

MEETING SUMMARY
Minnesota Health Care Transformation Task Force
July 30, 2007 9:30 a.m. – 4:00 p.m.
Orville L. Freeman Building, St. Paul

Attendance

Task Force Members:

Representative Thomas Huntley, Co-Chair
Commissioner Cal R. Ludeman, Co-Chair
Peter Benner
Senator Linda Berglin
Charles Fazio
Thomas M. Forsythe
Michael Howe
Carolyn Jones
Sean Kershaw
Paula Klinger
Tony Miller
Charles Montreuil
Maureen Reed
Senator Julie Rosen
Representative Paul Thissen
David Wessner
R. Scott Wright

Guests:

Governor Tim Pawlenty

Staff:

James Golden
Jenn Holcomb
Scott Leitz
Harold Miller
Julie Sonier

Welcome, Introductions, and Overview of Agenda

Co-Chairs Cal Ludeman and Tom Huntley welcomed the Task Force members, introduced each of them, and thanked them for their willingness to serve on the Task Force. Commissioner Ludeman introduced the staff who will be supporting the work of the Task Force.

Representative Huntley reviewed the legislation establishing the Task Force and the specifications for the Action Plan that the Task Force is charged with producing. Commissioner Ludeman noted that there have been a number of efforts made in recent years to identify options for reducing health care costs and improving access to health care and to assess the citizens' views on these options. He said that the responsibility of the Task Force will be to take all of the information and input that has been assembled to date and create an Action Plan to achieve the goals specified in the legislation.

Representative Huntley reviewed some of the progress that had already been achieved legislatively, such as the requirement for uniform billing that would take effect in January, 2009. He noted that the legislature's Health Care Access Commission was also working on issues regarding insurance coverage for Minnesotans, and that the Commission would be coordinating its work with the work of the Task Force. He said that all four of the legislators on the Task Force were also serving on the Health Care Access Commission, which would help to insure coordination.

Charge to the Task Force

Governor Tim Pawlenty emphasized the importance of the Task Force's work and thanked the members of the Task Force for their willingness to serve. He said that Minnesota has a strong base to build on in achieving the goals in the legislation, since it has the healthiest population and the highest rate of health insurance coverage of any state in the country. He said that proposals to expand access to health insurance coverage are appealing politically, but it is essential to also ensure cost control within the system in order to make expanded coverage feasible, and that is why both of the goals established for the Task Force are so important. He urged the Task Force to be bold in its recommendations, but to also be pragmatic, in order to ensure that the Task Force's plan is actually implemented.

Additional points made by the Governor and the Task Force members in the discussion included:

- Although no options should be viewed as "off the table," the Task Force's recommendations need to be realistic. For example, the Governor said there is not political support nationally for a single-payer system, so the Task Force shouldn't waste time on that as a strategy. At the same time, there will inherently be opposition to bold recommendations, since some people and organizations will have to give up something that they have now. For example, encouraging people to get care from centers of excellence may be a helpful option. The Task Force can provide leadership to build support for the needed changes.
- Most citizens consume health care services without consideration for the cost, so there needs to be more transparency about quality and price, and there need to be more incentives for consumers to utilize higher quality/lower cost health care services. However, many disadvantaged individuals will have difficulty engaging effectively in market-driven healthcare, and will likely need government support and assistance.

- The Task Force will need to focus its efforts on the areas where large amounts of spending exist in order to achieve the goal of a 20% reduction in spending.
- Truly high quality care is less expensive, but there needs to be greater alignment of incentives and a process for encouraging innovation in the delivery of health care services.
- Although there are many good prevention and health promotion efforts in place, there will likely need to be financial incentives as well as education if prevention efforts are going to be successful. Addressing issues like obesity cannot just be the responsibility of the health care system; it's a community problem. Additional spending on research may be needed to find the right answers.

