

Health Care Transformation Task Force

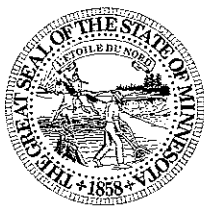
Recommendations Submitted To:

Governor Tim Pawlenty

And the

Minnesota State Legislature

January 2008



Health Care Transformation Task Force

February 1, 2008

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To the Governor and the Minnesota State Legislature:

We are pleased to submit the enclosed recommendations of the Health Care Transformation Task Force for your consideration. The challenge of ensuring that all Minnesotans have access to high quality health care at a sustainable cost is a significant one, and we believe that the Task Force's proposals will put Minnesota on the right path toward this goal.

The Task Force has laid out a blueprint for comprehensive reform that will provide a strong basis for health care reform efforts in Minnesota in 2008 and beyond. The plan will require the active participation of Minnesota citizens, employers, health care providers, health plans, and government. Transforming the health care system in Minnesota will not be easy, but it is critically important to change the system in ways that will make it more sustainable, efficient, and equitable.

Finally, we want to publicly acknowledge the extraordinary work of the Task Force members over a period of many months. All of the Task Force members have made valuable contributions to the final report, and should be commended for their service to the citizens of Minnesota on this important work.

Sincerely,

Handwritten signature of Cal R. Ludeman in cursive.

Cal R. Ludeman, Commissioner
Minnesota Department of Human Services
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Executive Summary

The Health Care Transformation Task Force is charged with developing an action plan to improve affordability, access, and quality of health care, and the health status of Minnesotans. The Task Force has 13 members appointed by the Governor, four members appointed by the Legislature, and one ex officio member.

Fundamental reforms to the health care system in Minnesota are necessary to achieve these goals. In recent years, health care costs have been rising unsustainably, and Minnesota's historically strong private health insurance market has eroded while the rate of uninsurance has risen. The quality of health care is uneven, and it is well below the levels that Minnesotans should expect for the money we are spending. In addition, unhealthy behaviors such as tobacco use, poor diet, and physical inactivity are driving health care costs up. 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.

The Task Force's plan for transforming health care in Minnesota is based on five core principles:

- **The health of Minnesota's population must be improved.** The Task Force recommends that Minnesota adopt aggressive goals for reducing the rates of overweight and obesity, tobacco use, and the use of alcohol and other drugs. The active involvement and support of communities, schools, employers, health care providers, and government will be needed to achieve these goals.
- **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 Task Force's recommendations in this area build on Minnesota's strong foundation of community collaboration to define and measure quality health care. Increased transparency of health care prices and quality, combined with more patient-centered decision-making and incentives for providers to innovate on ways to improve quality and reduce cost, will help Minnesota achieve this goal.
- **Health care payment systems must be restructured to support and encourage evidence-based, high-value health care.** The Task Force recognizes that current payment systems do not support innovation that improves quality and reduces cost – in fact, sometimes current systems penalize providers that do a good job of managing care. The way we pay for health care must be fundamentally changed in ways that support improvements in quality and establish accountability for the total cost of care.
- **The overall size and cost of the health care system should be reduced.** In this area, the Task Force recommendations include strategies to reduce overuse of health care services, reduce administrative costs, and to ensure that new technologies are only used and paid for when they provide good value.

Executive Summary

- **All Minnesotans should be able to obtain necessary health care at an affordable cost.** The Task Force’s proposals in this area would establish affordability standards for health insurance coverage, and an expectation that individuals maintain a minimum level of health insurance coverage (with subsidies when the cost of coverage exceeds affordability standards). It would change the way that Minnesota’s individual and small group health insurance markets function, and establish a health insurance exchange to help employers and individuals navigate the market. It does not require employers to pay for health insurance coverage, but does require employers to facilitate employees’ ability to pay for health insurance with pre-tax dollars.

Successful transformation of Minnesota’s health care system will require active participation and engagement from consumers, employers, health care providers, health plans, and government. The recommendations in this report focus on areas 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. Although the process of change is likely to be difficult, it is necessary in order to make progress toward the goals of a health care system that is more sustainable, efficient, and equitable.

Legislature's Charge to the Task Force

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

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. To reach the goal of ensuring that all Minnesotans have access to affordable health insurance coverage, we must transform the health care system so that it provides high quality care at a sustainable cost. 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:

- Putting a higher priority on preventing and managing 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;
- 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;
- Changing the way we pay for health care, to increase the quality and safety of care and to reduce health care costs;
- 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; and
- Making health insurance more affordable, understandable, and accessible to all Minnesotans and creating an expectation that all Minnesotans obtain coverage.

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?

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.¹
- 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.²
- 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%.³
- National research shows that an increasing percentage of families – even families with employer-based health insurance – are spending more than 10% of their incomes on health care.⁴
- 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 2006.⁵

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%).⁶
- 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.

Why is Reform Needed?

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

- National research shows that only about half of adults receive recommended care for their conditions, and the same is true for children.⁷
- 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%.⁸
- Quality varies widely and is unacceptably low for chronic disease. For example, the percentage of diabetics receiving optimal care ranges from 1% to 20% across Minnesota clinics.⁹
- 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.¹⁰

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 2001,¹¹ 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%.¹²
- 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 2002.¹³

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

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 preventable chronic disease, especially conditions associated with tobacco use and overweight/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

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 affordable coverage, make sure that everyone has access to the advantages of paying for health insurance with pre-tax dollars, make it easier to navigate the market, 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

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 12th graders, and from 15.3% to 10.9% for 9th 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 and/or maintain a healthy weight.

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

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

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 providers would share in any savings they achieve, providers would have

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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 and care management;
- 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. For people with private insurance, providers would no longer receive different prices for services depending on what health insurance plan a patient has. Health plans and providers would no longer negotiate over price discounts, and health plans would structure benefits so that consumers would pay more out of pocket for using higher-cost providers;
- Within the total cost of care model, 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.

This proposal is different in important ways from previous efforts to reduce health care cost growth and improve quality. For example, under the managed care model that was popular in the 1990s, health plans tried to contain cost by restricting the services that

Restructuring the Payment System

providers could order without prior approval. Under the Task Force's proposal for providers to set their own prices and assume responsibility for cost and quality, there are no similar restrictions. Providers, in consultation with patients, will be in charge of deciding what care is provided. Providers will also have control over setting their own fee levels, and comparative information on price and quality will be available to help consumers make choices based on cost and quality. Providers who are successful at finding innovative ways to provide high quality care at lower cost will benefit financially, rather than being penalized as they are in the current system.

The role of health plans will also change fundamentally from what it is today – instead of competing on which plan can negotiate the biggest discounts from provider fees, plans will compete based on how well they can help consumers effectively navigate the system and on how well they help consumers to stay healthy. Even though providers will be accountable for the total cost of care that they promise to the market, they will not be held responsible for catastrophic costs of unexpected high claims – health plans will continue to bear that risk just as they do now.

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

In the absence of any other changes, health care spending in Minnesota is expected to reach about \$43.9 billion in 2011 and \$57.4 billion in 2015. 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 and quality when choosing a provider;
- Reduce administrative costs incurred by providers (e.g., standardize the quality information that health plans require from providers, reduce the cost of debt collection);
- Establish collaborative efforts 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

- 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

Health care reform will not be successful unless the reformed system ensures that health care is affordable and accessible for all Minnesotans. The Task Force recognizes that this goal cannot be achieved in a sustainable way 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 so that no Minnesotan will be denied health insurance due to a pre-existing condition, and phase out the Minnesota Comprehensive Health Association (MCHA, the state's high-risk insurance pool);
 - 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;
 - Continue to allow variation in health insurance premiums based on age, health behaviors (e.g., smoking), and geography, but eliminate other differences in premiums based on health status. This change will result in less difference between the highest and lowest premium rates on the market, and will reduce volatility in premiums that can cause large spikes in premiums for small businesses if just one employee has a serious illness; 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;

Health Insurance Access and Affordability

- 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;
- 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, 2011, 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

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

- 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 from a model of market competition based on negotiated discounts with providers and to 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 16.1% in 2011 compared to baseline projections, and 21.4% by 2015. Taking account of the estimated net cost to cover the uninsured, the net savings is estimated at 14.1% in 2011 and 19.4% in 2015. Not all potential savings associated with the Task Force's proposals could be quantified – for example, there is an unknown potential for savings in long-term care costs associated with lower rates of preventable chronic disease.

