED. There is a big gap between what people want and what the current system delivers. Many Minnesotans told us that we will not be able to fix the health care system without making major changes. Isolated, band-aid approaches will not have a lasting effect. They may even have the unintended effect of further increasing health care costs. We need more than incremental tweaks to the existing system. We need a sustained, long-term effort to transform the health care system and we need a transition plan to get us from here to there without disrupting care. Minnesotans are ready for change and willing to do their part.

We believe in creating a health care system based on community values through:

- Providing better health.
- Assuring access to safe, high quality treatment at a price we can afford.
- Offering a variety of choices to suit individuals needs and preferences.
- Being transparent and easy to understand.
- Making information on quality and cost readily available to the public.
- Having efficient health care organizations and minimal administrative costs.
- Flexibility and adaptability as the world changes.
- Accountability and responsibility for all of us - individuals, communities, government, payers and providers.

If we can achieve these goals, Minnesota will have the best health and best health care in the world.

In the short term, we need more information about the system, a place for individuals, government and the health care industry to work together and a process for planning and managing change. We also know that any plan must be based on the values of Minnesotans, so we firmly believe the dialogue with Minnesotans must continue. We know there are limited resources available in the government, so we need to all pitch in to make the changes happen. Our health is our goal, our responsibility, and our challenge. By working together we can get from here to a health care system that meets all of our needs.

WE ARE ALL IN THIS TOGETHER. Few of us can afford to pay the cost of a serious illness without insurance. We use a health insurance model to share the risk with others. In any given year, 20 percent of us will use no health care services while one percent will consume 27 percent of the health care dollars. By sharing the risk through

insurance, we can afford health care when we need it. We count on the system to balance our individual needs with the needs of others in the insurance system. The Minnesota Citizens Forum discovered that Minnesotans understand this concept and embrace it, but they have lost faith in the system's ability to do this fairly. They lack trust because they are left in the dark and do not have a say in important decisions. Past efforts to control costs have contributed to this distrust. Restoring trust in the system is the key to making sustainable improvements that Minnesotans can support.

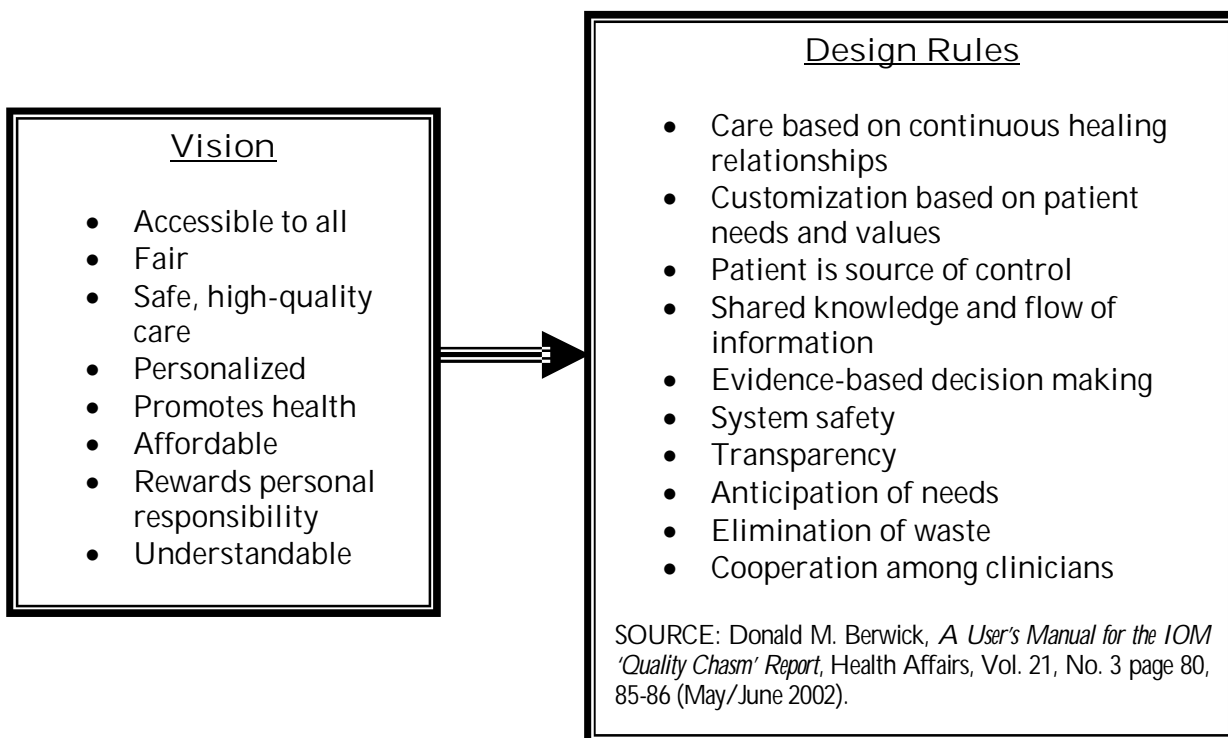
BUILDING ON EXISTING EFFORTS. Minnesota is a hotbed of nationally recognized leadership and innovation in health care. Our health care system has a strong climate of creativity, collaboration and commitment. Activities are already underway that take us halfway to our vision of how our health care system should work. Our goal is to build upon these existing efforts rather than creating new ones. We have learned from the past that we cannot afford or sustain an entirely new set of programs and requirements layered on top of old programs. Instead, we need to retool what we already have and redirect existing resources. We should create an environment that encourages collaboration among existing efforts to eliminate redundancies and capitalize on the ability to create successful new models for health care delivery.

MINNESOTA ACTING ALONE. Minnesota is bound by federal rules and programs that we cannot change on our own. While we understand that some of the changes to the health care system must take place at the national level, we feel many of the changes can happen locally. By creating a standard of health, access, quality and affordability that the rest of the nation will follow, we hope that we can lay the groundwork for national changes. We have done this before and we can do it again.

CHARGED WORDS. Because the health care reform discussion is so politically charged, some words have become associated with a particular political or philosophical agenda or mean different things to different people. We tried to avoid loaded terms such as "universal coverage," "free-market system," "consumer-driven health care," "evidence-based medicine," "personal responsibility" and "single-payer health care system." When we use these terms, we tried to explain what we meant. For example, when we use the term "health care" in this report, we are using it in its broadest sense – to include mental health, dental health and long term care – even though we have not developed specific recommendations in these areas.