Overview of the Minnesota Health Care System

Julie Sonier, Director of the Health Economics Program of the Minnesota Department of Health, presented a comprehensive overview of trends and strategies for cost containment. Some key points made in her presentation included:

- Rapid growth in health care spending is not a new problem; it has been with the nation for decades. Past efforts at cost reduction have only been temporarily successful.
- Most health care spending is highly concentrated among relatively few people; for example, 55% of health care spending is associated with only 5% of the population.
- Minnesota spends less on health care per person and as a share of the economy than the U.S. as a whole, but health care spending has been growing faster in Minnesota than the U.S. during recent years.
- The 20% reduction in health care spending expected by the legislation creating the Task Force translates into an \$8.2 billion reduction over the projected spending of \$41.1 billion in 2010.
- Minnesota has, for the first time, experienced a statistically significant increase in uninsurance rates over the past several years. This is being caused by a reduction in the percentage of people covered by employer-based insurance, which in turn is being caused by (1) a smaller share of the population that is employed, and (2) a larger proportion of employed people working in jobs and for employers that do not provide health insurance.
- The costs of private health insurance have been increasing faster than incomes and inflation, both in total and for the portion of insurance coverage paid by the individual.
- Spending on public health insurance programs has been increasing due to both (1) rising enrollment and (2) rising cost per enrollee.
- There are many different factors that contribute to the increases in health care spending, such as market structure, labor costs, technology, demographics, and lifestyle.

- The largest contributors to health care spending growth between 2003 and 2005 were outpatient hospital services (24.2%), inpatient hospital services (20.9%), and physician services (18.6%).
- The over-60 population is expected to more than double over the next two decades, a far greater increase than in any other age group. Since health care spending for the over 65 population is more than twice as high as for younger people, this will push total costs up.
- Lifestyle factors contributing to poor health and higher health care costs are worsening. For example, there has been a dramatic increase in obesity nationally and in Minnesota over the past two decades. Obesity-related health care spending accounted for an estimated 27% of inflation-adjusted increases in per capita health spending.
- Advances in technology are also a major contributor to increases in health care spending. Although in general, technological advances have created significant benefits in terms of quality of life improvements for the public, there are strong incentives in the current payment system to use intensive interventions instead of care management and prevention.
- Investments in additional facilities and equipment generally lead to greater utilization of services, but studies have shown that regions with higher usage of services do not have better health outcomes.
- There are a variety of potential strategies for containing costs, including:
 - Market Structure Strategies, such as pooled purchasing, increasing competition among health plans and providers, and controlling investment in new facilities.
 - Technology-Related Strategies, such as controlling or limiting investment in expensive new facilities and creating better incentives for appropriate use.
 - Lifestyle/Behavior-Related Strategies, such as prevention and employer-based health promotion efforts.
 - Consumer/Provider Incentives, such as insurance benefit design, tiered networks, and improved price/quality transparency.
 - Quality/Value Improvement Efforts, such as better management of chronic disease, value-based purchasing, and patient safety improvement.

The Task Force asked for additional detail on the health status of Minnesotans in addition to the obesity statistics presented.

Task Force Process

Harold Miller, the Facilitator for the Task Force, said that his goal was to help the Task Force develop the best plan possible in response to the legislation, and to do so as efficiently as possible by the February 1, 2008 deadline. He noted that the Task Force members collectively had a tremendous amount of expertise to draw on, and he encouraged everyone to contribute their ideas and to be as creative as possible.

He recommended that the Task Force follow a four step process:

1. Identify options for actions to be considered for inclusion in the Action Plan;
2. Evaluate those options based on criteria to be developed by the Task Force, such as their impact on the legislative goals and their feasibility;
3. Prioritize the options and decide which to recommend; and
4. Translate the recommendations into specific goals and deadlines, as required by the legislation.

He said that the staff from the Department of Health were committed to helping with the second step (evaluating options), but they need as much lead time as possible to do so. Consequently, a major agenda item for today's meeting was identifying issues and potential options that the Task Force members felt should be considered for future discussion.

He suggested that the first two legislative requirements for the Action Plan – (1) actions to reduce health care expenditures by 20% by 2011 and limit the rate of growth to inflation plus 2%, and (2) ensuring all Minnesotans have health coverage by 2011 – be considered the overarching goals, and the remaining six requirements be considered primarily as supporting actions to achieve those goals. The Task Force members agreed, but felt that achieving higher quality care should be considered a third overarching goal. It was further suggested that the Task Force's action plan strive to provide the best health care, the most affordable care, and the most consistently delivered health care for Minnesotans of any place in the country, if not the world.

Topics and Options for Future Discussion

The Task Force discussed each of the elements of the Action Plan required by the enabling legislation, and identified a number of issues and potential options for additional research and future discussion. These are listed in the Appendix.