Expected Impact of the Transformation Plan

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.

Finally, it is important to note that the Transformation Plan is expected to have impacts on Minnesota that go beyond its impacts on the health care system. For example, employers will experience lower absenteeism and higher productivity from a healthier workforce. As a result, Minnesota businesses will be more competitive both nationally and globally.

Potential Health Care Cost Savings

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

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

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

Recommendations for Implementing the Transformation Plan

Many different organizations will be involved in achieving the fundamental changes that are needed throughout the health care system in Minnesota, and these efforts will require coordination. The Task Force recommends creating a Health Care Transformation Organization (HCTO) to coordinate the transformation efforts and ensure that the plan is fully implemented by 2011.

The Health Care Transformation Organization would be created as a private, non-profit organization with a board appointed by the Governor and the Legislature. Its responsibilities would include:

- Designating a Health Care Value Reporting Organization to collect and report on health care quality, including outcomes, processes of care, and patient satisfaction;
- Implementing and evaluating the payment system reforms that call for pricing transparency, pricing for “baskets” of services, and accountability for the total cost of care;
- Reporting on progress toward containing health care cost growth and improving health care quality; and
- Making recommendations to the Governor and the Legislature about additional actions that may be necessary to achieve success.

The HCTO would be charged with utilizing expertise that already exists in organizations such as the Institute for Clinical Systems Improvement, Minnesota Community Measurement, the Health Information Exchange, the Smart Buy Alliance, health plans, health care providers, and others to avoid duplicating functions that these organizations already perform. A “sunset” review would be conducted in 2013 to evaluate the continued need for the HCTO.

The Task Force also recommends creating a mechanism to capture a portion of the cost savings that result from the transformation plan, in order to fund the subsidies needed to ensure that all Minnesotans have access to affordable health insurance and other costs of implementing the plan.

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Minnesota Health Care Transformation Task Force STATEWIDE ACTION PLAN FOR THE TRANSFORMATION OF HEALTH CARE IN MINNESOTA

As approved by the Task Force, January 24, 2008

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TRANSFORMATION PRINCIPLE I: IMPROVE HEALTH.

The Health of Minnesotans Must Be Significantly Improved and All Stakeholders in the State Should Accept Responsibility for Helping Achieve Aggressive Health Improvement Goals

What the Transformed Health Improvement System Should Look Like:

A. Aggressive Goals for Reduction in Obesity, Tobacco Use, Alcohol Abuse, and Drug Addiction Should Be Priorities for the State as a Whole and for Employers, Schools, Communities, and the Health Care System in Order to Prevent Minnesotans from Developing Chronic Disease and Other Health Problems

- I-A1. The percentages of Minnesotans who are overweight and obese should be reduced as follows:
 - a. Have no increases in the percentages of Minnesotans who are obese or overweight in 2008 and 2009; and
 - b. Reduce the total percentage of Minnesotans who are obese and overweight by at least 1 percentage point per year beginning in 2010, so that by 2020, no more than 15% of Minnesotans are obese, and no more than 35% are overweight (i.e., at least 50% of Minnesotans have a healthy weight).
- I-A2. The percentage of Minnesotans who use tobacco should be reduced as follows:
 - a. Reduce the percentage of Minnesotans who use tobacco by at least 0.7 percentage points in 2008;
 - b. Reduce the percentage of Minnesotans who use tobacco by at least 1.0 percentage point in 2009;
 - c. Reduce the percentage of Minnesotans who smoke by 2 percentage points per year beginning in 2010, so that the percentage who use tobacco is cut to 8.4% by 2013; and
 - d. Continue reducing the percentage of Minnesotans who use tobacco each year after 2013 to a goal of less than 5%.
- I-A3. The percentage of Minnesotans who abuse alcohol (through binge drinking) should be reduced, as follows:
 - a. Continue reductions in binge drinking rates by 0.3 percentage points in both 2008 and 2009; and
 - b. Reduce the binge drinking rate by 1.0 percentage point per year from 2010 through 2013.
- I-A4. The percentage of Minnesotans who are dependent on illicit drugs should be reduced, as follows:

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- a. Maintain illicit drug dependency levels at 1.9% in both 2008 and 2009; and
 - b. Reduce illicit drug dependency by 0.1 percentage point in 2010 and each year thereafter, to 1.5% by 2013.
- I-A5. The Minnesota Department of Health should make recommendations regarding the frequency with which Minnesotans should complete a confidential health risk assessment in order to help in establishing individual goals for health improvement. The recommendations should be based on considerations of the costs of health risk assessments and their likely benefits for different subpopulations. Minnesotans should complete health risk assessments in accordance with the recommendations and establish individual goals for health improvement.
- I-A6. The Minnesota Departments of Education and Health should establish a cost-effective system for measuring the Body Mass Index of children, in order to measure progress in reducing the percentage of children who are overweight and obese.
- I-A7. The Legislature and state agencies should encourage and/or require employers, schools, communities, and health care organizations throughout the state to adopt similar, age-specific goals for each of these priority health conditions and diseases by December 31, 2008. Wherever possible, goals should be disaggregated by demographic group, particularly racial and ethnic minorities, in order to enable better targeting of interventions and measurement of progress. The Minnesota Department of Health should publish these goals. Achievement of these goals should be a high priority for each of these organizations and groups. In particular,
- a. The State of Minnesota should be accountable for achieving the goals for its employees.
 - b. The Minnesota Department of Education should be engaged to determine the best way to ensure that schools are held accountable for making progress on health improvement goals, particularly those with a close relationship to learning, consistent with available resources.
- B. By 2011, Additional Goals Should Be Established for Reductions in Other Health Conditions, for Improvements in Environmental Factors, and for Prevention of Other Diseases That Will Reduce Health Care Costs**
- I-B1. The additional goals should be based on an analysis by the Minnesota Department of Health of:
- a. The magnitude of the impact of the health condition, environmental factor, or disease on health care costs and quality of life;

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- b. The potential change in the incidence or prevalence of the condition/factor/disease based on interventions with demonstrated effectiveness; and
 - c. The strength of the scientific evidence connecting the condition or factor to disease and costs.
- I-B2. In all cases, goals should be (a) ambitious enough to achieve significant reductions in health care costs and/or reductions in the growth in health care costs, but (b) realistic based on what has been achieved in the past, what has been achieved in other communities, and what analyses indicate is achievable in the future. In addition to aggregate goals, wherever possible, goals should be disaggregated by demographic group, particularly racial and ethnic minorities, and by sector (employers, schools, etc.) in order to enable better targeting of interventions and measurement of progress.
- C. The Minnesota Department of Health’s Comprehensive Statewide Health Improvement Plan for Achieving the Goals Should Be Adopted and Implemented by the Legislature and All Key Stakeholders**
- I-C1. By December 31, 2008, each community, school district, workplace, and health care setting should develop and implement its own plan for achieving the goals, consistent with the Steps to a Healthier Minnesota program and the Minnesota Department of Health’s Statewide Health Improvement Plan. (See the Recommendations under I-E for additional detail.) These plans should include ways to achieve the goals through prevention (e.g., by preventing smoking, overweight, and alcohol and drug abuse), as well as by reducing the number of people who already engage in an unhealthy behavior, preventing further deterioration in health status, or reversing a reversible environmental condition. The plans should consider the special needs of diverse populations in order to reduce the disparities in health status that currently exist. The plans should seek to use existing resources more effectively before proposing actions that increase costs or require additional funding. Where it is clear that additional resources are essential in order to carry out a plan and where it is clear that there will be a positive return on investment from use of those resources, these resources should be provided. Communities and other organizations seeking financial support from the state for health improvement programs should be held accountable for achieving the goals. The Minnesota Department of Health should encourage and support the development of innovative approaches to achieving the goals which minimize the need for communities, school districts, employers, and health care providers to incur additional costs.
- I-C2. The Legislature should enact standards for physical activity in schools in order to help achieve the goals for reducing the percentage of

