

**Report of the Health Care Transformation Task Force**

**Recommendations Submitted To:**

**Governor Tim Pawlenty**

**and the**

**Minnesota State Legislature**

**January 2008**

# Health Care Transformation Task Force Members

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## Co-Chairs:

Commissioner Cal Ludeman, Minnesota Department of Human Services  
Representative Tom Huntley

## Task Force Members:

Peter Benner, formerly AFSCME  
Senator Linda Berglin  
Dr. Charles Fazio, Medica  
Tom Forsythe, General Mills  
Michael Howe, Minute Clinic  
Carolyn Jones, Governor Pawlenty's Office  
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Tony Miller, Carol Inc.  
Commissioner Dr. Sanne Mangan, Minnesota Department of Health (Ex Officio)  
Charles Montreuil, Carlson Companies  
Dr. Maureen Reed  
Senator Julie Rosen  
Representative Paul Thissen  
David Wessner, Park Nicollet  
Dr. Scott Wright, Mayo Clinic

Staff support for the Task Force was provided by the Minnesota Department of Health.

## Legislature's Charge to the Task Force

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The 2007 Legislature required the Governor to convene a Health Care Transformation Task Force to develop an action plan for transforming the health care system in Minnesota in ways that improve affordability, access, quality of health care, and the health status of Minnesotans.

The Task Force's plan must include:

- Actions that will reduce health care expenditures by 20 percent by January 2011, and limit the rate of growth in health care spending to no greater than the percentage increase in the Consumer Price Index for all urban consumers plus two percentage points each year thereafter;
- Actions that will increase the affordable health coverage options for all Minnesotans and other strategies that will ensure all Minnesotans will have health coverage by January 2011;
- Actions to improve the quality and safety of health care and reduce racial and ethnic disparities in access and quality;
- Actions that will improve the health status of Minnesotans and reduce the rate of preventable chronic illness;
- Proposed changes to state health care purchasing and payment strategies that will promote higher quality, lower cost health care;
- Actions that will promote the appropriate and cost-effective investment in new facilities, technologies, and drugs;
- Options for serving small employers and their employees, and self-employed individuals; and
- Actions to reduce administrative costs.

## Vision for a Transformed Health Care System

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The Health Care Transformation Task Force envisions a health care system in Minnesota that substantially improves upon the quality, cost, and access that we experience today. Fundamental changes to the system will be necessary to achieve these goals, and all Minnesotans must play a role in creating this change.

The essential building blocks of the Task Force's plan for reform include:

- Changing the way we pay for health care, to increase the quality and safety of care and to reduce health care costs;
- Making cost and quality more transparent and easily understandable, to empower individuals with the information they need to make good decisions about their health care;
- Making health insurance more affordable, understandable, and accessible to all Minnesotans and creating an expectation that all Minnesotans obtain coverage;
- Putting a higher priority on preventing chronic disease, by using proven health promotion strategies to reduce the levels of overweight and obesity, smoking, and other lifestyle-related factors that contribute to higher health care costs; and
- Minimizing the administrative costs of the health care system by making sure that information technology is used to the fullest extent possible and by reducing other administrative costs of health plans and health care providers.

The success of each of these reform strategies is dependent on all of the other reforms. In other words, the Task Force believes that a comprehensive package of reforms is necessary to achieve the goal of improved health care quality, cost, and access for all Minnesotans.

## Why is Reform Needed?

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Minnesota has one of the nation's healthiest populations and has the lowest uninsurance rate in the nation. Our state has a reputation for a health care system that provides high quality care at relatively low cost compared to other states. Yet costs are rising unsustainably, the rate of employer-based health insurance has fallen, and even the highest quality providers have a long way to go in ensuring that everyone gets the care they need to stay healthy. In addition, unhealthy behaviors are driving up health care costs by increasing the number of people with preventable chronic diseases.

### **The burden of rising health care costs is unsustainable:**

- Health care spending in Minnesota increased from \$19.3 billion in 2000 to \$29.4 billion in 2005, a 52% increase in just five years.<sup>1</sup>
- Private health insurance premiums are becoming less affordable. Between 2000 and 2006, average premiums rose from about \$2,060 per person annually to \$3,460 – an increase of 68%. During this period, health insurance premiums rose over 3 times faster than wages and per capita income, and over 4 times faster than inflation.<sup>2</sup>
- In addition to the burden of higher premiums, consumers' out of pocket health care costs are rising as well. Between 2000 and 2006, the average out of pocket cost for Minnesotans with private health insurance increased from \$221 to \$562 – an increase of over 150%.<sup>3</sup>
- Like the cost of private insurance, the cost per enrollee for people with public insurance is rising. Over the past several years, public programs have faced the additional cost pressure of rising enrollment. In total, spending for Minnesota's Medical Assistance, MinnesotaCare, and General Assistance Medical Care programs increased by 74% from 2000 to 2006.<sup>4</sup>