In addition to the areas specifically mandated in the legislation, the Task Force suggested that specific attention also be given to three additional areas:

- Consumer Engagement
- Public Education
- Health Care Information Systems

The Task Force also agreed that clear definitions would have to be agreed on for the goals stated in the legislation, e.g., the exact definition of “all Minnesotans having health coverage.”

It was agreed that the Task Force needed to strike the appropriate balance between (1) recommending changes and innovations in very specific areas of health care and for specific populations versus (2) recommending system-level changes that would support and encourage appropriate changes and innovations across a broad range of

individuals and conditions. Although the Task Force cannot and should not try to redesign the details of health care delivery, it needs to ensure that its recommendations are implementable, and that will require it to consider how proposed recommendations will function in specific cases. Consequently, the Task Force may discuss very specific types of patients and conditions to understand the types of challenges which need to be overcome, even though its recommendations will be primarily at the broader system level.

In addition, it was agreed that while it was essential that the Task Force identify actions that would achieve results on the primary goals by the target date of January 1, 2011, this did not preclude the Task Force from recommending actions whose benefits would occur over a longer period of time. For example, some health prevention efforts may not be able to significantly reduce costs within 4 years, but could have significant impacts further in the future.

As part of the research supporting the Task Force's deliberations, two types of information were viewed as desirable across a wide range of different topics:

- What is already being done in Minnesota on the topic, and what programs or plans are already in process that will be implemented in the timeframe being examined by the Task Force?
- What similar efforts have been attempted in other states or communities on the topic, and what lessons can be learned from those efforts?

Schedule/Process for the Task Force

The Task Force agreed that it should meet approximately every 3 to 4 weeks between now and the end of January. Additional meetings may be scheduled in November and/or December if necessary to complete the Task Force's work. Meetings will generally be scheduled for 9:30 a.m. – 4:00 p.m. unless other scheduling conflicts preclude that. Task Force members will be polled to determine meeting dates when the largest number of members can attend.

It was agreed that the Task Force should consider actions related to cost reduction and quality improvement first, and then examine ways to expand health care coverage, since it will be easier to expand coverage if the costs of health care are lower and more value is being provided. In addition, the Task Force should prioritize its examination of options based on their potential for reducing costs. It was also agreed that the Task Force should consider implementation issues associated with recommendations from the very beginning, rather than examining those issues only at the end of the process.

It was agreed that, in general, the Task Force would work as a full group rather than in subcommittees, in order to insure that the full range of perspectives of the Task Force members would be included in the discussions, and that the staff would develop draft materials and recommendations for consideration by the Task Force. However, Task Force members would be welcome to develop ideas, analyses, and materials for consideration by the Task Force, either as individuals or working in voluntary subgroups.

State Coverage Institute

Commissioner Ludeman announced that the Robert Wood Johnson Foundation had selected Minnesota to participate in its State Coverage Institute. He said he hoped that some of the members of the Task Force would be willing to also serve on the state's Team for the Institute, which would require participation in a 3-day meeting in Chicago.

Scott Leitz, Assistant Commissioner of the Department of Health, provided additional background on the project and on the responsibilities of the individuals serving on the State Team. He noted that the State Team would be led by Commissioner Ludeman.

Next Steps

Commissioner Ludeman asked the Task Force members to complete the schedule survey so that the staff could identify dates for the next meetings of the Task Force. He thanked everyone for their participation, and adjourned the meeting.

APPENDIX: Potential Options for Future Discussion

Potential Actions for Improving the Quality and Safety of Health Care

- Focus on what drives the cost and quality of treatment for chronic diseases
- Define the optimal outcomes for health care and make the actual outcomes achieved transparent to purchasers and patients
- Set high standards and pay accordingly, particularly for the health care conditions associated with the highest expenditures
- Provide information to consumers on what treatments are most effective, and on which providers deliver the best value in care
- Make quality information simple enough for consumers to understand and actionable
- Enable providers to share data regarding patients' health status and treatment in order to improve coordination of care
- Define which providers should be considered "centers of excellence" in treatment
- Build on existing models for improving and reporting on quality, e.g., the Institute for Clinical Systems Improvement (ICSI) and Minnesota Community Measurement
- Provide more funding and support for reporting on quality
- Make investments in improved information technology
- Require providers to gather data on performance measures and report on performance
- Provide incentives to providers to follow best practice guidelines