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- children who are overweight and obese. School districts should have flexibility as to how to most cost-effectively achieve these standards within available resources, and the Minnesota Department of Health should provide information and technical assistance to school districts on successful approaches for achieving the standards.
- I-C3. The Legislature should encourage community land use and comprehensive plans to incorporate places for physical activity by citizens, e.g., creating more walkable communities, in order to help achieve the goals for reducing the percentage of Minnesotans who are overweight and obese. Communities should have the responsibility to pay for improvements needed to implement the plans.
- I-C4. The Legislature should require that food provided to children by school districts should meet or exceed U.S. Department of Agriculture nutritional standards, and that compliance with the standards should be achieved in the healthiest, cost-effective manner, in order to help achieve the goals for reducing the percentage of children who are overweight and obese. School districts should have flexibility as to how to most cost-effectively achieve these standards within available resources. The Minnesota Department of Health should establish guidelines and provide technical assistance to school districts on how to best meet or exceed the standards.
- I-C5. The Legislature should enact legislation to help reduce the percentage of Minnesotans using tobacco by:
- a. Increasing enforcement of prohibitions on tobacco access by minors;
 - b. Providing funding for anti-tobacco mass media campaigns; and
 - c. Imposing a health impact fee on tobacco products so that the price of tobacco products is high enough to substantially reduce initiation of tobacco use, increase cessation of tobacco use, and allow achievement of statewide goals for reducing tobacco use, with the revenues used to pay for health improvement programs and other actions needed to implement the Transformation recommendations.
- I-C6. The Legislature should maintain the current limitations on smoking in public places that are included in the Freedom to Breathe Act. Communities wishing to impose additional limitations on smoking as part of their local plans for achieving the health improvement goals should be encouraged to do so using the powers available to them under existing law.
- I-C7. The Legislature should require that health insurance cover all evidence-based clinical preventive services designated by the Institute for Clinical Systems Improvement (e.g., immunizations, screening

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tests, counseling and preventive medications, etc.) without cost-sharing requirements.

I-C8. Health plans and employers should be encouraged to offer incentive-based cost differentials in health insurance plans for individuals who are tobacco-free and who maintain a healthy weight, in compliance with federal law. To the extent that state law prevents such differentials, the Legislature should rescind those restrictions.

I-C9. The Minnesota Department of Health should reassess its existing programs and where possible, redirect resources to programs that will help achieve the health improvement goals.

I-C10. Sufficient additional resources should be provided to implement the Statewide Health Improvement Plan.

I-C11. Employers, schools, communities, and health care providers should provide the resources needed by their employees to implement the plan.

D. Progress in Achieving Health Improvement Goals Should be Publicly Reported

I-D1. The Minnesota Department of Health should report annually on progress toward achieving the goals. To the maximum extent possible, progress measures should be disaggregated by community, organization, demographic group, etc. in order to identify where shortfalls are occurring and enable technical assistance efforts to be appropriately targeted. Shortfalls in achieving goals for racial and ethnic minorities should be highlighted so that they can be addressed.

I-D2. Organizations that implement priority intervention programs and/or achieve significant progress toward priority goals should receive certifications and awards and be publicly recognized. Organizations which fail to achieve progress might also be publicly reported.

I-D3. The cost savings (or increases) in each goal area and from each intervention should be reported, along with an analysis of who benefited from the savings (e.g., purchasers, health plans, providers, etc.).

E. The Comprehensive Statewide Health Improvement Plan Should Be Updated Annually

I-E1. The Minnesota Department of Health should work with other appropriate organizations to identify the known effective interventions for addressing the health improvement goals. Interventions that are directed at individuals, at populations, and at environmental factors should be included.

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- I-E2. Representatives of key stakeholders (employers, schools, communities, and health care organizations) should work together to identify the barriers to replication of effective interventions, e.g.:
- Cost
 - Accessibility
 - Acceptability
- I-E3. The key stakeholders should develop strategies for overcoming the barriers for different populations in each of the settings. Where research already exists identifying successful interventions, these interventions should be incorporated into the strategies. Where there is not sufficient evidence about what approaches would work, research and demonstration projects should be undertaken. For example, research could be conducted to determine whether rewards or penalties are more effective, and whether it is more effective to change the supply side (e.g., the availability of unhealthy foods) or the demand side (i.e., the willingness of individuals to eat unhealthy foods). An evaluation should be conducted of the potential cost and effectiveness of tax incentives and insurance premium reductions or rebates for weight reduction and health promotion, including tax deductibility for the costs of health clubs and other health promotion behavior.
- I-E4. The Minnesota Department of Health should encourage the delivery of public health services in the settings and methods which are most cost-effective.
- I-E5. Where legal or regulatory barriers prevent implementation of effective programs, changes should be made (or advocated for). For example, the state could help employers overcome regulatory barriers to health improvement and incentive programs.
- I-E6. Wherever possible, organizations that have successfully implemented health improvement interventions should document the business case for health improvement interventions in order to encourage other organizations to implement them and/or to determine what resources are needed to offset costs. The business case should include the contribution that success would make to lowering direct health care costs and to reducing indirect costs to each stakeholder, such as lower employee absenteeism, better performance in school, etc.
- I-E7. Programs should be evaluated by the Minnesota Department of Health or the organizations that undertake them, based on the extent to which they cost-effectively make progress toward the goals established under Recommendations I-A and I-B, and successful interventions should be rapidly disseminated to, and implemented by, additional appropriate organizations, with adequate resources to

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achieve success. Unsuccessful interventions should be promptly eliminated.

Implementation Steps and Responsible Organizations

F. Actions by the State Legislature

- I-F1. By June 30, 2008, the Governor should recommend and the Legislature should enact legislation implementing the policy initiatives described in Recommendations I-C2, I-C3, I-C4, I-C5, and I-C7.
- I-F2. The Governor's Budget Proposal for the 2010-2011 biennium should include proposals to fully implement the Statewide Health Improvement Plan, including funding mechanisms and other strategies to fully implement the programmatic initiatives developed under Recommendation I-C in order to achieve the goals defined under Recommendation I-A and Recommendation I-B.

G. Actions by the State Executive Branch

- I-G1. The State of Minnesota should continue encouraging each of its employees to complete an annual health risk assessment, and it should establish annual goals for improvement of employee health consistent with the statewide goals.
- I-G2. By June 30, 2008, the Minnesota Departments of Education and Health should recommend a way to ensure that schools are held accountable for making progress on health improvement goals, particularly those with a close correlation to learning, consistent with available resources.
- I-G3. By July 1, 2009, the Minnesota Departments of Education and Health should establish a cost-effective system for measuring the Body Mass Index of children.

H. Actions by Other Organizations

- I-H1. Every employer, school, community, and health provider should encourage its employees to complete health risk assessments, to discuss the results with their physician, medical home, or health care home and to establish and achieve annual health improvement goals, consistent with the recommendations developed by the Minnesota Department of Health (see Recommendation I-A5). Employers, schools, communities, and health providers should implement cost-effective health improvement programs that will help employees achieve their goals.
- I-H2. Every Minnesota family should complete health risk assessments consistent with the recommendations developed by the Minnesota Department of Health (see Recommendation I-A5), discuss the results

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with their physician, medical home, or health care home, establish annual health improvement goals, and participate in health improvement programs to achieve their goals.

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TRANSFORMATION PRINCIPLE II: INCREASE QUALITY.

Dramatic Improvements Must Be Made in the Quality, Costs, and Patient-Centeredness of Health Care in Minnesota Through a Combination of Collaboration and Competition by Providers

- Health care providers, with the participation of health plans, patients, and purchasers, must collaborate to determine the necessary, quality care that should be delivered in order to achieve good outcomes;
- Health care providers must compete to achieve the most efficient and effective execution in delivering necessary, quality care;
- Health care purchasers must encourage and support the transition to improved delivery of health care; and
- Consumers must have reliable, understandable information about the quality of care in order to utilize the highest-quality, most efficient health care providers.