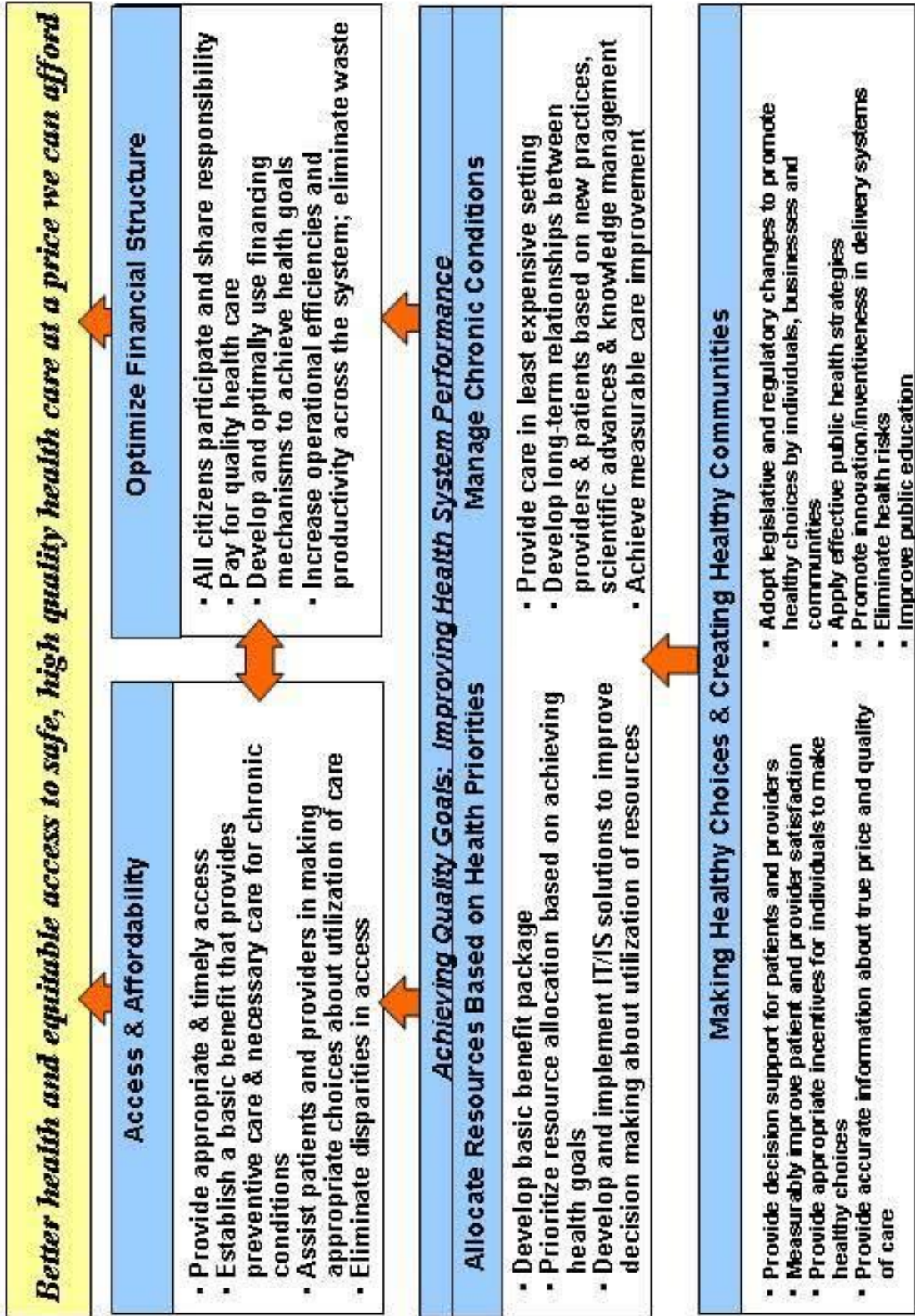
A VISION FOR THE FUTURE. We believe Minnesotans deserve a Minnesota health care system that delivers better health and equitable to safe, high quality treatment at an affordable price. Everyone must do their part to realize the vision, including individuals, communities, those who work in the system and those who finance it. We know that while some of these changes can be implemented immediately, many of the changes will require years of work and will succeed only if there is steady leadership from committed individuals.

Much work has already been done to provide a roadmap for improving health care. We found the work of the federal Institutes of Medicine and the work of Don Berwick to be particularly helpful. The following is just one example of how Minnesota’s vision can be translated to “design rules” for change.



Another way of thinking about how to transform our vision into implementable steps is the strategy map on the following page. This map highlights the interactions of several important elements of a comprehensive health care system. The foundation of a healthy Minnesota begins with individuals making healthy choices and living in communities that promote healthy lifestyles. Layered on this foundation is a health care system organized to deliver value in preventive services and effective treatment of chronic conditions in a system based on achieving quality goals and measurable improvements in performance. When the system achieves appropriate and timely access, eliminates waste and achieves consistent efficiency, the overall costs are more affordable. The result is better health and equitable to safe high quality health care at a price we can all afford.

A Strategy Map for Minnesota Health Care 2010



Chapter Six

RECOMMENDATIONS

Our recommendations are built on the large expanse of common ground existing among Minnesota citizens and leaders from health care, business and government. The current health system is very complex, but it is simple to describe what needs to change. We can drive a car without knowing exactly how the engine works. The following recommendations require major changes, but by working together and building on existing efforts already underway, the job will get done. For each recommendation, we have identified actions that should be taken to implement our recommendations.

1. PUT MINNESOTANS IN THE DRIVER'S SEAT

Minnesotans should make the decisions about health care, both individually and collectively. Minnesotans need to define what the health care system should do as opposed to the system defining itself. There also must be a collective discussion on how to fund the system and what affordability means. Employers, HMOs, and health insurance companies should play a supportive role, but not the lead role. This means we will have to rethink what the marketplace looks like.

- a. Personal choice and responsibility. Encourage the general trend toward giving individuals more choices and control of their health care treatment, with incentives for choosing higher quality, lower cost providers. Minnesotans told us they do not feel they have any control over the health care system. They believe the important decisions are made by employers, health insurance companies and the government without their participation or input. The health care system should be transformed to one in which individuals have greater choice and control over decisions about their health coverage and their health care services. The general trend toward “consumer-centered health care” is heading in the right direction. It will increase awareness of costs and create incentives for responsible choices about personal health and use of the health care system. For example, the Minnesota Department of Employee Relations has implemented a health plan which asks state employees and their families to pay more out of pocket if they choose to use higher cost providers. This is the direction we all need to move. However, consumer-centered health care should not create financial barriers that prevent people from getting preventive care and cost-effective services they need to remain healthy. These kinds of services should be exempt from deductibles and cost-sharing requirements.
- b. Health plan options. Consumers should have the opportunity to choose from a full array of health plan choices ranging from low-cost to high-cost while preserving the basic concept of insurance which uses money from the currently healthy to subsidize the currently sick. Affordability is in the eye of the beholder and depends on each person’s assessment of value (cost and benefit). We found

in our Minnesota dialogue that most Minnesotans do not believe everyone must have the same level of health care coverage, even in a universal system. Some people will inevitably have less coverage by choice or necessity, but those who want to and can afford it should be able to buy more coverage or extra services by paying the extra cost. Care must be taken to preserve a broad risk pool, however, by preventing currently healthy people from refusing to pay into the system for the basic benefits that all people receive.