Potential Actions for Reducing Racial and Ethnic Disparities in Access and Quality

- Provide multi-lingual education about what services exist
- Develop appropriate medical homes for minority citizens
- Pay enough to encourage/enable providers to practice in locations accessible to minorities
- Provide health care services in a more culturally-sensitive manner
- Provide language training for health care providers
- Enable people to maintain continuity of care in conjunction with other life transitions
- Provide better outreach to people of color, i.e., proactive public health, not just passive information
- Create a "patient advocate" for people from minority groups
- Insure adequate services in both rural and inner-city urban areas
- Recruit and train health providers to practice in underserved areas, including training minorities as health care professionals

- Provide health care coverage for undocumented/illegal immigrants
- Improve the extent and responsibilities of school-based health services

Potential Actions for Improving the Health Status of Minnesotans and Reducing the Rate of Preventable Chronic Illness

- Evolve health benefits to increase coverage for the most efficient and effective methods of care and reduce coverage for the least efficient and effective methods
- Transfer resources from acute care to public health
- Increase focus on prevention, including measurement of the extent to which prevention activities occur
- Reduce the rate of addiction, particularly through employer-based programs
- Steal ideas boldly from other successful public health programs
- Assess the status/effectiveness of current state health promotion/prevention programs, and look for what's missing or where coordination can be improved
- Stop funding ineffective programs
- Provide better incentives for individual responsibility regarding health
- Expand health promotion/prevention through community-based programs
- Look at successful models (e.g., smoking reduction) and try to translate them to other areas
- Identify key markers for health status and set specific goals for improvement, particularly (a) tobacco use, (b) obesity, (c) infant mortality, and (d) the number of useful years of life lost
- Establish a statewide patient health record
- Provide more health education to children in schools
- Pass legislation restricting foods, processes, etc. that are unhealthy, e.g., trans fats
- Make healthy foods more easily/cheaply available
- Create ways to promote healthy behaviors as part of institutions and systems, similar to the way that smoking has been limited in the workplace
- Develop innovative methods to reduce obesity, including asking the public for their ideas, sponsoring contests, etc.
- Invest in research on strategies for health promotion
- Improve labeling on foods and other products to educate consumers about negative impacts on health
- Encourage more individual responsibility for healthy behaviors

Some issues which need to be specifically addressed in evaluating and prioritizing options:

- What is the appropriate balance between citizen responsibility and government mandates to promote health?

- What should be the relative focus on efforts directed at children vs. adults vs. seniors?
- To what extent should savings achieved be reinvested in improving health care?
- What kinds of health problems and associated health care costs will be increasing in the future?

Potential Purchasing and Payment Strategies to Promote Higher Quality, Lower Cost Health Care

- Provide different copays for services based on income, based on the type of health condition that an individual has, etc.
- Pay for what works, and don't pay for what doesn't work
- Advocate for federal payment reforms through CMS (e.g., how charity care is paid for), and for federal waivers under Medicare/Medicaid for demonstration projects
- Establish appropriate levels of patient financial responsibility for compliance with health prevention and treatment, considering both the short-run and long-run impacts
- Reduce/eliminate cost-shifting between payers
- Allow prices to change more rapidly, and at the initiative of providers
- Authorize payment for (appropriate) care by non-physicians and outside of traditional office visits
- Establish "packages" of appropriate, quality health care with a single price, transparent to consumers and sold in the market
- Change the mechanism of payment for prescription drugs
- Enable consumers and purchasers to make decisions on value through transparent, comparable information on price and quality
- Prohibit payment for "never events"
- Avoid creating payment penalties for providers who become more efficient
- Establish clear standards and processes for paying for treatments of unknown effectiveness, including appropriately limiting the participation of individuals/organizations who benefit financially and increasing consumer awareness of the tradeoffs
- Develop a better understanding of why differences in value occur, and find ways to help low-value providers improve
- Identify services where payments can be reduced in order to allow payments to be increased where needed, while still reducing overall spending
- Prohibit payment for unnecessary care
- Limit self-referral by health care providers
- Reduce the disparity in payment between primary care and specialty care
- Encourage/assist facilities to close (thereby making health care more comparable to other business sectors)