What the Transformed Health Care Delivery System Should Look Like:

A. Health Care Providers Should Deliver the Highest Quality, Most Efficient Care Possible

- II-A1. Providers should be encouraged to participate in collaboratives for improving patient outcomes through evidence-based processes (e.g., the processes sponsored by the Institute for Clinical Systems Improvement).
- II-A2. Providers should deliver care to patients consistent with evidence-based guidelines, where such guidelines exist. However, providers should also be expected and encouraged to develop innovations in care delivery that will increase value (i.e., higher quality and lower costs), and to demonstrate the effectiveness of the innovations through a collaborative.
- II-A3. Providers should be required to implement and use electronic medical record systems and systematic patient tracking systems as a condition of payment. Statewide standards for electronic medical record systems and patient registries should be established, using existing national registry standards and linking to national systems where possible. (A “systematic tracking system” is a list of patients all of whom have a common condition or group of conditions, along with information about the care they receive and the outcomes they experience. It would be used for evaluating the effectiveness of care programs across a large group of patients and also to help providers ensure adherence with clinical guidelines by identifying individual patients who need specific procedures or services consistent with guidelines.)

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- II-A4. Collaboratives should define the minimum standards/expectations for outcomes of care, and both purchasers and payers should refuse to pay for care that does not meet the standards. The process of defining standards/expectations for care should not exclude consideration of complementary and alternative medicine, and standards should not exclude complementary and alternative medicine where there is evidence of its effectiveness. Standards for a provider serving as a “medical home” or “health care home” should be included.
- II-A5. Health plans and providers should contribute financially to cover the cost of the collaborative processes for improving the quality of care. Self-insured companies should also be encouraged to contribute, to the extent that contributions are not being made on their behalf through health plans serving as third-party administrators.
- II-A6. Providers should involve patients in decision-making about care, and ensure that information about treatment options is provided by someone without a financial interest in the patient’s choice. If needed, legislation should be considered to provide appropriate liability protections for providers using shared decision-making with patients.
- II-A7. Health care providers should provide patient-centered, culturally appropriate care to all of their patients, including racial and ethnic minorities. Interpreter services will be needed to enable non-English speaking patients to communicate effectively with health care providers. Communities and employers with large numbers of racial and ethnic minorities should take responsibility for helping ensure that culturally appropriate health care can be provided. Medical associations should ensure that education and training programs are available for providers regarding ways to provide culturally appropriate care.

B. Information on Provider Quality Should Be Publicly Available

- II-B1. All providers should be required to submit standardized electronic information on the outcomes and processes associated with patient care (with protections for patient confidentiality) to a Health Care Value Reporting Organization designated by the Health Care Transformation Organization (see Recommendation VI-A) for the purposes of public reporting. This would include any reports currently submitted to specialty societies and other regional or national quality improvement organizations. (See also Recommendation III-C1.) To the maximum extent possible, the Health Care Value Reporting Organization should attempt to utilize data that providers are already submitting to other quality measurement organizations, professional societies, etc. in order to minimize the need for providers to assemble and submit duplicate or conflicting information.

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- II-B2. The measures of outcomes and processes to be collected should be defined by the Health Care Value Reporting Organization, with input from providers, payers, and consumers. The priority should be on reporting the *outcomes* a provider achieves for similar patients, where good measures of outcomes and good methods of risk adjustment exist. Where good outcome measures and/or good complexity/risk adjustment methods do not exist, reporting should focus on the extent to which the provider complies with evidence-based guidelines for care, if there is strong evidence supporting the relationship between process measures and outcomes. To the maximum extent possible, the Health Care Value Reporting Organization should utilize measures of outcomes and processes that providers are already submitting to other quality measurement organizations, professional societies, etc. in order to minimize the need for providers to assemble and submit duplicate or conflicting information.
- II-B3. The Health Care Value Reporting Organization should also collect information from patients on the extent to which providers act as true agents for patient decision-making and the extent to which they provide culturally appropriate care to racial and ethnic minorities, either using the results of patient satisfaction surveys currently collected by providers or others, and/or using newly-developed patient satisfaction surveys.
- II-B4. The Health Care Value Reporting Organization should publish audited information on the quality of care systems, providers, and services in order to help consumers find the highest-value providers and services. Reports should specifically identify any disparities in the quality of services delivered to racial and ethnic minorities.
- II-B5. The Health Care Transformation Organization should solicit proposals from existing organizations and collaborations of organizations, such as Minnesota Community Measurement or the Chartered Value Exchange for Minnesota, to serve as the Health Care Value Reporting Organization or to carry out functions of the Health Care Value Reporting Organization. The Health Care Transformation Organization should contract with the organization or organizations best qualified to carry out these functions, including consideration of the extent to which the organization is governed by individuals who do not have a direct financial interest in health care services, equipment, or facilities.
- II-B6. Health plans and providers should be required to contribute to cover the costs of the Health Care Value Reporting Organization in collecting, analyzing, and disseminating data on quality. Self-insured companies should also be encouraged to contribute, to the extent that contributions are not being made on their behalf through health plans serving as third-party administrators.

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Implementation Steps and Responsible Organizations

C. Actions by the State Legislature

- II-C1. By June 30, 2008, the Governor should recommend and the Legislature should enact legislation requiring all health care providers to, no later than December 31, 2009, submit standardized electronic information on the outcomes and processes associated with patient care which will be publicly reported by the Health Care Value Reporting Organization, and requiring the Health Care Value Reporting Organization to publish annual reports on the risk-adjusted quality of care delivered by individual providers no later than June 30, 2010.
- II-C2. By June 30, 2008, the Governor should recommend and the Legislature should enact legislation requiring health plans and health providers to annually contribute funding to cover the costs of quality improvement processes through the Institute for Clinical Systems Improvement beginning in 2009. The Governor and Legislature should also encourage self-insured companies to contribute, to the extent that contributions are not being made on their behalf through health plans serving as third-party administrators.
- II-C3. By June 30, 2008, the Governor should recommend and the Legislature should enact legislation requiring health plans and health providers to annually contribute funding to cover the costs of quality reporting by the Health Care Value Reporting Organization beginning in 2009. The Governor and Legislature should also encourage self-insured companies to contribute, to the extent that contributions are not being made on their behalf through health plans serving as third-party administrators.
- II-C4. By June 30, 2009, the Governor should recommend and the Legislature should enact legislation, if needed, to provide appropriate liability protections for providers using shared decision-making with patients.

D. Actions by the State Executive Branch

- II-D1. The Minnesota Department of Health should establish statewide standards for electronic medical record systems and systematic patient tracking systems, consistent with existing national registry standards and linking to national systems where possible, and in accordance with existing state law.
- II-D2. By January 1, 2009, the Department of Employee Relations and the Department of Human Services should encourage that providers participate in appropriate quality improvement collaboratives, including collaboratives established by the Institute for Clinical Systems Improvement.

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E. Actions by Other Organizations

- II-E1. By December 31, 2008, the Institute for Clinical Systems Improvement should establish or continue quality improvement collaboratives for conditions and treatments where significant savings in health care costs are possible, including for all major chronic diseases. These collaboratives should define the minimum standards/expectations for outcomes of care.
- II-E2. By June 30, 2009, the Institute for Clinical Systems Improvement should develop standards for involvement of patients in decision-making about care.
- II-E3. By June 30, 2009, all health care providers should establish processes for involving patients in decision-making about care, and ensure that information about treatment options is provided by someone without a financial interest in the patient's choice.
- II-E4. By June 30, 2009, the Health Care Value Reporting Organization should establish a system for providers to report outcomes and processes associated with patient care. Other organizations that are developing quality measurement and reporting systems, including Minnesota Community Measurement, Stratis, and the Minnesota Hospital Association, should work with the Health Care Value Reporting Organization to establish a single system for collection and reporting of data on provider quality.
- II-E5. By December 31, 2009, all health care providers should begin submitting standardized electronic information on the outcomes and processes associated with patient care to the Health Care Value Reporting Organization.
- II-E6. By December 31, 2009, the Health Care Value Reporting Organization should establish a system for complexity/risk -adjusting the measures reported by providers on outcomes and processes associated with patient care.
- II-E7. By June 30, 2010, the Health Care Value Reporting Organization should begin issuing public reports on provider quality using the data submitted by providers, adjusted for patient complexity/risk.
- II-E8. By December 31, 2009, the Health Care Value Reporting Organization should begin collecting information from patients on the extent to which their health care providers are appropriately involving them in decisions about care.
- II-E9. By June 30, 2010, the Health Care Value Reporting Organization should begin issuing reports on the extent to which health care providers are appropriately involving patients in decisions about care.

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TRANSFORMATION PRINCIPLE III: REFORM PAYMENT.