- c. Chronic diseases and disabilities. Special considerations should be made to make sure that individuals with a chronic disease or disability can afford to receive the care they need to avoid preventable complications of disease. We know that 10 percent of the population drives 67% of the costs. We heard from many individuals with chronic diseases or disabilities and their family members that a lot of money is wasted by care that is delivered at the wrong time, place, or manner. They gave us examples of how recent increases in cost-sharing and cutbacks in benefits forced them to forego or delay care to the point where they eventually required more expensive treatment. For these consumers, modifications to general cost-sharing requirements under “consumer-centered” health care are needed. New models are emerging that can show the way to create a win-win situation where patients have the support they need to stay as healthy as they can, at a lower cost overall.
- d. Public dialogue. A permanent process should be established for a continuing dialogue with the public and for conducting research on Minnesotans needs, values and preferences. We learned a great deal about what Minnesotans want in a health care system, but the work is not done. This should be an ongoing activity which will heighten public awareness and provide valuable public input on how the health care system is working. Much great work has been done in this area, including the Minnesota Decides project conducted by BlueCross BlueShield of Minnesota (BCBSM), the 2003 Healthcare Cost Drivers Dialogues facilitated by the National Institute of Health Policy and BCBSM, and the Medical Alley project to promote public discussion of health care priorities. There needs to be collaboration and sharing of information. People need to be encouraged to talk on their own and to make decisions as a community about what is important to them in health care.

2 . FULLY DISCLOSE COSTS AND QUALITY

Ignorance is not bliss. Minnesotans have been left in the dark for too long. They should be fully informed about health care costs and quality. Individuals should be able to compare the price and quality of health care providers and health plans in order to make informed decisions. This will be eye-opening for the public. Most people have no idea how much variation exists in quality and price. As members of a community, they should know where the money goes, how it is used, who profits from it and what quality and outcomes they get for their money. They should also know the cost to the community when people receive no care or low quality care. Better information on health care costs, quality and financing systems are needed to support both public policy decisions and consumer decisions in a competitive marketplace. Buyers and government should work together to provide comprehensive information on costs and quality at both the individual level and the overall

system level. This information needs to be disseminated in a way that helps people understand and manage their health care needs.

- a. Full disclosure of prices and costs. The public should have access to detailed information on costs and financing in the current system including prices, underlying costs, cross subsidies, cost-shifting, profits and administrative expenses. Many Minnesotans told us that they do not understand how health care is financed, why costs are so high and where the money goes. They said if they had better information about the current financing system, they would be able to give us more suggestions on how to reduce costs. We recommend that the Minnesota Department of Health conduct a health care cost study in 2004 to describe the current financing and payment system. The MDH study should describe where the money comes from and where it goes in the current health care financing system including administrative costs, taxes and profits. The study should also identify and compare inequities in pricing, payments and quantify any cost shifting. This study would lay the groundwork for financing reforms in 2005.
- b. Health care information web site. A health care information web site should be created to gather in one place comprehensive information about health care costs and quality in Minnesota, including comparisons between health care providers and between health plan companies (see recommendation 3 below). People have been left in the dark about health care costs and quality for too long. Minnesotans want more information to help them make *individual* decisions about coverage and treatment and *collective* decisions about how the entire system should work. The web site could also offer information and advice to help people improve their health and manage their health conditions. This website could consolidate national and state links provided through federal agencies, national accreditation organizations, Leapfrog, Minnesota Department of Health and other sources. It could contain provider and system links, provide health risk assessment tools and health improvement planning tools for every Minnesotan.
- c. Public awareness campaign on costs. Implement a public awareness campaign to increase the public's knowledge of the costs of health care. This would include information on how much people *really* pay, the cost drivers, cost trends and consequences of rising costs. It should also describe how insurance works and how we are all affected by the access, treatment and quality received by any one of us. The Minnesota Citizens Forum meetings were the beginning of the process, but more information must be made available to the public. Knowledge is power. The more people know and understand, the more empowered they are to make decisions about the health care that is right for them.