### **Minnesota's historically strong private health insurance market has eroded, and uninsurance has risen:**

- Between 2001 and 2004, the percentage of Minnesotans with health insurance through an employer fell from 68.4% to 62.9%. Although enrollment in public insurance programs rose from 21.2% of the population to 25.1%, the uninsurance rate also increased (from 5.7% to 7.4%).<sup>5</sup>
- Most of the decline in employer health insurance has been the result of declining access: a smaller share of Minnesotans have a connection to an employer that offers coverage, and those who do are less likely to be eligible to sign up for coverage.
- About 20% of the uninsured in Minnesota could sign up for employer coverage but do not do so, mainly because of cost.

**The quality of health care is uneven, and it is well below the levels that we should expect for the money we are spending:**

## Why is Reform Needed?

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- National research shows that only about half of adults receive recommended care for their conditions, and the same is true for children.<sup>6</sup>
- In Minnesota, there are wide variations in quality across provider groups. For example, the percentage of 2-year olds who are up to date on their immunizations ranges from 28% to 91%, and the percentage of adults who received appropriate cancer screening services ranges from 25% to 69%.<sup>7</sup>
- Quality measures vary widely for chronic disease as well. For example, the percentage of diabetics receiving optimal care ranges from 1% to 20% across Minnesota clinics.<sup>8</sup>
- Higher health care spending is not necessarily associated with better quality – *more* care is not the same as *better* care. Research has shown that regions with high Medicare spending do not have better quality, access to care, health outcomes, or patient satisfaction.<sup>9</sup>

### **Unhealthy behaviors drive health care costs up:**

- The cost of overweight and obesity accounted for over 25% of national growth in per capita health care spending between 1987 and 2001,<sup>10</sup> due to both rising rates of overweight and obesity and an increasing gap between the cost of caring for overweight and obese patients compared to patients who have a healthy weight. One research study found that on average, health care spending for a person who is obese is 37% higher than spending for a person with normal weight.
- In Minnesota, the percentage of adults who are obese rose from 15% in 1995 to 25% in 2006, while the percentage of adults with normal weight fell from 49% to 37%.<sup>11</sup>
- Medical costs associated with smoking, alcohol use, and other drugs are also high. The amount of health care spending in Minnesota attributable just to smoking was nearly \$2 billion in 2002.<sup>12</sup>

**Minnesota's future success depends on its ability to address these important issues that affect the health and economic well-being of all its citizens.**

## Principles for Health Care Transformation in Minnesota

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The Transformation Task Force's plan for comprehensive health reform in Minnesota is based on five core principles:

- **The health of Minnesota's population must be improved.**

One of the best ways to contain health care costs is to keep people healthy, especially to prevent chronic disease that results from unhealthy behaviors. If current trends continue, more and more Minnesotans will be at risk of chronic disease associated with overweight and obesity. If we want to control costs, we need to stop adding more people with preventable chronic disease to the health care system.

- **We need dramatic improvements in the quality, cost, and patient-centeredness of health care in Minnesota, and we should use a combination of collaboration and competition to achieve these improvements.**

The variation in quality that we see in our health care system today is unacceptable, and there is room for quality improvement almost everywhere. We need to come together as a community to agree on what constitutes high quality care and encourage competition among providers on how best to achieve the highest possible quality at the lowest cost.

- **Health care payment systems must be restructured to support and encourage evidence-based, high-value health care.**

The way that we pay for health care today does not promote accountability for either cost or quality. In the current system, common sense approaches that have significant potential to improve health and lower cost are not supported – for example, health care providers are not paid to prevent expensive complications of chronic disease; some providers that have chosen to invest in chronic care management on their own have lost money by doing a better job of keeping people out of the hospital. We need to create incentives for providers to innovate on ways that improve quality and lower cost, and allow health care providers to share in the savings. We also need to establish accountability for both the quality and cost of care, and do a better job of helping consumers understand differences in quality and cost.

- **The overall size and cost of the health care system should be reduced.**

Reducing health care spending in Minnesota by 20 percent will require significant changes in the way that the health care system in Minnesota operates today. Helping consumers understand that more health care is not always better care will be a key step in this process, as will helping people understand the true variation in health care cost and quality that exists in Minnesota today. We also need to lower health care providers' and health plans' costs of doing business, and encourage greater

## Principles for Health Care Transformation in Minnesota

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competition among providers and among health plans on cost and quality. We need to make sure that we are getting better value out of the money we spend on health care, particularly with regard to determining how we pay for new technologies and treatments.