Health Care Payment Systems Should Be Restructured to Support and Encourage Evidence-Based, High-Value Health Care

- **Providers should be accountable for and compete based on the cost and quality of care they deliver for the population they care for;**
- **Individuals should be empowered with information on the quality and cost of care and should be responsible for choosing providers and services based on value, with minimal restrictions on switching providers;**
- **Payment systems should support improved coordination of care (medical home/health care home concept);**
- **There should be full transparency and vigorous provider competition on price and quality; and**
- **A sufficient number of purchasers and payers should support the restructured payment system in order to achieve and sustain the “critical mass” needed to make the reform successful.**

What the Transformed Health Care Payment System Should Look Like:

A. Payment Systems Should Hold Health Care Providers Accountable for Quality, Efficiency, Care Coordination, and the Total Cost of Care

III-A1. Payment reforms to achieve greater provider accountability for quality, efficiency, care coordination, and the total cost of care should be achieved in 3 stages. Some providers, such as large integrated care systems, may be ready immediately to participate in Level 3; others may only be ready for Level 1. At a minimum, all primary care physicians, specialty care physicians, clinics, hospitals, and other providers who provide the services defined in the standardized benefit set for bidding (see Recommendation III-A4b) should move to Level 3 by January 1, 2012.

- III-A2. **Level 1** of payment reform will involve making payments to providers explicitly depend on the quality and efficiency of care they provide:
- a. Providers meeting specific targets (or who show a significant amount of improvement over time) will be eligible for these quality/efficiency-based payments. These payments will be incorporated into existing payment systems in a budget neutral way, most likely as withholds.
 - b. The quality/efficiency measures will be based on the measures defined in Recommendation II-B2, with a priority on measures of outcomes, rather than processes, wherever possible.

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- c. For primary care providers, the quality measures will focus on preventive services, coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary disease, and depression.
- d. For specialty care, where the availability of quality measures is more limited, specialty societies have developed quality indicators that can be measured and reported publicly, and specialists should be encouraged to rapidly develop additional quality indicators.
- e. Hospital payments will also be adjusted for quality and efficiency using existing measures where available.
- f. Other indicators of care quality and efficiency should be incorporated where appropriate, such as the existence of care infrastructure (e.g., electronic record systems), collection and internal/external reporting of results, measures of efficiency on specifically defined procedures, and measures of the overall cost of care for individuals.

III-A3. **Level 2** of payment reform will involve providers assuming greater responsibility for coordinating care for patients, particularly those with chronic conditions.

- a. Providers at level 2, including those serving as “medical homes” or “health care homes” (see Recommendation III-C4), will receive “care management fees” for monitoring and managing care. The amount of the care management fee should be adjusted for the complexity/risk of the patients served; e.g., higher fees would be paid for patients with multiple, complex chronic illnesses, and lower fees would be paid for healthy patients who require only preventive care.
- b. Providers will need to meet specific standards, including having specific types of care management systems in place, to be eligible to receive the care management fees. Initially, the standards likely will be based on processes, but they should quickly evolve to be based on cost and quality results.
- c. Although the care management fee creates an additional payment to providers, it is expected that increased use of care management will result in less use of acute care services and overall cost savings.
- d. The quality/efficiency-based payments in Level 1 would also be included in Level 2, and could be modified to ensure that there are adequate financial incentives for providers receiving the care management fee to reduce the total cost of care. Providers whose quality or efficiency do not enable them to qualify for the quality/efficiency-based payments under Level 1 would not be eligible to receive the care management fee.
- e. The complexity/risk adjustment system for the care management fees should consider the additional time and resources needed by

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patients with limited English-language skills, cultural differences, or other barriers to health care.

- f. Care management fees could be phased in, focusing first on the chronic disease populations where the largest financial savings could be achieved relatively quickly (e.g., by reducing hospital admissions and readmissions for patients with chronic illnesses).

III-A4. **Level 3** of payment reform will involve providers and care systems assuming responsibility for the total cost of care for the patients they care for, as well as the quality of the care they provide. However, providers will not be responsible for higher costs of care that are solely due to caring for sicker patients, as long as the illnesses were not preventable through actions by the provider.

- a. Providers and care systems will submit bids to health insurance plans, other health care purchasers, or consortiums of plans and purchasers, on the total cost to provide care under a standardized benefit set for a population with a standard complexity/risk profile. (“Total cost” would include the costs of all services under the standardized benefit set, but not costs for services outside of that benefit set.) Ultimately, provider bids should be based on value (i.e., quality and cost), rather than simply cost.
- b. The Health Care Transformation Organization (see Recommendation VI-A) will work with purchasers to establish a standardized benefit set on which all bids will be based. This benefit set should include, but not necessarily be limited to, the essential value-based benefit set established under Recommendation V-A8, and should not include coverage for technologies, services, and medications that are determined not to provide value based on Recommendation IV-D.
- c. In order to be eligible to bid, providers and care systems will need to meet minimum standards for quality of care established by quality improvement collaboratives (see Recommendation II-A4). However, the minimum quality standards should not be set so high as to excessively limit the number or capacity of providers available to provide care for consumers, particularly during the transition period to the new payment system.
- d. The bids from providers and care systems may be rejected by health insurance plans or other health care purchasers if they do not decrease costs over current levels.
- e. The Health Care Transformation Organization will establish a mechanism for soliciting and accepting bids from providers and care systems. This mechanism should ensure that bids from different providers and care systems can be compared by consumers based on relative value (i.e., quality and cost).

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- f. Consistent with Recommendations III-C2 and IV-A4, consumers should pay less for health insurance coverage if they select a provider or care system of higher value (i.e., lower cost and higher quality) than if they select a provider of lower value. The differential in cost to the consumer should be sufficient to provide a financial incentive for consumers to select higher-value providers.
- g. Even after selecting a care system, consumers should still be able to select a specific health care provider to provide a particular service based on the relative value of that particular provider, as determined by the provider's price (which would be reported publicly, consistent with Recommendation III-B2, and wherever possible in "basket" form, consistent with Recommendation III-B3), and by the provider's quality (which would be reported publicly, consistent with Recommendation II-B). Consistent with Recommendation III-C2, consumers should expect to pay more for selecting higher-cost providers for a specific service, both as an incentive to use lower-cost/higher-value providers and to enable the care system to keep the costs of care within its bid price.
- h. The payments to providers for care of the consumers who select them will be complexity/risk -adjusted based on the health and special needs of the population they manage, to avoid penalizing providers for caring for a less healthy population or a population with language or cultural barriers. Complexity/risk adjustment will be focused on things that providers cannot control or materially influence, and will be combined with quality incentives to reward providers (or not penalize them) for keeping their patients healthy (i.e., to lower the patients' complexity/risk). Factors used in the complexity/risk adjustment system should include, but not be limited to:
 - the health status of the individual in the year the individual enters the provider's care;
 - worsening of a patient's health conditions that were not reasonably preventable by actions the provider could have taken. In addition, the provider should not be penalized for improvement in the health condition of individuals within the care of the provider for more than a year;
 - the English-language skills and other characteristics (such as socioeconomic status) that bear directly on the cost of care; and
 - the percentage of individuals served by the provider or care system whose care is paid for by public health insurance

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programs that pay below the single price set for the commercial market.

(The Level 3 payment system will be significantly different from traditional capitation systems, since under most capitation systems, providers have to bear “insurance risk” for differences in the health of their patients, which in turn gives them an incentive to avoid accepting sicker patients. Under Level 3 payment, providers will be responsible for managing the cost of care for a patient who has a particular combination of health and special needs, but the provider will be paid more for caring for a patient who is sicker or has more complex needs.)