- Make insurance payments to individuals to purchase health care, rather than directly to providers.
- Enable payments to be made for services in different care settings
- Privatize public health care programs
- Re-examine the restrictions that health plans place on the kinds of care that individuals can receive
- Reduce the range of prices that a provider can charge different payers for the same service
- Establish price controls for health care services
- Enable/encourage direct contracting between purchasers (employers) and providers, rather than through health plans
- Re-examine the Competing Care Model and implement a new/improved version
- Review and reform the taxes that Minnesota places on health care providers
- Remove the component of current payments intended to cover uncompensated care costs if universal coverage is achieved
- Eliminate provider network contracting by health plans when transparent pricing/quality/value assessment tools are in place
- Provide better coaching and assistance with lifestyle changes as opposed to utilization of prescription medications
- Authorize payment for alternative medicine providers where appropriate
- Encourage more individual responsibility for identifying and using higher-value providers and services

Some issues which need to be specifically addressed in evaluating and prioritizing options:

- What has been the impact of consolidation of providers?
- Where on a continuum, ranging from (1) one big insurance pool in which everybody shares equally, to (2) a system where an individual's cost is determined by their relative needs, should the desired system be?
- What roles should health plans and providers play in controlling costs?
- Should payment structures for mental health care be the same as or different from those for other health conditions?

Potential Actions for Promoting Appropriate and Cost-Effective Investment in New Facilities, Technologies, and Drugs

- Evaluate the need for new facilities
- Enable/encourage unneeded facilities to fail and go out of business, rather than increasing payments to keep them in operation
- Encourage more investment in rural and other under-served areas
- Expand/improve treatment capacity for underserved populations, such as mental health, veterans, and people with substance dependencies

- Fix the antitrust rules which limit cooperation among providers
- Enforce the appropriate aspects of anti-trust rules more effectively
- Determine an appropriate policy on specialty hospitals
- Reduce the incentives in the current payment system for creating new facilities
- Establish a clear benefit-cost test for new drugs, with manufacturers responsible for documenting the evidence justifying payment
- Streamline the FDA process; consider both minor improvements and major reforms
- Eliminate the Certificate of Need process
- Transport patients out of state for care where appropriate rather than replicating facilities and services in-state
- Stop paying for “me-too” drugs
- Require patients to participate in a clinical trial in order to receive payment for experimental drugs
- Establish clear requirements as to the contributions to public health required of providers and health plans in exchange for non-profit/charitable status
- Allow providers appropriate levels of discretion in deciding on treatment options
- Define the appropriate federal role in supporting capital investment

Potential Actions for Providing Health Coverage for Small Employers and Self-Employed Individuals

- Enable people to change jobs without affecting their health care coverage
- Define what is “affordable” for employers and employees in terms of health insurance
- Eliminate risk-rating in the small group market, and establish a statewide risk adjustment pool to protect insurers
- Require guaranteed issue of insurance in the small group market
- Require guaranteed issue of insurance in the individual market
- Eliminate the prohibitions on pooling of insurance coverage for franchisees with direct employees and subsidiaries
- Encourage more effective use of existing federal tax incentives for health care coverage
- Establish a statewide community rating process for health insurance
- Eliminate current exemptions from coverage requirements for self-insured and ERISA employers
- Pool small employers with the state for purchasing purposes
- Establish a mandate that individuals have health insurance, backed by appropriate financial penalties (e.g., loss of personal tax exemptions)
- Create an income-based subsidy mechanism to enable lower-income individuals to purchase coverage at an affordable level

Some issues which need to be specifically addressed in evaluating and prioritizing options:

- To what extent is it appropriate for public funding to be used to make private insurance affordable?

Potential Actions for Reducing Administrative Costs

- Establish common billing forms
- Simplify forms and utilize e-commerce approaches to billing
- Encourage/enable greater collaboration among health plans to reduce administrative costs
- Eliminate unnecessary state and federal mandates and regulations that have little value
- Move away from inspection of processes to review of outcomes
- Simplify/improve application forms for public health benefit programs
- Create packages of care with a single price, rather than separate billing codes and prices for individual services
- Identify and eliminate processes that don't add value
- Eliminate risk-rating in the small group market
- Establish a statewide IT protocol for sharing of computer information
- Eliminate the Minnesota Comprehensive Health Association (MCHA) and the MCHA assessment once guaranteed issue of health insurance is in place