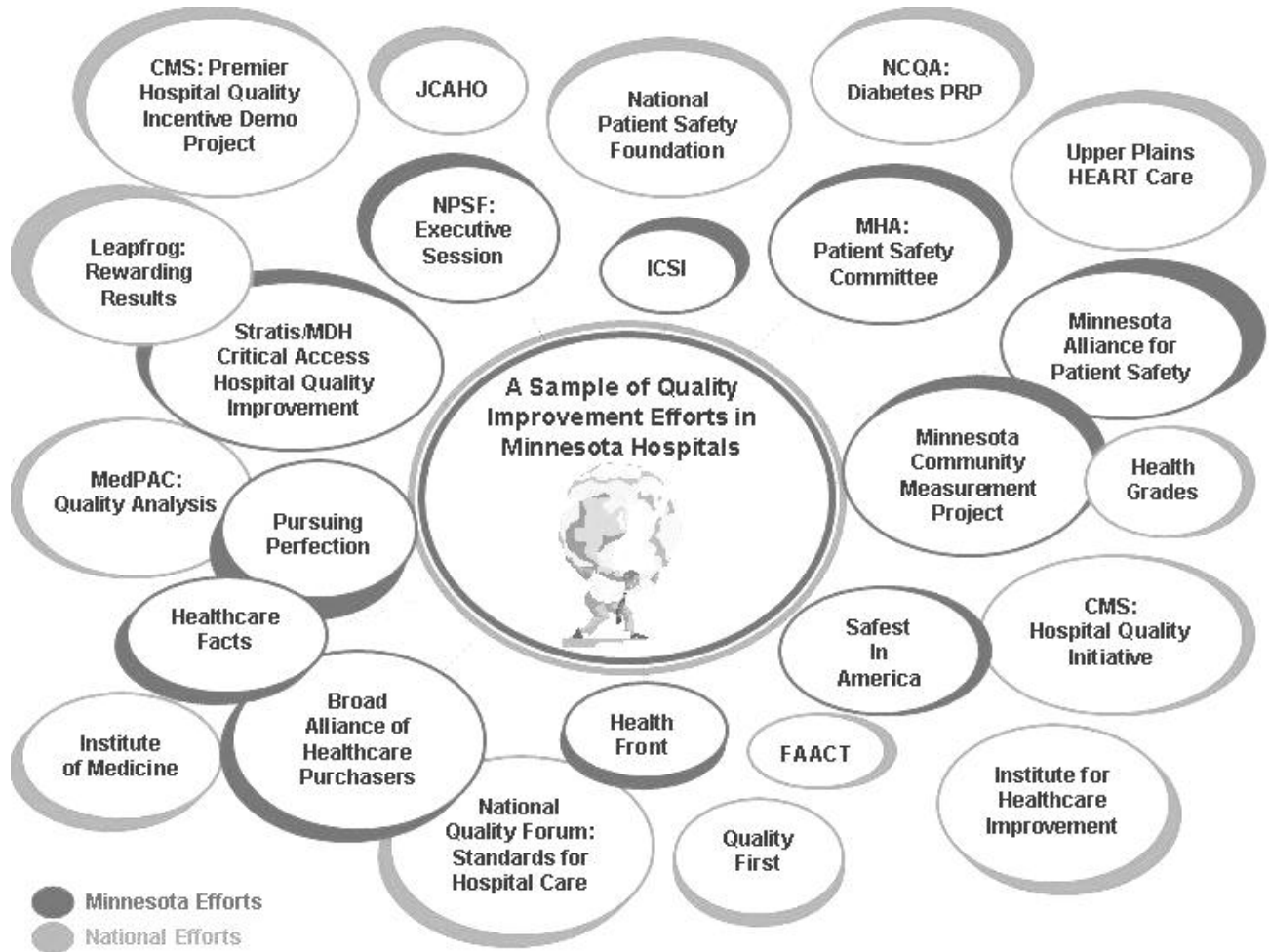
3. REDUCE COSTS THROUGH BETTER QUALITY

Many examples were given of how health care dollars are often wasted on ineffective treatments, mistakes and poor quality care. By some estimates, 30 to 40 percent of our health care dollars are spent on ineffective and unnecessary care. Health care costs can be reduced by improving quality of care and eliminating health disparities. Recent improvements in the Veterans Administration health care plan are examples of how to improve quality and efficiency.

- a. Pay for results. Payment systems should be changed to reward better quality, safety and efficiency. In a later recommendation, we suggest changing the payment system to reward better health outcomes. This is a key to our success in reducing costs without reducing quality because it will reduce the waste that results from poor quality of care, ineffective treatments and harmful mistakes. By standardizing quality measures and reporting, we will have good comparative information to use for rewarding quality. Through collaboration on quality, doctors, hospitals and other health care providers will have the tools and training they need to improve quality.

- b. Standardization. Methods of measuring and reporting quality should be more standardized. A barrier to improving quality is the lack of industry standards on how quality is measured and reported. Different approaches are taken by different employers, health plans, regulators, government health care programs and accreditation agencies. The diagram on the following page illustrates the many different quality expectations and reporting requirements Minnesota hospitals must cope with. This is an inefficient and ineffective approach that is very expensive, yet does not produce good, apples-to-apples comparisons of quality. By standardizing quality measures and reporting, we can reduce administrative costs and provide better information on quality. Excellent efforts to coordinate and consolidate are already underway in Minnesota, including the Institute for Clinical Systems Improvement (ICSI) and the Joint Community Measurement Project being pilot tested by Minnesota's health plans and medical groups. These efforts should be supported and expanded.

Diagram 7: A Sample of Quality Improvement Efforts in Minnesota Hospitals



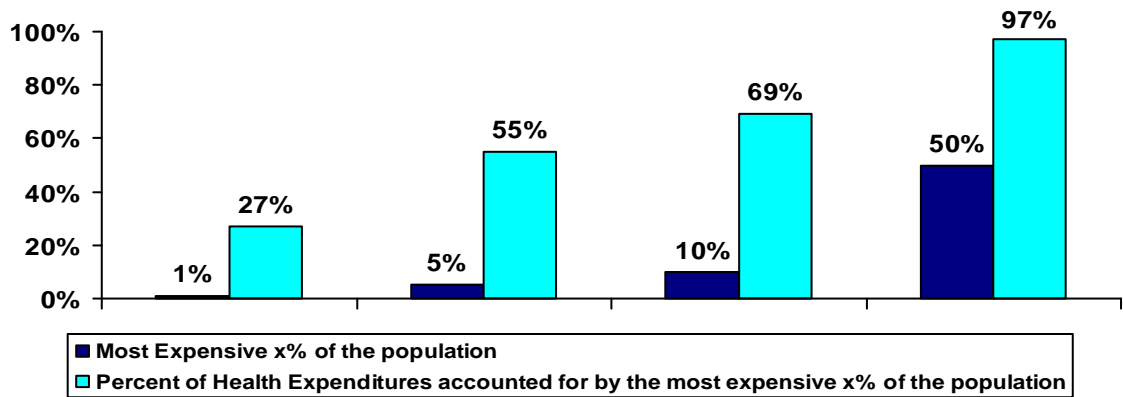
SOURCE: Sheila Moroney, National Institute of Health Policy, January 2004

- c. Public reporting. Quality information about health plans and health care providers should be made available to the public on the health care information web site and in other formats. Minnesotans want more information on quality of care. Researchers have documented a wide variation in quality of care and outcomes from one patient to the next and between different health care providers, yet this information is not available to the public. By making this information publicly available, people will be able to make informed choices and poor quality providers will be motivated to improve. The information will also be useful in designing payment systems that reward those who provide high quality care.
- d. Collaboration on quality. Existing quality initiatives should be brought together in a state forum to develop a statewide quality plan and coordinate efforts that will achieve specific quality improvement goals. Minnesota is the home of several projects that are on the cutting edge of efforts to measure quality and to improve it. We have a community of nationally respected leaders and researchers who are working on quality. Between the various initiatives, millions

of dollars are spent each year. Improved collaboration and coordination will allow these dollars to be leveraged to produce the greatest possible gains. The quality forum should set priorities based on what is important to the state's consumers and buyers of health care. There are opportunities to utilize the work of organizations like StratisHealth (QIO), ICSI, and insurers to achieve better quality reporting and improvement at a lower cost. We should not have to create any new initiatives if we coordinate the activities already occurring throughout the state.

- e. New approaches for chronic disease and disability. Encourage and support new community-based models for maintaining better health and quality treatment for patients with chronic diseases or disabilities. In Minnesota, it is estimated that one percent of the population incurs 27% of the health care costs and that five percent of the population incurs over half of all health care expenses. Most of these people have chronic illnesses. For those of us with chronic diseases, our ability to obtain the right services, at the right time and right place is essential to a healthy life. When barriers exist, whether financial, geographic, cultural, linguistic or informational, needed care is often delayed until our conditions further deteriorate and, as a result, the cost of treatment ends up being greater. With such a high percentage of health care costs being consumed by a small number of us, we have a special interest in assuring access and cost-effective care for individuals with a chronic disease or disability. There is an opportunity to simultaneously save money and improve quality through better care and coordination of services for people with a chronic disease or disability.