- i. Because this mechanism holds providers accountable for the total cost of care of the population they manage (other than differences in cost due to differences in the health of patients that were not preventable through actions by the provider), providers will have incentives to innovate and redesign systems and make investments to provide care more effectively and efficiently.
- j. The quality/efficiency-based payments in Level 1 will be included initially in Level 3, but they are intended to be temporary and phased out when, under Level 3, patient choice and competition result in improved quality and increased efficiency. However, the quality/efficiency-based payments may continue in non-competitive markets as needed to ensure high quality and low cost.
- k. The Health Care Transformation Organization should develop a detailed design and implementation plan for Level 3, including the mechanisms by which providers will be paid. One option is for the actual payments to providers to continue to be based on the current fee-for-service and episode-of-care payment system (as an administrative mechanism for tracking delivery of services and resource use, and as a cash flow mechanism for reimbursing providers), with the levels of fee payments adjusted to match the bids made by the provider. Other potential options would be for a provider to be paid through newly-defined “baskets of care” (see Recommendation III-B3) or for a medical home or health care home to be paid a single amount on a per-patient basis (e.g., covering the full range of services involved in appropriate care management), if an alternative mechanism (other than fee for service codes) can be established for adjusting the amount based on the complexity/risk of the patient and for services that the patient receives from other providers. If the option chosen as the underlying administrative mechanism for tracking services and

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for determining the specific amount of payment in any period includes the use of the explicit care management fees under Level 2, then the quality standards required for providers to receive these care management fees would remain in place. Also, other modifications to the fee structure, such as creation of fee codes for the use of allied health professionals (such as nurse practitioners and physician assistants) and for patient contacts made by phone and email, may be needed to enable providers to be appropriately compensated for more efficient and effective systems of delivering care. However, services that fail to meet the standards defined in Recommendation III-B4 should not be eligible for payment under this fee-based, bid-adjusted mechanism.

- I. At a minimum, all primary care physicians, specialty care physicians, clinics, hospitals, and other providers who provide the services defined in the standardized benefit set for bidding (see Recommendation III-A4b) should be encouraged to participate in Level 3 as soon as possible, but no later than 2012. Providers that do not have the size or capability to directly bid to provide care may either (a) join with other providers in a larger system of care that can submit a bid, (b) provide services under contract to providers who do submit a bid, or (c) be paid based on their costs of care relative to other providers who do bid, after adjusting for differences in the complexity/risk of the patients they serve. The Health Care Transformation Organization will establish procedures for providers to participate in Level 3, and may, if necessary, facilitate the provision of technical assistance to providers who need it to assemble bids, to contract with other providers who are submitting bids, or to otherwise participate in the Level 3 payment system. The Level 3 bidding and payment structure should be designed in a way that does not encourage consolidation of providers; the term “system of care” is intended to include virtual networks of providers, not just formally integrated care systems.

III-A5. A method should be established by the Health Care Transformation Organization for measuring the effectiveness of the new payment system and making adjustments to it if needed.

III-A6. When implementing the new payment systems and the concepts of “care management services and payments” and “medical homes” or “health care homes,” every effort should be made to learn from and avoid repeating problems that existed with the managed care systems used in the past to control health care costs.

B. The Basic Structures of Payment and Pricing Must Also Be Reformed

III-B1. Fee levels for primary care, care management, and other cognitive services should be increased relative to other services, in a cost-

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neutral way. Current payment systems are believed to underpay for these types of services compared to procedures. This reform would promote greater use of primary care, and paying more for primary care would address some of the financial incentives that have resulted in fewer medical students choosing primary care careers. (This would not require a complete reweighting of all fee levels for all services; however, it is expected that some fees would drop, offsetting in part or in whole the increases in payments for primary care, care management, and cognitive services.)

III-B2. In order to ensure transparency of costs, all providers should establish and make publicly available a single price for each service billed on a fee for service basis or offered under a “basket of care” as defined in Recommendation III-B3. That price would be offered to consumers and would be accepted as payment in full by the provider from all private payers (and by public programs such as Medicare and Medicaid to the extent possible) for the service provided. Providers will no longer negotiate prices with numerous third party payers, and payment rates for a service to a particular provider will no longer vary based on the type of insurance a person has. Instead, providers will set prices that are visible throughout the community and easy to understand. This change is intended to promote greater competition by providers, as well as reduce health plan and provider administrative costs. (Providers and health plans could continue to negotiate on network participation by providers.) However, consistent with Recommendations III-A4h and III-A4k, if services rendered to consumers covered under a Level 3 contract are paid administratively based on the fee-for-service system, those fees would be adjusted periodically based on the provider’s overall bid to ensure that the total cost of care provided matches the bid amount, which means that the actual payment for a particular service for these consumers might be different than the established price.

III-B3. Payers and providers should establish mechanisms to enable consumers to select and pay a single price for “baskets” of health care services, particularly for major, high-volume services (both acute care and chronic care management), to better enable providers to compete on both quality and cost for those services. (A “basket” means a collection of individual services that are currently paid separately under the fee-for-service system, but which are ordinarily combined by a provider in delivering a full diagnostic or treatment procedure to a patient. For example, a “hip replacement basket” would include all of the charges for the hospital stay, the surgeon’s fees, the medication costs, and post-surgical rehabilitation, and a “heart disease management basket” would include all of the charges by a primary care physician or cardiologist for testing, evaluation, and care management for a patient with heart disease during a specific period

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of time.) This change would improve price transparency for consumers, and would also explicitly create incentives for providers to improve efficiency and quality. In addition, it would provide additional points of provider competition beyond just health plan/care system choice, as described in Recommendation III-A4g. Core components of the baskets would be defined by a community-wide process, to enable “apples to apples” comparisons by consumers. Providers would be free to innovate on care design, extra services, and efficiency within the baskets. The Health Care Transformation Organization (see Recommendation VI-A) will develop and implement the process for defining the baskets and their core components, utilizing the expertise of and coordinating with the programs of the Institute for Clinical Improvement, the Health Care Value Reporting Organization, and other relevant organizations.

III-B4. Providers should not be paid for services that fail to meet minimum quality standards (see Recommendation II-A4) or for the costs associated with “never events,” hospital-acquired infections, medical errors, etc. Consumers should only be required to pay for a service which fails to meet minimum quality standards if they choose to use the service after being notified by the provider in advance that the service will not be covered under their health insurance because it fails to meet minimum quality standards.

III-B5. Providers with medical education programs should continue to receive separate payments through the state’s Medical Education and Research Costs (MERC) Fund so the providers do not need to increase their prices for health services to cover the costs of medical education.

C. Individuals Should Be Given Information and Incentives to Choose More Cost-Effective, Higher-Quality Providers

III-C1. All providers should be required to submit information on the prices they are paid for care to the Health Care Value Reporting Organization established in Recommendation II-B, which would publish this information in conjunction with quality information in order to help consumers find the highest-value providers. Reporting on prices would be done in a way that is understandable for consumers.

III-C2. Consumers should incur lower costs for using more cost-effective, higher-quality providers. Health plans should set allowed reimbursement based on the level of payments to high-quality, cost-effective providers, and enrollees who seek care from higher-cost/lower-value providers should be required to pay the difference in cost. (Reimbursement levels and consumer differentials would be based on the provider’s price for services and baskets of services under payment reform Levels 1 and 2, and would be based on the

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provider's bid under payment reform Level 3.) To the extent that state legislation limiting cost-sharing in insurance products precludes these changes, it should be amended.

- III-C3. The differentials in costs to consumers of using higher-priced providers (see Recommendation III-C2) should be set at levels that are sufficient to incent significant movement of consumers to providers with lower prices and equivalent-or-higher quality, in geographic areas where there are choices among providers (see Recommendation IV-C). However, consumers should not be forced to pay more to use lower-value providers if there is strong evidence that higher-value providers do not have sufficient capacity to care for them.
- III-C4. For those consumers where there is evidence that a medical home or health care home provides value, they should be given incentives to choose and use a medical home or health care home. This goal could be accomplished through lower premiums, lower cost-sharing, or other incentives. "Virtual" medical homes or health care homes should be permitted for consumers who wish greater flexibility in managing their care, and specialized medical homes or health care homes should be permitted for persons with highly specialized medical conditions or chronic diseases, as long as these specialized medical homes or health care homes provide coordination of the full range of care for these individuals, not just the care for a particular condition or group of conditions. Medical homes and health care homes should be expected to meet minimum standards of quality and value, consistent with Recommendation II-A4.
- III-C5. Consumers should not be restricted from switching providers. However, health insurance plans might require consumers to pay more if they choose to switch medical homes or health care homes frequently.
- III-C6. In order for price and quality transparency initiatives to have the greatest effect, consumers need access to easy-to-use information on both price and quality. Internet-based tools and other mechanisms should be developed to help consumers make comparisons and to understand differences in out-of-pocket costs based on their own specific health plan benefits. (See also Recommendation IV-A.)
- III-C7. During the initial implementation of the system, consumers should not be forced to pay more to use lower-value providers if there is strong evidence that higher-value providers do not have sufficient capacity to care for them.