- **All Minnesotans should be able to obtain necessary health care at an affordable cost.**

In today's health care system, people who don't have the option of getting health insurance through an employer are at a disadvantage compared to those who do. They have to navigate a confusing array of health plans and products on their own, without good sources of comparative information on what they are buying. They usually have to pay with after-tax dollars, which makes health insurance much more expensive for them than for people who buy through an employer and pay with pre-tax money withheld from their paychecks. We need to make sure that everyone has access to the same tax advantages of health insurance, make it easier to navigate the market, make sure that everyone has access to affordable coverage, and create an expectation that all Minnesotans will have and maintain a minimum level of health insurance coverage.

The remainder of this report provides a summary of the strategies that the Task Force recommends for transforming health care in Minnesota. Additional details, along with recommended timelines for implementation and steps to be taken by specific organizations, are included in Appendix A.

## Improving Population Health

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The Task Force recommends adopting aggressive goals for reducing unhealthy behaviors that put Minnesotans at higher risk for chronic disease and increase health care costs. These goals should be considered statewide priorities, and we need active engagement from employers, schools, communities, and the health care system to achieve them. The Task Force recommends the following goals (detailed annual targets and additional details of the recommendations are included in Appendix A):

- Increase the share of Minnesota adults who have a healthy weight to at least 50% by 2020 (up from its current level of 37%). Reduce the percentage who are obese to 15% or lower, and reduce the percentage who are overweight to 35% or lower;
- Increase the share of Minnesota adults who are tobacco-free to at least 91.6% by 2013 (up from the current level of 81.7%);
- Reduce the percentage of Minnesotans who are binge drinkers, from 17.6% for adults to 12.7% by 2013, from 30.1% to 25% for 12<sup>th</sup> graders, and from 15.3% to 10.9% for 9<sup>th</sup> graders by 2013; and
- Reduce the percentage of Minnesotans who are dependent on illicit drugs from 1.8% in 2005 to 1.5% or lower by 2013.

Recommended strategies for achieving these goals include:

- Publish and disseminate goals by age and demographic group, and measure and report progress toward the goals separately for these groups;
- Adopt, fund, and implement the Minnesota Department of Health's Comprehensive Statewide Promotion Plan, based on the "Steps to a Healthier Minnesota" program;
- Evaluate interventions to determine "what works" and provide technical assistance to schools, employers, communities, and health care providers to disseminate successful strategies and encourage collaboration;
- Establish additional goals by 2011 for reductions in other preventable health conditions and improvements in environmental factors;
- Encourage Minnesotans to complete a health risk assessment annually and establish individual goals for health improvement;
- Enact statewide standards for physical activity in schools;
- Require that nutritional standards used in schools exceed the standards established by the U.S. Department of Agriculture;
- Require that health insurance cover preventive services designated by the Institute for Clinical Systems Improvement (ICSI) with no cost sharing or at low levels of cost sharing that will not be a barrier to low-income people;
- Increase the price of tobacco products by raising the health impact fee; and
- Encourage health plans and employers to charge higher premiums to individuals who use tobacco products.

## Improving the Quality, Cost, and Patient-Centeredness of the Health Care System

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The Task Force recommends using a combination of collaboration and competition to achieve dramatic improvement in health care quality, cost, and patient-centeredness in Minnesota. Its recommendations in this area are intended to build upon the strong foundation of collaborative efforts to measure and improve health care quality that has been built by organizations such as Minnesota Community Measurement and the Institute for Clinical Systems Improvement (ICSI):

- Health care providers should collaborate to determine community standards for optimal care. Health plans, patients and purchasers should participate in this process, but it should be led by providers;
- Health care providers should compete to achieve the highest levels of care quality; and
- Health care purchasers should encourage and support the transition to improved delivery of care.

Recommended strategies for achieving these goals include:

- Encourage providers to participate in collaboratives for improving patient outcomes through evidence-based processes. Funding for these collaborative processes should come from health plans, purchasers, and providers;
- Continue and expand measurement and reporting of quality through Minnesota Community Measurement. Measures should include evidence-based care processes, patient outcomes, patient-centeredness, and patient satisfaction. Funding for quality measurement and reporting efforts should come from health plans, health care providers, and purchasers;
- Encourage providers to innovate in finding ways to deliver evidence-based care that improves quality and/or reduces cost;
- Require providers to use electronic health record systems and systems for follow-up as a condition of payment;
- Stop paying for care that does not meet minimum standards;
- Develop standards for patient involvement in decision-making about care; and
- Involve patients in decision-making and ensure that care is patient-centered and culturally appropriate.