Diagram 8: Concentration of Health Care Spending: A Small Share of the Population Accounts for Most Health Care Spending

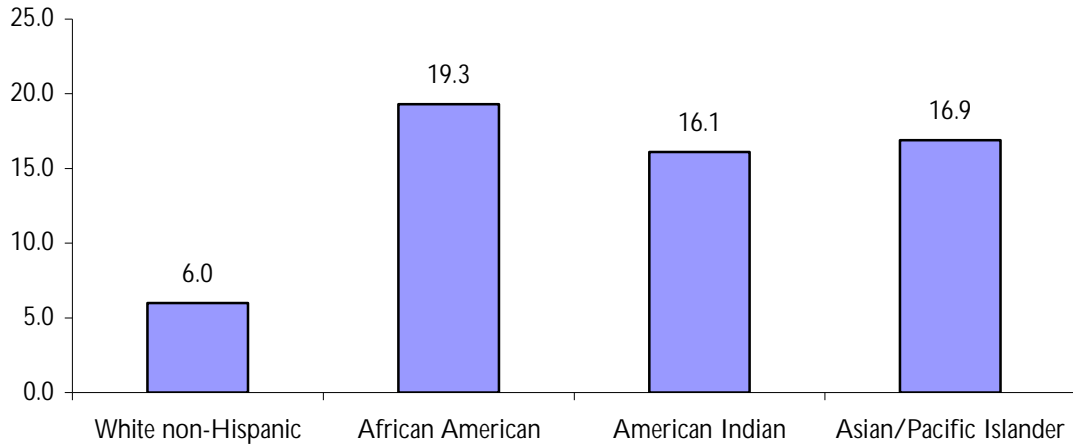


SOURCE: Berk and Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs*, March/April 2001. Expenditure estimates for civilian non-institutionalized population.

- f. Quality disparities. Our definitions of quality should include cultural competence and no disparities in health status, access and quality. We heard from communities of color that our health care system fails to meet their needs for high quality, culturally competent care. Research has shown that a wide gap

exists between the health status and quality of care for communities of color compared to other communities. For example, virtually all occurrences of invasive cervical cancer and death are preventable through regular preventive screenings and treatment of precancerous abnormalities. As the diagram below shows, the incidence rates of cervical cancer for African American, American Indian and Asian/Pacific Islander women are significantly higher than those for white women.

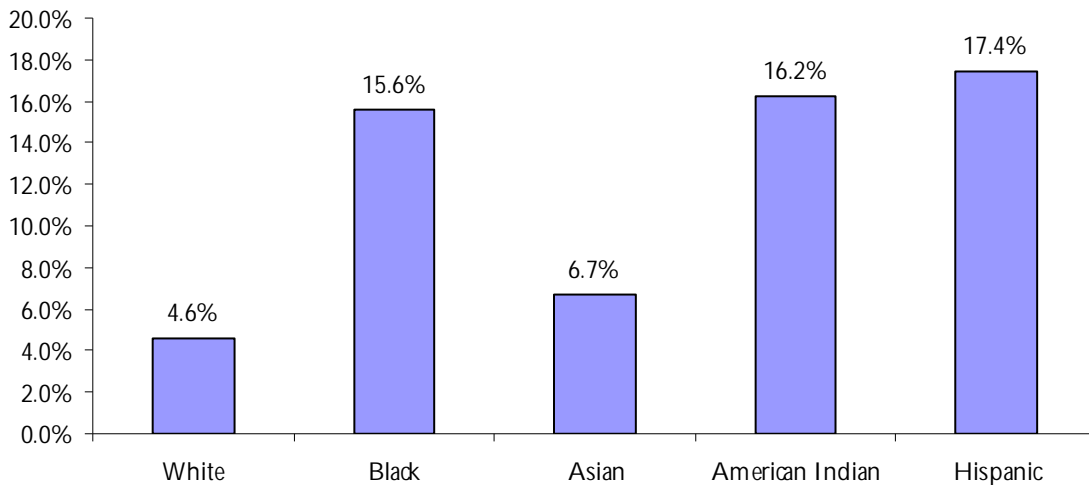
Diagram 9: Cervical Cancer Incidence, Minnesota 1995-1998



SOURCE: Population of Color in Minnesota, Minnesota Department of Health, Center for Health Statistics (2001); Minnesota Cancer Surveillance System.

Similar disparities exist when looking at the uninsured. As the diagram below illustrates, uninsurance rates for non-whites, with the exception of Asian/Pacific Islanders, are two to three times higher than uninsurance rates for whites.

Diagram 10: Percent of Uninsured by Race



SOURCE: 2001 MN Health Access Survey, MDH Health Economics Program

As our workforce becomes increasingly more diverse, the health care system must develop ways to better serve this growing market. The State of Minnesota has made eliminating health disparities a priority and should continue to do so in collaboration with others in the health care system.

4 . CHANGE INCENTIVES TO ENCOURAGE HEALTH

The decisions we make as individuals can negatively affect our health in ways that cannot be repaired by the health care system. Super-sized, caloric, high-fat fast food has replaced healthy home-cooked meals. Poor diet, lack of exercise, high stress lifestyles and smoking result in higher rates of obesity, heart disease, cancer and mental illness. The current system does not reward individuals for living healthy, nor does it reward health care providers for improving their patients' health. The broader environment, too, does not encourage good health. Incentives in the health care system should be changed to produce better health and outcomes. Buyers, communities and government should work together to promote better health habits through additional incentives and assistance. And everyone should be working together to use public health strategies to achieve healthier communities.

- a. Payment system changes. Payment systems should be changed across the entire health care system so that financial incentives produce better outcomes and better health. The current payment system fuels rapid growth in health care because it rewards providers for providing more and more services, drugs and equipment with little accountability for outcomes and efficiency. The current system actually penalizes providers who help their patients be healthy or who find ways to reduce utilization while improving outcomes.
- b. Individual incentives. People who maintain good health should be rewarded with discounts on health care, lower premiums or other benefits. It is important to provide education and support to help people improve their health, but financial incentives are an effective way to motivate people.
- c. Community health. Employers, government and communities should expand efforts to provide programs and other incentives to encourage individuals to adopt healthier behaviors. A large percentage of our health care spending goes for preventable illness and injury. For example, the obesity epidemic will lead to higher rates of diabetes, heart disease and other costly health problems. While individuals know that changes need to be made, we all - individuals, communities, health care providers, employers, health plan companies and others - share responsibility for improving our health. We encourage the Governor to give public recognition to businesses and communities who adopt programs to encourage better health. We believe the initial priorities for statewide community health efforts should be obesity and smoking.
- d. Obesity. Minnesota should launch an aggressive campaign to reduce obesity, especially among children. We recommend that obesity be made a top priority for a statewide health improvement campaign to be undertaken jointly by state, local public health agencies, employers, schools, health care providers, health plan companies and other partners. Among other things, communities should discourage the marketing and sale of pop and junk food in schools, reinstate

mandatory physical education and work with schools to provide education to students on how to be healthy and a responsible health care consumer. Adults should take the Minnesota Citizens Forum's challenge to walk 10,000 steps a day. If we all do something to become physically active, as a community, we can challenge obesity head-on.