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D. A Critical Mass of Purchasers and Payers Must Support the New Payment System on a Sustained Basis

III-D1. In order to make it worthwhile for providers and care systems to participate in this new payment system, it needs to involve a significant percentage of their patients. Similarly, in order to make it cost-effective for payers to change their payment systems, a significant number of providers need to participate. Therefore, in order to be successful, payment reform must include as many providers and payers as possible. Potential mechanisms for achieving and sustaining “critical mass” include:

- a. Making participation a condition of receiving payment for any patient paid for with state funds (i.e., state employees and public program enrollees) – this requirement would apply to both health plans and health care providers;
- b. Requiring participation by all state and local units of government, including school districts;
- c. Requiring participation by the small group and individual markets;
- d. Requiring participation by the entire fully-insured market;
- e. Encouraging voluntary participation by other market players (e.g., self-insured employer plans); and/or
- f. Creating economic incentives for plan and provider participation.

III-D2. The Health Care Transformation Organization (see Recommendation VI-A) should make recommendations for how Medicare should participate in the new payment system and otherwise support the transformation of Minnesota’s health care system, and the Health Care Transformation Organization should work with the Centers for Medicare and Medicaid Services and the Minnesota Congressional Delegation to gain approval for any demonstration programs or changes in Medicare policy to enable this to happen.

E. The Health Care Transformation Organization (See Recommendation VI-A) Should Plan the Details of the New Payment System, Evaluate Its Effectiveness, and Make Modifications Necessary for Success

III-E1. The Health Care Transformation Organization should develop a detailed design and implementation plan for payment reform that incorporates the elements of Recommendations III-B and III-C into the overall structure in Recommendation III-A in a way that can work logically and effectively, attract the critical mass of payers envisioned in Recommendation III-D, and achieve or exceed the goals defined in Recommendation III-F. As the payment reform system is implemented, the Health Care Transformation Organization should monitor it closely, identify any barriers to implementation and

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unintended consequences, and develop plans and proposals for improving the system to address those problems.

- III-E2. The Health Care Transformation Organization may contract with other organizations, including the Health Insurance Exchange established by Recommendation V-E, to carry out all or part of its responsibility to plan the details of the new payment system, and to evaluate the effectiveness of the new payment system.
 - III-E3. In addition to the requirements under Recommendation VI-A1, the Board of Directors of the Health Care Transformation Organization should include individuals with expertise in health care payment but without conflicts of interest.
 - III-E4. The Health Care Transformation Organization should work collaboratively with the Centers for Medicare and Medicaid Services (CMS), both to utilize the expertise of CMS and to encourage CMS to implement similar payment reforms for Medicare and Medicaid.
- F. Minnesotans Should Call on Health Care Providers to Reduce Their Costs and Prices As Much As Possible, So That Total Health Care Costs Will Be at Least 20% Lower in 2011 Than They Would Be Under Current Trends, and to Maintain or Further Reduce Costs and Cost Growth in Future Years.**
- III-F1. Health care providers should use the evidence available regarding significant waste and inefficiency in most aspects of health care delivery to reduce their costs and prices for services and the overutilization of services by patients.
 - III-F2. The Health Care Transformation Organization should issue and widely publicize annual reports on the extent to which health care providers have reduced their costs and prices, on the extent to which total health care costs each year are lower than they would have been under previous trends, on the extent to which total costs are on track to be at least 20% lower in 2011 than they would have been under previous trends, and on the extent to which costs and cost growth are maintained or reduced in future years.
 - III-F3. If total costs are not at least 20% lower by 2011, the Health Care Transformation Organization should conduct and publicly issue a detailed analysis of the reasons why costs have not been reduced by this amount, including identifying any practices by health care providers, health insurance plans, or others that have prevented or restrained the functioning of a competitive market that improves health care value for consumers. If the Health Care Transformation Organization determines in 2009 or 2010 that total costs are not on track to be at least 20% lower in 2011, it should issue a similar report prior to 2011.

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Implementation Steps and Responsible Organizations

G. Actions by the State Legislature

- III-G1. By June 30, 2008, the Governor should recommend and the Legislature should enact legislation charging the Health Care Transformation Organization with the responsibility for developing a detailed implementation plan for the new payment system.
- III-G2. By June 30, 2009, the Governor should recommend and the Legislature should enact legislation requiring that participation by providers and health plans in the new payment system is a condition for receiving payment for any patient paid for with state funds (state employees and persons whose health care is paid for through state programs).
- III-G3. By June 30, 2009, the Governor should recommend and the Legislature should enact legislation requiring that all local governments, including school districts, use only health plans and providers participating in the new payment system.
- III-G4. By June 30, 2009, the Governor should recommend and the Legislature should enact legislation requiring that all health plans sold to the individual and small group markets participate in the new payment system.

H. Actions by the State Executive Branch

- III-H1. By October 1, 2010, the Minnesota Department of Human Services should implement the new payment system for all participants in the state's public health care programs, including MinnesotaCare and the Medicaid program. The Department should seek any necessary approvals from the Centers for Medicare and Medicaid Services (CMS) for implementation of the payment system in Minnesota's Medicaid program.
- III-H2. By January 1, 2011, the Minnesota Department of Employee Relations should implement the new payment system for all state employees.

I. Actions by Other Organizations

- III-I1. By December 31, 2008, the Health Care Transformation Organization should develop a detailed implementation plan for the new payment system with involvement from purchasers, payers, and patients. The plan should provide for initial implementation of the new payment system no later than January 1, 2010. The Health Care Transformation Organization should begin working to facilitate implementation of the new system upon completion of the plan, and should continue to revise and enhance the plan on an ongoing basis until it has been successfully implemented.

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- III-I2. By June 30, 2009, business groups such as the Buyers Health Care Action Group, the Chamber of Commerce, and the Minnesota Business Partnership should encourage their self-insured employer members to support and participate in the new payment system.
- III-I3. By June 30, 2009, each of the largest health care providers in the state should commit to participate in the new payment system.
- III-I4. By June 30, 2009, each of the major health plans in the state should commit to participate in the new payment system.
- III-I5. Purchasers and payers should adjust their existing pay-for-performance systems to align with the structure of the new payment system.
- III-I6. By June 30, 2009, the Health Care Transformation Organization should make recommendations for how Medicare should participate in the new payment system and otherwise support the transformation of Minnesota's health care system, and the Health Care Transformation Organization should begin working with the Centers for Medicare and Medicaid Services and the Minnesota Congressional Delegation to gain approval for any demonstration programs or changes in Medicare policy to enable this to happen.

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TRANSFORMATION PRINCIPLE IV: REDUCE COSTS.

The Overall Size and Cost of the Health Care System Should Be Reduced

How the Costs of Health Care Providers Should Be Reduced:

A. To The Maximum Extent Possible, Minnesota Should Rely on Market Forces to Encourage Providers to Reduce the Cost of Care Per Patient While Maintaining or Improving Quality

IV-A1. Expanded consumer-friendly information on the quality and prices of health care providers (see Recommendations II-B4 and III-C1) should be implemented as quickly as possible.

IV-A2. An extensive consumer education campaign should be undertaken to explain:

- a. how the new system of patient choice and provider payment will work; and
- b. why higher-cost providers and services do not necessarily provide higher quality health care.

IV-A3. Health plans, entrepreneurial businesses, and others should be encouraged to develop highly effective information-sharing tools, and to undertake extensive and innovative consumer education efforts about:

- a. how consumers can utilize information on quality and price to choose a health care provider or service;
- b. the benefits for consumers of using a medical home and the options for choosing a medical home or health care home;
- c. the full costs (prices) of health care services;
- d. why higher-cost providers and services do not necessarily provide higher quality health care; and
- e. how improvements in a consumer's health status can also lower their expenditures for health care.

IV-A4. Providers should be required to show consumers the full price of each health care service they use (i.e., the amount charged to their health plan), not just their copayment/co-insurance cost.