## Restructuring the Payment System

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The ways that we pay for health care today do not reward quality and value. Under the current system, common sense approaches to delivering health care that would lower cost and improve quality are not paid for or supported – in fact, providers who do a better job of managing care and keeping people out of the hospital may lose money compared to those that don't manage care well. For health care providers, there are limited financial incentives for prevention, care coordination, quality, innovation, or value. Consumers have few incentives to choose providers based on quality or cost, and they have little information on cost and quality. We need a system that pays for and encourages value, not volume of services.

A reformed payment system would change financial incentives in ways that improve health care quality, reduce health care cost, engage consumers in decision making, and encourage more market competition among health care providers and health plans. The Task Force's recommendations for restructuring the payment system include five specific goals:

- Establish provider accountability for the total cost and quality of care;
- Empower individuals with information and give them choices with responsibility;
- Improve coordination and management of care, especially for people with chronic disease;
- Increase transparency and provider competition on price and quality; and
- Achieve and sustain the “critical mass” that will create powerful incentives for providers to devote the necessary investment and effort needed to fundamentally redesign the ways they provide health care.

Specific steps that the Task Force recommends for achieving these goals include:

- Recognize that some health care providers are much farther along than others in having systems in place that would enable them to coordinate care and ultimately take responsibility for the total cost of care by moving toward payment reform in three stages:
  - Level 1 would explicitly tie payment to quality of care;
  - Level 2 would establish explicit care management payments to providers that demonstrate they have the infrastructure and systems needed to function as an effective medical or health care home, capable of coordinating care. As in Level 1, providers receiving Level 2 payments would need to achieve specific quality standards;
  - Level 3 would establish a system of accountability for the total cost of care. Provider groups and care systems would compete for patients by submitting bids on the total cost of care for a given population. Patients would choose provider groups and care systems based on cost and quality, and payments to providers would be risk-adjusted based on the health of the population they manage. Level 3 providers would also be accountable for quality. Because

## Restructuring the Payment System

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providers would share in any savings they achieve, providers would have incentives to innovate and compete on ways to better manage population health.

- Create an expectation that all health care providers will participate in Level 3 by 2012;
- Promote greater use of primary care by increasing relative payment levels for primary care, care management, and other cognitive services;
- Establish financial incentives for consumers to choose and use a medical or health care home that coordinates their care;
- Simplify pricing of health care services to make it easier for consumers to understand and use cost information. Providers would establish a single price for services provided to non-Medicare and non-Medicaid patients. Health plans and providers would no longer negotiate over price discounts, but health plans could structure benefits so that consumers would pay more out of pocket for using higher-cost providers;
- Establish transparent prices for “baskets” of services (e.g., maternity care) to help consumers make better choices based on cost. Establish community-wide definitions of the “baskets” to enable apples-to-apples comparisons;
- Continue to expand quality measurement and reporting;
- Develop user-friendly interfaces for consumers to make comparisons based on cost and quality;
- To achieve the critical mass necessary for payment reform to succeed, consider a range of options for increasing the number of people who purchase health care under the new system – for example, make participation in the new system a condition of receiving payment for any person whose health care is paid for with state funds, or who receives health insurance through a local government or school district; and
- Establish a new, non-profit organization to implement and administer the new payment system.

The transition to a payment system that rewards, rather than penalizes, providers who innovate in finding ways to deliver health care that result in higher quality and/or lower cost will involve major shifts in the ways that most health plans, health care providers, purchasers, and patients are used to doing business. It is important to note that the Task Force’s proposed approach to payment reform is not untested. For example, the Buyers Health Care Action Group (BHCAG) implemented a similar model in the 1990s; while initially very successful in attracting the participation of health care providers and large employer groups, the BHCAG experience also demonstrates the importance of achieving and sustaining the critical mass needed to provide long-term incentives for providers to redesign the way they deliver care.

While the transition to a system that pays for what we *want* the health care system to do (and stops paying for what we *don’t* want) may be difficult, we know that continuing to pay for health care the way that we do today is unsustainable.

## Reduce the Overall Size and Cost of the Health Care System

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Reducing health care spending in Minnesota by 20 percent will require significant changes in the way that the health care system in Minnesota operates today. Key goals that the Task Force established for reducing the overall size and cost of the health care system include:

- Help consumers understand that more health care is not always better care, and help people understand the true variation in health care cost and quality that exists in Minnesota today;
- Reduce health care providers' and health plans' costs of doing business;
- Encourage greater competition among providers and among health plans on cost and quality; and
- Establish community standards for evaluating new technologies and treatments to ensure that they provide good value.