- e. Tobacco. Minnesota should strengthen efforts to reduce tobacco use, with a special focus on youth smoking. Tobacco has a devastating effect on the health of Minnesotans. After several years of declining smoking rates, recent cutbacks in tobacco prevention funding have resulted in a resurgence of smoking, especially among young people. Research has shown that higher cigarette prices reduce smoking rates, especially among children. We recommend the addition of a \$1.00 per pack "user fee" on cigarettes to reduce smoking rates and raise revenue for state efforts to reduce smoking, improve health and provide access to uninsured Minnesotans.
- f. Public health. The public health system should be adequately funded and should play the lead role in convening community partnerships to improve the health of all Minnesotans, whether insured or uninsured. Public health has a critical role not only in reducing avoidable behavioral or environmental hazards, but also in detecting and containing widespread risks like the West Nile virus or SARS to the whole community. An inadequate public health infrastructure ultimately means slower detection, containment, increased health care costs, economic loss and avoidable illness and death. Ironically, these core public health protection functions are being greatly reduced by the high costs of medical treatment for individuals. The Minnesota Citizens Forum discussed for a long time the Healthy Minnesotans Public Health Improvement Goals 2004 issued by the Minnesota Department of Health. Rather than trying to isolate specific goals, the Leadership Panel felt that we, as a community, should be working to achieve all of these goals by 2010. In order to do this, the public health system must be adequately funded and businesses, government, communities, health care providers, and individuals all must work together to make the Public Health Improvement Goals a priority.

5. ACHIEVE UNIVERSAL PARTICIPATION

Minnesotans are strongly in support of a universal health care system where everyone has access to the health care they need. Over 90 percent of Minnesotans support a "universal health care system"—it is a shared community value. We must work together to eliminate barriers to the system whether they are financial, geographic, linguistic or cultural. Coverage is an important part of financial access. Lack of coverage results in poor health, less preventive care and delays in needed treatment that eventually add costs to the system. However, a universal system is not just about access and coverage, it is also about meaningful *participation* so that we have a health care system in which everyone obtains appropriate health care, including preventive care, at a cost they can afford, and everyone contributes to better health through their behavior and their financial contribution. We share the financial risk of medical expenses through insurance so that we can afford health care when we need it. If everyone is not contributing financially, especially when healthy, we run the risk that others will not receive care when they need it.

The polarized, political debate between a “single-payer” government health insurance plan and a private, market-based health care system continues, and in the mean time nothing changes and we slip deeper into the health care crisis. We looked to Minnesotans for the answer. We found that almost all Minnesotans agree on two fundamental principles: (1) we want a responsive system where everyone gets the health care they need, and (2) we want a privately based health care system that offers as much choice as possible. Our recommendations will lead us to an integrated and uniquely Minnesotan universal health care system that promotes healthy private sector competition while assuring that the overall system serves the best interests of all Minnesotans.

- a. Universal health care system. Minnesota should set a goal of “universal participation” in the health care system. We struggled to find the appropriate term to use when talking about Minnesotans’ support for a universal system in which everyone gets the services they need at the right time and in the right place. The same term may be viewed by some as positive and others as negative. For example, to many people the term “*universal coverage*” is equated with a “single-payer” system of government-financed health care, which has a strong positive connotation for some and a strong negative connotation for others. Yet, universal coverage can be achieved through several different ways, some of which do not involve a government-financed or government-administered system. As another example, “*universal access*” has a positive ring to some people, but to others it is negative because it means that while everyone can get medical treatment, some people will still face financial barriers to getting preventive services and may be financially devastated by the costs of their treatment because they do not have health coverage.

For Minnesota, we recommend a universal system that combines both private and public financing and uses predominately privately based health care services. We recommend a system of “*universal participation*” in which (1) everyone receives needed health care, including preventive care, at a cost they can afford, in a system financed by both public and private dollars, and (2) everyone participates in improving the health of individuals and communities.

- b. Health coverage for the uninsured. The state of Minnesota should continue its commitment to the goal of health coverage for all Minnesotans, with a priority for covering all children. While *universal access* can be achieved without everyone being enrolled in a health insurance plan, through the development of alternative models for providing uninsured persons with appropriate health care, including preventive care, while ensuring that they pay into the system according to their ability, we recommend *universal health coverage* continue to be the ultimate goal.

Minnesota enjoys a relatively low percentage of persons who do not have health insurance. Research has shown that people without health insurance experience poorer health and inferior access to needed services, even if free health care is available to them through emergency rooms and free clinics. When we are uninsured, we are likely to delay preventive care and early treatment of illness and injury until our health problems become more serious and expensive to treat. When we need health care desperately, we are not turned away, but most of us

cannot pay for extensive care and, as a result, our care will be subsidized by higher fees charged by health care providers to paying customers and insurance companies and by tax dollars from state and local governments. This method of financing is inefficient and results in poorer health and lower quality care for the uninsured.

We do not believe that expanding government programs is the only way to make progress toward universal coverage. The most important thing we can do is to improve affordability of health care through system reform, so that more people can buy their own health coverage and the State of Minnesota can do more with its limited resources. In the foreseeable future, economic realities preclude major expansion of government programs to serve more uninsured people. However, the state should set priorities and use limited resources to expand coverage for those uninsured persons who have the greatest need. A basic benefit package must be defined and the risk pool clearly identified in a way that insurers can provide coverage at a reasonable cost for working families. The following chart, prepared by the National Institute of Medicine, lists five principles for insuring the uninsured. We think that any basic health care package must be able to answer the questions it contains.

Assessing Proposals for Major Health Insurance Reform Principals for Eliminating Uninsurance

The Institute of Medicine's Committee on the Consequences of Uninsurance recommends five principles¹ to guide reforms to extend health insurance to all Americans. The following list of questions can be used to measure how close proposals and strategies for extending coverage come to fulfilling these principles.