The Task Force recommends the following actions for achieving these goals:

- Expand the availability of consumer-friendly information on quality and price, and educate people on how to use it to make wise choices;
- Conduct an extensive consumer education campaign to educate people on how the reformed payment system will work, and why more (or more expensive) care is not necessarily better care;
- Educate consumers about the relative effectiveness and cost of treatment options for their condition;
- Establish financial incentives for consumers to carefully consider cost when choosing a provider;
- Streamline and coordinate administrative costs incurred by providers (e.g., standardize the quality information that health plans require from providers, reduce the cost of debt collection);
- Establish a visible health care collaborative to measure and decrease waste;
- Reduce health plans' and providers' cost of regulatory compliance;
- Eliminate health plan activities that are duplicative of provider activities, and eliminate health plan functions that are no longer necessary under a transformed system;
- Improve public reporting of health plan administrative costs, and encourage purchasers to consider administrative efficiency when choosing a health plan;
- Create transparency in fees paid to health insurance brokers, and allow lower premiums to be charged when insurance is not purchased through a broker;
- To increase market competition, encourage new providers to enter areas where there are shortages;
- Consider modifying licensure of some health professionals to expand their scope of practice in ways that address shortages of providers and allow higher-level professionals to "practice at the top of their license";

## Reduce the Overall Size and Cost of the Health Care System

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- Establish a collaborative, non-regulatory body to review the evidence for new technologies and determine whether they should be covered by health insurance; and
- Limit payment for new technology to those patients and conditions for which effectiveness has been proven by randomized controlled trials or other strong evidence.



## Health Insurance Access and Affordability

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Achieving the goal of health insurance coverage for all Minnesotans will not be sustainable unless the cost containment efforts detailed in previous sections of this report are successful. In addition to containing cost, the Task Force has established several other goals related to health insurance access and affordability:

- Ensure that all Minnesotans have access to affordable health insurance, regardless of whether they have coverage available through their job and regardless of whether they have health problems;
- Make sure that everyone has access to the same tax advantages for buying health insurance;
- Make it easier for people to navigate health insurance markets and understand choices among competing health plans; and
- Create an expectation that all Minnesotans maintain a minimum level of health insurance coverage.

The Task Force recommends the following actions for achieving these goals:

- Improve the way that the individual and small employer group health insurance markets in Minnesota function by:
  - Establishing guaranteed issue in the individual market, and phasing out the Minnesota Comprehensive Health Association (MCHA, the state's high-risk insurance pool) over time;
  - Merging the individual and small group markets, unless the results of a forthcoming modeling analysis indicate that this would cause serious problems in the market;
  - Limiting the variation in health insurance premiums to differences based on age, health behaviors (e.g., smoking), and geography; and
  - Implementing a system of risk equalization payments across health plans that will eliminate incentives for health plans to avoid high risk customers and reward plans that do a good job of managing care for sicker populations.

In order to avoid potentially disruptive impacts on Minnesota's health insurance markets, these changes should not be implemented without also implementing a requirement that all Minnesotans obtain and maintain health insurance coverage.

- Require that all Minnesota employers with more than 10 employees establish a Section 125 plan that, at a minimum, allows employees to pay for health insurance coverage with pre-tax dollars;
- Establish a non-profit health insurance exchange with public oversight to:
  - Provide technical assistance to small employers in establishing and operating Section 125 plans, and minimize the administrative burden for employers that choose to purchase health insurance through the exchange;
  - Serve as a convenient source of standardized information to consumers comparing the cost and quality of different health insurance products;

## Health Insurance Access and Affordability

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- Encourage individuals and small groups to purchase coverage through the exchange, but allow coverage to be purchased outside the exchange as long as pricing is the same inside and outside of the exchange;
- Establish an independent board to define an essential benefit set that:
  - Includes necessary, evidence-based care;
  - Excludes care that has been demonstrated to be ineffective; and
  - Covers other services that produce good outcomes at a reasonable cost.
- Define “affordability” of health insurance coverage and provide subsidies to people who cannot afford a minimum level of health insurance under the following standard:
  - Minnesotans with gross household income at or below 300% of federal poverty guidelines should not be expected to contribute more than 7% of gross income for health care coverage;
  - Minnesotans with income at or below 400% of poverty guidelines (but above 300% of poverty) should not be expected to contribute more than 10% of gross income for health care coverage.
- Avoid creating incentives for employers that currently offer health insurance to drop coverage; and
- Require that all Minnesotans obtain health coverage by January 1, 2010, unless:
  - No insurance that meets affordability standards is available; and
  - No subsidy is available to make available insurance policies affordable.

## **Expected Impact of the Transformation Plan**

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Successful transformation of Minnesota's health care system will require active participation and engagement from consumers, employers, health care providers, health plans, and government.

### **Consumers will need to:**

- Be more actively engaged in decision making about their own health care and understanding the options available to them;
- Make lifestyle changes to reduce their risk of preventable chronic disease;
- Use information on price and quality to select health plans, health care providers, and services with the most value;
- Pay more for services and providers that are higher cost compared to others of comparable quality; and
- Obtain and maintain health insurance coverage.

### **Employers will need to:**

- Support and encourage employees to engage in healthy behaviors;
- Enable employees to take advantage of the ability to pay for health insurance with pre-tax dollars;
- Actively support and participate in changing the way that health care is paid for so that health care providers have incentives to re-design systems of care in ways that improve quality and reduce cost; and
- Support and participate in community-wide efforts to improve the quality of care, increase price and quality transparency, and evaluate new technologies to ensure that they are only used when they add value.

### **Health care providers will need to:**

- Participate in collaborative efforts to develop evidence-based guidelines for treatment and increase price and quality transparency;
- Find innovative ways to deliver care that improve quality and reduce cost, including broader implementation of information technology to increase the efficiency and quality of care;
- Accept responsibility for quality and care coordination, and ultimately for the total cost of care; and
- Ensure that they provide care that is patient-centered and culturally appropriate.

### **Health plans will need to:**

- Support and contribute to communitywide efforts to establish evidence-based guidelines for care and increase price and quality transparency;

## Expected Impact of the Transformation Plan

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- Actively support and participate in changing the way that health care is paid for so that health care providers have incentives to re-design systems of care in ways that improve quality and reduce cost;
- Establish financial incentives for consumers to choose and use a medical or health care home that coordinates care, and establish incentives for consumers to make decisions based on cost and quality;
- Educate consumers about how to use cost and quality information, and about how to make wise health care choices;
- Eliminate unnecessary or duplicative administrative activities; and
- Shift away from a model of market competition based on negotiated discounts with providers and toward competition based on activities that encourage consumers and health care providers to make decisions that improve quality and contain cost.

### Government will need to:

- Enact the necessary changes to law to implement the transformation plan, including funding where necessary;
- Implement programs that support improvement in the health of the population;
- Actively support and participate in community-wide processes to develop evidence-based guidelines for care and increase price and quality transparency; and
- Actively support and participate in changing the way that health care is paid for so that health care providers have incentives to re-design systems of care in ways that improve quality and reduce cost.

The Task Force's plan for health care transformation in Minnesota focuses on issues that the Task Force believes to have the greatest potential impact on health care cost while putting Minnesota on the right track for creating a health care system that provides high quality care in a way that is financially sustainable over the long term. However, achieving the potential savings associated with some of these initiatives will take time. In addition, because of the complexity of the health care system and the fact that many of the changes that are being proposed involve such fundamental change, there is substantial uncertainty about the size and timing of the potential savings.

The table below summarizes the potential savings associated with major elements of the Task Force's plan. In total, the Task Force's plan is estimated to result in potential savings of approximately 13.7% in 2010 compared to baseline projections, and 20.0% by 2015. Taking account of the estimated net cost to cover the uninsured, the net savings is estimated at 11.7% in 2010 and 18.0% in 2015.

Although the figures in the table represent best estimates of the order of magnitude of potential savings, there are no mechanisms in the Task Force's plan that guarantee that this level of savings will be achieved. Additional detail about the basis for these savings estimates is provided in Appendix B.

## Expected Impact of the Transformation Plan

### Potential Health Care Cost Savings

	2010		2015	
	\$ millions	% of total spending:	\$ millions	\$ of total spending
<b>Base: Projected Spending</b>	\$41,100.0		\$57,400.0	
<b>Potential cost savings:</b>				
Payment reform	\$4,110.0	10.0%	\$5,740.0	10.0%
Prevention and health promotion:				
Overweight/obesity	\$160.4	0.4%	\$1,236.3	2.2%
Smoking	\$496.2	1.2%	\$1,684.3	2.9%
Alcohol and drugs	\$96.1	0.2%	\$417.8	0.7%
Cost of interventions*	(\$57.1)	(0.1%)	(\$57.1)	(-0.1%)
	\$695.6	1.7%	\$3,281.3	5.7%
Administrative efficiency	\$822.0	2.0%	\$2,468.2	4.3%
<b>Subtotal: cost savings</b>	<b>\$5,627.6</b>	<b>13.7%</b>	<b>\$11,489.5</b>	<b>20.0%</b>
Net cost to cover uninsured**	(\$801.0)	(1.9%)	(\$1,155.0)	(2.0%)
<b>Net savings</b>	<b>\$4,826.6</b>	<b>11.7%</b>	<b>\$10,334.5</b>	<b>18.0%</b>

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

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

# Appendix A

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## Appendix B: Basis of Savings Estimates

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The table on page 17 shows baseline projected spending (i.e., the projected level of spending in the absence of any policy changes) in 2010 and 2015. In the absence of any other changes, health care spending in Minnesota is expected to reach about \$41.1 billion in 2010 and \$57.4 billion in 2015.<sup>13</sup> Potential savings from the Task Force's recommendations are calculated against these baseline levels of spending. The estimates in this table represent *system-wide* savings or costs – it is likely that these will vary by payer.