1. Health care coverage should be universal.
 - Are individuals required to obtain coverage or are employers required to offer it?
 - Who is eligible for which types of coverage?
 - Who is not eligible for coverage?
 - How easy or difficult is it for eligible people to enroll?
 - What kinds of subsidies are available for lower-income individuals and families?
2. Health care coverage should be continuous.
 - Is re-enrollment required? If so, how frequently?
 - How streamlined is that process?
 - What happens to people who lose or change jobs?
 - What happens to people who have a change in income or family circumstances?
 - What happens to children upon reaching the cut-off age for coverage under a parent's policy?
 - What happens to early retirees?
3. Health care coverage should be affordable to individuals and families.
 - How much are families and individuals expected to contribute toward the premium?
 - What kinds of premiums, co-payments, and deductibles are included? Do these cost-sharing amounts vary with family size, health status, family income, or other criteria?
 - What subsidies are available to individuals and families, and what are the criteria for qualifying for them?
4. The health insurance strategy should be affordable and sustainable for society.
 - Do the assumptions and estimates about the number of people to gain coverage and the cost per person seem realistic?
 - Does everyone contribute to the new system? If not, who is excluded and why?
 - Who bears the main burden to support the extended coverage?
 - Are the sources of revenue/financial support for the extended coverage, such as taxes, likely to be relatively stable even in tough economic times?
 - How will funding currently in the system for service to the uninsured, such as the Disproportionate Share (DSH) Adjustment, be treated? How much of the current funding will be shifted to the new system?
 - Are utilization controls and cost-control mechanisms built into the program?
 - Is the benefit package designed to encourage the use of cost-effective services?
 - Does the new strategy emphasize simplicity and administrative efficiency?
5. Health care coverage should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient centered, and equitable.
 - Does the benefit package include preventive and screening services, mental health services, and outpatient prescription drugs as well as hospital and outpatient medical care?
 - Are there incentives for enrollees to fully use essential services, such as screening and preventive services?
 - Are there incentives for the enrollees to avoid overuse and inappropriate use of services?
 - Are there incentives for providers to offer high-quality care consistent with medical guidelines and scientific evidence?

¹ The five principles are presented in the committee's final report, *Insuring America's Health*. They are based on the findings of the committee's earlier reports: *Coverage Matters*, *Care Without Coverage*, *Health Insurance Is a Family Matter*, *A Shared Destiny*, and *Hidden Costs, Value Lost*. These reports and more information about uninsurance is available at www.iom.edu/uninsured.

- c. Cost-effective health care services for the uninsured. Uninsured Minnesotans should be given access to affordable basic preventive care and other cost-effective services that will improve their health and reduce the need for more costly treatment. In the short-term we believe incremental steps can be taken to improve access to *services for the uninsured*. Easier access to certain services will reduce overall costs to the health care system. It is especially important to make these services available to uninsured Minnesotans with existing health conditions, especially those who are likely to enroll in government programs in the future if their health deteriorates. Sooner or later, people with unmanaged health problems will need expensive health care services that will be provided at the expense of taxpayers or shifted onto the private sector. Children should be a priority since health care problems left untreated during development often result in decreased productivity and lower life quality during adulthood. Assistance could also be targeted to those who have the greatest need and represent the greatest opportunity for reducing future costs by improving access to early intervention and effective management of chronic health conditions.
- d. Participation of people who can afford health coverage. Explore ways to ensure participation in the health care system by uninsured who can afford to buy health coverage, but choose not to. A universal system is not just about access, but also about making sure everyone is paying into the system according to their ability. A small, but growing number of uninsured persons, can afford to buy health coverage but choose not to. Often these are young, healthy people who do not think they will need health care and have other priorities on which to spend their money. When they have a serious health problem, they receive treatment they can't pay for and the costs are shifted to everyone else. It is important to have everyone paying into the system according to their ability.
- e. Financing for the uninsured. Change the current system of financing uncompensated care for the uninsured. The costs of serving many of the uninsured are already in the health care system and fall disproportionately on some hospitals and clinics or are shifted onto the private sector. The Minnesota Department of Health should develop several options for improving the financing system, for consideration by the Governor and the Minnesota Legislature.
- f. Non-economic barriers to access. Eliminate non-economic barriers to access of needed health care services. Some people have health coverage and still are not able to get the health care they need because of geographic, linguistic, or cultural barriers. Communities of color, in particular, told us many people forego or delay treatment because they do not feel comfortable that they will be treated fairly and appropriately in the health care system, and often do not receive care that is appropriate to their individual needs and preferences. Research has shown that their fears are justified. Communities, government, payers and providers should come together to eliminate non-economic barriers. There is not one magic solution that will immediately eliminate these disparities, but rather each community needs to work with government, payers and providers to develop solutions to conquer their own unique barriers.

- g. Insurance market reform and purchasing pools. Reform the insurance market and promote purchasing pools to create better opportunities for individuals and small businesses to purchase affordable health coverage or obtain needed health care through models other than insurance. We discussed, on several occasions, various options for transforming the insurance market, including purchasing pools, eliminating the employer-based system and others. The current market creates affordability and access problems for individuals who buy their own health insurance policies and for small employers who have fewer options and less control over their health coverage than larger, self-insured employers. The current employer-based insurance system can sometimes limit Minnesotans' choices and disrupt continuity of care when an employer changes its employee health coverage plan. We are aware that other individuals and groups such as Senator Sheila Kiscaden, the Minnesota Chamber of Commerce and the Children's Defense Fund have invested time in developing new models for consideration by policy makers (see the Cover All Kids Coalition's conference publication from November 2003). Because others are working on this issue, and due to time constraints, we did not develop specific recommendations on this issue, but we believe this is an extremely important topic and attempts should be made in other settings to develop a proposal to be integrated into a larger health care reform package for the 2005 legislative session.

6. SUPPORT NEW MODELS FOR HEALTH CARE EDUCATION

Minnesota is facing a growing shortage of health care workers, even in urban areas typically not affected by worker issues. Fewer children are growing up wanting to become doctors, nurses, dentists or other health care providers. Those that do become health care workers are not enough to meet the geographic, linguistic and cultural needs of our ever-changing Minnesota population. Systems must be put in place to allow for adequate funding and planning of Minnesota's health care workforce requirements and the subsequent needs for students in the health care programs. Given the impact of aging on the state's demographics, more geriatricians and geriatric nurse practitioners will be needed. The same is true with respect to the recruitment of faculty and students of color as a result of Minnesota's growing immigrant populations and ever-increasing health disparity gap. For each category of health professional, plans need to be developed to ensure that adequate numbers and types of health care professionals are educated and available in the state. New models for educating health professionals need to be developed, which include greater use of technology and more interdisciplinary coursework. These models should be the result of public-private partnerships, academic and service partnerships and partnership between businesses, communities, and educational institutions.

7. REDUCE THE COST OF OVERHEAD AND ADMINISTRATION

The complexity, duplication and lack of accountability in the current system results in unnecessary costs for overhead and administration. Significant savings can be achieved by streamlining and standardizing administrative procedures and government regulations. At town hall meetings and through the Minnesota Citizens Forum website, many Minnesotans

offered suggestions for reducing administrative costs. New technologies are emerging that could greatly reduce the amount of paperwork required for recordkeeping, reporting, billing and other administrative activities. There are also major opportunities to reduce administrative costs and burdens by standardizing forms and procedures throughout the health care system.