The largest estimated savings come from payment reform. The fundamental restructuring of the payment system that the Task Force has proposed is expected to result in savings from several different sources:

- First, consumers will likely switch to lower-cost providers when they have financial incentives to do so. The experience of Minnesota's state employee group when a tiered insurance product with cost sharing that varies based on provider cost was introduced provides evidence that consumers are in fact responsive to these incentives.
- Second, providers will have incentives to lower prices in order to be more competitive in the market. Again, the experience of the state employee group indicates that when consumers have information on cost and financial incentives to choose lower cost providers, providers are willing to negotiate lower prices in order to avoid being placed in higher cost tiers and risk losing patients. Although the state employee group is one of the largest health care purchasers in the state (covering about 115,000 lives), it is still a relatively small share of the overall population. Implementing patient financial incentives based on price and quality transparency on a much larger scale is expected to result in much more powerful incentives for providers to lower prices in order to remain competitive.
- Additional savings are expected to result as the health care system shifts away from a system that rewards volume of services toward a system that rewards providers for managing care well. The Task Force's proposals to explicitly reward providers for quality and to pay for care management services are expected to have some impact on cost and quality, but the largest impact is expected to result from transforming the payment system in ways that establish accountability for the total cost of care. It is difficult to predict the size of the savings that may result, but evidence about current variation in costs across providers indicates that the potential is significant:
  - For example, there is over a 60% difference in the cost of care provided to members of the state employee group by the highest cost providers compared to the lowest-cost providers, even after adjusting for differences in health.
  - In addition, one national study estimated the potential savings to Medicare from reducing variation in practice patterns at 30 percent of total spending.<sup>14</sup>

## Appendix B: Basis of Savings Estimates

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- A recent report from the Commonwealth Fund estimated the potential savings to Medicare from implementing payment based on “episodes of care” for its fee for service beneficiaries at about 5 to 6% of projected annual Medicare spending.<sup>15</sup> The concept of paying for episodes of care, like the Level 3 payment reforms recommended by the Task Force, envisions changing financial incentives in ways that encourage higher quality and more efficient use of health care resources.

Improving population health also represents a significant opportunity to achieve health care cost savings. The savings estimates from reducing overweight and obesity, smoking, alcohol, and use of illicit drugs are based on an assumption that the Task Force’s targets are achieved, combined with information from various sources on the average excess health care costs per person that are associated with these behaviors. The estimates also include a cost of \$57.1 million per year to implement the programs that are necessary to support achieving these goals. In total, the net potential savings associated with prevention and health promotion is estimated at about 1.7% in 2010, rising to 5.7% in 2015 as more aggressive targets are achieved.

Although several of the Task Force proposals would reduce administrative costs by changing the ways that health plans and health care providers do business, the highest potential savings associated with administrative efficiency come from making greater use of information technology. A recent report prepared for the State of Oregon estimated the potential net long-term savings from implementing a fully interoperable electronic health records system at 4.3 percent of total health care spending in the state. About one-third of the savings would be from reduced medical costs (e.g., fewer duplicative tests and fewer adverse drug interactions), and two-thirds from increased productivity of health care professionals and lower costs of administrative functions.

The table on page 17 also includes the estimated cost to expand health insurance coverage to all Minnesotans. From the perspective of the health care system as a whole, the net cost of expanding coverage is the cost of the increased use of health care services that is expected to occur when all Minnesotans have health coverage. The net annual cost to the system in 2010 is estimated at about \$800 million, rising to over \$1.1 billion by 2015.

In addition to the aggregate system-wide cost to cover the uninsured, it is important for policymakers to consider the likely impacts on individual payers, particularly the increase in state government spending that would be necessary. The cost to the state will depend on what specific policy changes are made to cover the uninsured, such as changes in the rules of eligibility for public insurance programs. About 60% of Minnesota’s uninsured are believed to be currently eligible for public programs but not enrolled – if all of these people enrolled in existing state programs the estimated total cost would be over \$1.2 billion (with state government cost of about \$710 million after enrollee premiums and

## Appendix B: Basis of Savings Estimates

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federal contributions). More precise estimates of the cost of various coverage and affordability proposals are currently under development.



## Appendix C: Legislative Charge to the Task Force

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### Health Care Transformation Task Force (2007 Minnesota Laws Chapter 147, Article 15, Section 21)

#### Sec. 21 HEALTH CARE TRANSFORMATION TASK FORCE.

Subdivision 1. **Task force.** (a) The governor shall convene a Health Care Transformation Task Force to advise and assist the governor regarding activities to transform the health care system, and to develop a statewide action plan as provided under subdivision 3. The task force shall consist of:

- (1) two legislators from the house of representatives appointed by the speaker, and two legislators from the senate appointed by the Subcommittee on Committees of the Committee on Rules and Administration;
- (2) two representatives of the governor and state agencies, appointed by the governor;
- (3) three persons appointed by the governor who have demonstrated leadership in health care organizations, health improvement initiatives, health care trade or professional associations, or other collaborative health system improvement activities;
- (4) three persons appointed by the governor who have demonstrated leadership in employer and group purchaser activities related to health system improvement, at least two of which must be from a labor organization; and
- (5) five persons appointed by the governor who have demonstrated public or private leadership and innovation.

The governor is exempt from the requirements of the open appointments process for purposes of appointing task force members.

(b) The Department of Health shall provide staff support to the task force. The task force may accept outside resources to help support its efforts.

Subd. 2. **Public and stakeholder engagement.** The commissioner of health shall review available research to determine Minnesotans' values, preferences, opinions, and perceptions related to health care and to the issues confronting the task force, and shall report the findings to the task force.

Subd. 3. **Duties.** (a) By February 1, 2008, the task force shall develop and present to the legislature and the governor a statewide action plan for transforming the health care system to improve affordability, quality, access, and the health status of Minnesotans. The plan may consist of legislative actions, administrative actions of governmental entities, collaborative actions, and actions of individuals and individual organizations.

## Appendix C: Legislative Charge to the Task Force

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Among other things, the action plan must include the following, with specific and measurable goals and deadlines for each:

- (1) actions that will reduce health care expenditures by 20 percent by January 2011, and limit the rate of growth in health care spending to no greater than the percentage increase in the Consumer Price Index for all urban consumers plus two percentage points each year thereafter;
- (2) actions that will increase the affordable health coverage options for all Minnesotans and other strategies that will ensure all Minnesotans will have health coverage by January 2011;
- (3) actions to improve the quality and safety of health care and reduce racial and ethnic disparities in access and quality;
- (4) actions that will improve the health status of Minnesotans and reduce the rate of preventable chronic illness;
- (5) proposed changes to state health care purchasing and payment strategies that will promote higher quality, lower cost health care;
- (6) actions that will promote the appropriate and cost-effective investment in new facilities, technologies, and drugs;
- (7) options for serving small employers and their employees, and self-employed individuals; and
- (8) actions to reduce administrative costs.

## Endnotes

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<sup>1</sup> Minnesota Department of Health, Health Economics Program

<sup>2</sup> Minnesota Department of Health, Health Economics Program

<sup>3</sup> Minnesota Department of Health, Health Economics Program

<sup>4</sup> Minnesota Department of Human Services

<sup>5</sup> Data on uninsurance and access to employer coverage is from MDH Health Economics Program and University of Minnesota School of Public Health, "Health Insurance Coverage in Minnesota: Trends from 2001 to 2004," February 2006.

<sup>6</sup> Elizabeth McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine*, June 26, 2003; Rita Mangione-Smith et al., "The Quality of Ambulatory Care Delivered to Children in the United States," *The New England Journal of Medicine*, October 11, 2007.

<sup>7</sup> Minnesota Community Measurement website, accessed December 17, 2007.

<sup>8</sup> Minnesota Community Measurement website, accessed December 17, 2007.

<sup>9</sup> Fisher et al., "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, v 138: 273-287, February 2003; and "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine* v 138: 288-298, February 2003.

<sup>10</sup> Kenneth E. Thorpe et al., "The Impact of Obesity on Rising Medical Spending," *Health Affairs*, October 2004.

<sup>11</sup> Minnesota Department of Health, data from Behavioral Risk Factor Surveillance Survey.

<sup>12</sup> Blue Cross Blue Shield of Minnesota, Center for Tobacco Reduction and Health Improvement, "Health Care Costs and Smoking: The Bottom Line," March 2005.

<sup>13</sup> These figures were calculated using the most recent available estimates for Minnesota health care spending from MDH and applying national projected growth rates from the Centers for Medicare and Medicaid Services.

<sup>14</sup> Fisher et al.

<sup>15</sup> The Commonwealth Fund Commission on a High Performance Health System, "Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Care Spending," December 2007, p. 36-38. MDH staff compared the savings estimates from this report to CMS spending projections for Medicare from 2008 to 2016 to calculate the approximate 5-6% annual savings.