- a. Industry standards. The health care industry should establish uniform standards for electronic billing, electronic medical records, reports and other administrative procedures. Millions of dollars are wasted on inefficient administrative procedures and transaction costs. We cannot afford to let this money be diverted from direct patient care.
- b. Electronic technology. The health care industry should work together to facilitate the rapid adoption of new electronic technologies that will improve efficiency, service and reduce administrative costs. The “smart card,” electronic billing and electronic medical record are good examples.
- c. Regulatory reform. The State of Minnesota should adopt a new approach to health care regulation. Existing state regulations add unnecessary costs and paperwork for health care providers and health plans. They focus on process rather than outcomes. They prevent innovation in the health care marketplace. Extensive reporting requirements cost money but produce data that is seldom if ever used. We suggest that the Governor create an interagency task force with an advisory panel of stakeholders to develop legislation to reform the regulatory system. National policies also affect health care in Minnesota. Federal policy changes should be sought to support state level reforms.
- d. Health care taxes. The Minnesota Department of Revenue should complete a study of health care taxes and recommend a tax reform plan to the Governor and the Legislature. Minnesota’s current health care system is unfair and imposes heavier financial burdens on small employers and individual policyholders compared to large, self-insured employers and group purchasers. It is also very complex and expensive to administer. The original purpose of most health care taxes, to finance health coverage for the uninsured, has been eroded as more and more health care tax revenues have been diverted to the general fund or earmarked for other uses. The tax reform plan should generate the same level of revenue as existing health care taxes, but be designed to reduce administrative costs and burdens and eliminate the inequities and tax disparities in the current tax system. The tax reform plan should also enhance the ability of the health care tax system to capture savings and benefits that accrue to the health care industry when the government uses tax revenues to provide coverage to the uninsured and improve health, access and quality. This will ensure that savings to the health care system are used to repay the initial investment. All revenues from health care taxes should be dedicated to the purpose of financing health care for those who cannot afford to pay the entire cost themselves.

RECOMMENDATIONS ON HOW TO GET THERE

A major effort is needed to make the transformational changes recommended above. The good news is that much agreement exists about the direction we need to go, everyone seems ready to do their part and leaders are stepping forward to spearhead the effort. These three ingredients – vision, commitment and leadership – will get us to our goal. We suggest the following specific steps to get started, but all should be done in a way that is open to the public and maximizes participation of Minnesotans to assure that the changes truly serve the needs of Minnesotans.

8. LEADERSHIP OF THE STATE

The State of Minnesota will lead the way by changing the way the state carries out its role as purchaser, regulator and provider of health care services. On Friday, February 6, 2004, Governor Tim Pawlenty announced that the State of Minnesota will develop a united health care purchasing and regulatory strategy that will set the example for the entire state. Without major change, health care costs will continue to drain state resources and force the difficult choice of either increasing the number of uninsured Minnesotans or reducing funding for other state priorities such as education, roads and the environment. There is support among most Minnesotans, including many influential leaders in health care and business, to make the changes we recommend. As the purchaser of health care for a large number of Minnesotans who are public employees or enrolled in government programs, the state will join with private purchasers to create a powerful force for change. The state can also serve as an incubator to support the development and testing of new purchasing models that will lead to better quality and lower costs for public employees and government programs.

9. BUYERS ALLIANCE

With state leadership, consumers, employers and other buyers will be brought together to form a united buyers alliance to get the leverage needed to drive major changes in the health care delivery system. Governor Pawlenty and some of the state's largest employers and business organizations have agreed to provide leadership. Purchasers and payers will strengthen and expand existing partnerships and set specific statewide goals and expectations for the health care industry in Minnesota. A universal health care system does not need to be government run, but it does need to have a method of addressing system-wide problems and facilitating beneficial competition in the marketplace. This can be accomplished by bringing together all those currently involved in financing health care (employers, health plan companies, government agencies and representatives of individual market consumers) to work together to assure that the overall health system meets the needs of Minnesotans and provides the choices and information that is needed for competition to work. By working together, purchasers can send a stronger message to the health care industry about what needs to change, and back up their expectations with financial incentives in their payment systems. A buyers alliance can also improve choices and competition in the marketplace, by using their purchasing power differently. Potential problems that could be tackled include the medical arms race for expensive equipment and specialty facilities, costly excess capacity, worker shortages and geographical, ethnic or cultural barriers. There is an important role for government, but there is a lot buyers can do without government mandates or regulation.

10. PUBLIC/PRIVATE PARTNERSHIP

Once consumers and buyers make it clear what they expect from their health care system, the health care industry will respond. An action-oriented, public/private partnership will be formed to help the health care industry retool and work together to manage a seamless transition from the old way to the new way of doing things. Private leaders from health care and business will work with Governor Pawlenty to organize this activity. All activities will be undertaken with participation and input from consumers and the public. The State of Minnesota will be a partner in its roles as a regulator and purchaser of health care. The new group will have the responsibility to work with affected persons and organizations to implement the changes recommended in this report.

11. BIPARTISAN LEGISLATIVE WORK GROUP

While much can be accomplished through public and private collaboration, without the need for legislation, the Minnesota Legislature will play an important role in changing the state's public policy to support improvements in health care policy. Health care leaders in the House and Senate from both parties have agreed to work together and with the Governor, in a bipartisan way, to agree on public policies and draft legislation for the 2005 legislative session.

TIMING

Quick action is also needed to put the ball in motion because it will take several years for many of our recommendations to bear fruit. Most of our recommendations do not require legislation during the 2004 session to get underway. However, work should begin now to draft comprehensive legislation for the 2005 session.

Of the recommendations above, several general categories create opportunities for action to be taken within the next six months to generate short-term reductions in health care costs. These include:

- Standardization of administrative procedures and transactions.
- Adoption of electronic technology for recordkeeping and transactions.
- Collaboration on quality measurement and reporting.
- Improvements in care for patients with chronic disease and disability.
- Cost-effective services to high-risk uninsured persons to reduce overall costs.

OTHER TOPICS

Several important topics came up frequently in our dialogue with Minnesotans and were discussed at the Leadership Panel meetings, but were not addressed in this report either because others were already working on solutions or we were unable to develop specific recommendations due to time constraints. These include:

1. Long-term care;
2. Mental health;
3. Dental health;
4. Prescription drugs; and,
5. Transportation issues in rural Minnesota.

Conclusion

This report offers a road map to take us to the kind of health care system Minnesotans want. It also suggests vehicles that can be used to get us there. Our work is only the beginning. A strong commitment and sustained effort by individuals, communities, health care providers and third-party payers is needed. By working together, we can achieve the goal of better health and equitable access to safe, high-quality, affordable health care for all Minnesotans.