B. Efforts By Providers to Reduce Costs and Improve Efficiencies Should be Encouraged and Facilitated

IV-B1. Administrative requirements imposed on providers by health plans should be streamlined and coordinated; in particular, requirements to report information on quality should be standardized across health plans.

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IV-B2. Administrative requirements imposed on providers by licensing organizations, both in the state and nationally (e.g., the Joint Commission), should be streamlined and coordinated.

IV-B3. Simpler, lower-cost methods of collecting payments from consumers should be developed in order to reduce provider administrative and bad debt collection costs.

C. In the Short Run, Additional Actions Should be Pursued to Increase Competition and Cost Reduction, Particularly in Consolidated Markets

IV-C1. New providers, particularly primary care providers, should be encouraged through training programs and incentives to enter geographic areas where a shortage of health care providers is projected. Providers located out of the state should not be precluded from providing high-value services in Minnesota.

IV-C2. In geographic areas where there are a small number of providers of a particular service (but not inadequate capacity to provide service to all consumers), quality and price comparisons provided to consumers (see Recommendations II-B4 and III-C1) should include comparable providers from other geographic areas and states, so that the relative cost of care and quality in Minnesota can be determined.

IV-C3. State legislation should be enacted or amended to reduce barriers faced by providers from entering markets or from providing lower-cost, higher-value services, particularly where other states have taken similar actions successfully. Potential opportunities include:

- a. modifying state licensure requirements prohibiting health professionals from providing services they can capably provide at lower costs, e.g., nurse practitioners, telemedicine techniques in rural areas, etc. can often provide high-quality services that meet a patient's needs;
- b. modifying state prohibitions on the corporate practice of medicine.

IV-C4. The attorney general should review all mergers and acquisitions of health care providers and health insurance plans to ensure that over-consolidation does not occur to such an extent or in such a way as to meaningfully undercut competition and/or the competitive marketplace needed to ensure the successful transformation of Minnesota's health care system.

D. Health Care Technologies, Services, and Medications Should Only Be Used When They Improve Value

IV-D1. A collaborative, non-regulatory body (such as the Institute for Clinical Systems Improvement) should be designated or established to review new technologies, services, and medications, including

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complementary and alternative medicine, and to recommend whether these technologies, services, and medications should be covered by health insurance plans. The methods used by NICE in Britain or by other technology assessment entities could serve as models.

Determination of eligibility for coverage should:

- a. be based on the strength of scientific evidence for effectiveness;
- b. take into account a Quality-Adjusted Life Years (QALY) or cost-effectiveness calculation; and
- c. require that the new technology, service, or medication be no more expensive than existing technology, services, and medications unless there are substantial improvements in patient outcomes.

The necessary relief from anti-trust restrictions should be obtained to allow all health plans to accept the collaborative organization's decision regarding payment, thus allowing individual health plans to discontinue their technology assessment committees.

- IV-D2. Payment for new technologies, services, and medications should be limited to those patients and conditions for which effectiveness has been proven by randomized controlled trials, or by other strong evidence-based science when randomized controlled trials do not exist.
- IV-D3. For technologies, services, and medications that have not been proven to be effective or ineffective, consumers should be told that evidence of effectiveness does not exist, and should be informed about alternative options for care, including lower-cost options.
- IV-D4. For new technologies, services, and medications that have been proven to be effective, but which do not provide substantially different benefits to patients than existing, lower-cost technologies, services, and medications, consumers should be told about the relative value of the alternatives and should be required to pay all or part of the difference in cost if they choose to use the higher-cost technology, service or medication.
- IV-D5. The Institute for Clinical Systems Improvement should convene providers, purchasers, and payers to develop and implement recommendations for reducing overutilization of services, similar to what was done with diagnostic imaging.
- IV-D6. The determination of which services should be included in the essential benefit set (see Recommendation V-A8) and in the standardized benefit set used for bidding in Level 3 (see Recommendation III-A4b) should be based on the value (i.e., the quality and cost) provided by each service.

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IV-D7. Health insurance plans should only pay for care that is known to be effective and should not pay for the direct costs of new technologies, services, or medications being evaluated during a clinical trial or other research study; these latter costs should be paid for through existing funding streams for clinical trials or by a private firm if it has developed the new technology, service, or medication. However, health insurance may be used to cover those portions of the health care services provided to a patient participating in the trial or study that would have been provided if the patient had been receiving a non-experimental treatment.

How the Costs of Health Insurance Plans Should Be Reduced:

E. Public Reporting Regarding the Administrative Costs of and Performance of Health Insurance Plans Should be Strengthened In Order to Encourage Competition and Cost Reduction

IV-E1. Uniform standards should be established for definitions of health plan administrative costs, and health plans should be required to itemize their services and costs in a consumer-friendly manner.

IV-E2. Similar uniform standards should be established for care delivery system administrative costs to eliminate confusion about what is a health plan administrative cost and what is a delivery system administrative cost.

IV-E3. Purchasers of health insurance should continue to request a uniform set of information on costs and performance from health plans, including their administrative efficiency, to enable comparisons to be made easily while minimizing the administrative costs imposed on the plans.

F. Health Plan Administrative Functions That Are No Longer Needed In The Transformed Health Care System Should be Eliminated

IV-F1. Health plans should identify potentially duplicative health care improvement processes implemented by both health plans and providers (e.g., disease management systems), and work with providers and health plans to eliminate the duplication.

IV-F2. Health plans should eliminate the functions that are no longer necessary under the transformed system, and reduce their administrative costs accordingly.

IV-F3. The state should work with the health plans to seek waivers of any federal requirements that preclude the elimination of unnecessary costs.

IV-F4. State agencies should work with health plans to reduce regulatory compliance costs as much as possible.

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IV-F5. Health plans should identify administrative costs that are incurred in order to administer unique benefit designs required by individual purchasers, and purchasers and plans should jointly work to modify these requirements in order to reduce administrative costs.

IV-F6. The use of health insurance brokers to purchase insurance should be voluntary for individuals and organizations, and any fees charged by health insurance brokers should be clearly reported separately from the cost of the health insurance plan itself.

G. Health Insurance Coverage For Health Care Services That Have Been Proven To Be Ineffective Should Be Eliminated

IV-G1. To the extent that state legislation exists that mandates coverage for ineffective services, it should be repealed.

Implementation Steps and Responsible Organizations

H. Actions by the State Legislature

IV-H1. By June 30, 2008, the Governor should recommend, and if necessary, the Legislature should enact legislation establishing a method of funding for a consumer education campaign about the new payment system.

IV-H2. By June 30, 2008, the Governor should recommend and the Legislature should enact legislation which requires health care providers to show consumers the full price of each health care service they use.

IV-H3. By June 30, 2008, the Governor should recommend and the Legislature should enact legislation requiring health plans to standardize quality information collected from health care providers.

IV-H4. By June 30, 2009, the Governor should recommend and the Legislature should enact legislation establishing incentives to increase the number of health care providers in shortage areas identified by the Minnesota Department of Health.

IV-H5. By June 30, 2009, the Governor should recommend and the Legislature should enact legislation modifying state licensure requirements and other statutes and regulations which inappropriately serve as barriers to providers entering markets or providing lower-cost, higher value services.

IV-H6. By June 30, 2008, the Governor should recommend and the Legislature should enact legislation establishing a mechanism for reviewing new technologies and reporting on their relative value.

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I. Actions by the State Executive Branch

- IV-I1. By December 31, 2008, the Minnesota Department of Health should implement an extensive consumer education campaign regarding the new payment system and the advantages of choosing higher-value providers. The campaign will evolve as providers transition from Level 1 to Level 3 of the payment system.
- IV-I2. By June 30, 2009, the Minnesota Department of Health should work with the Joint Commission (previously known as the Joint Commission on Accreditation of Healthcare Organizations or JCAHO) and other entities to standardize licensing and accreditation procedures for health care providers and to modify or eliminate requirements that increase costs without providing corresponding benefits.
- IV-I3. By December 31, 2008, the Minnesota Department of Health should complete a study of additional actions that could reduce provider costs and make recommendations to the Governor and Legislature on any actions which should be taken.
- IV-I4. By December 31, 2008, the Minnesota Department of Health should identify areas of the state where a shortage of health care providers exists or is likely to exist, work with other state agencies and professional associations to establish training programs to reduce the shortage, and recommend incentives that could help to eliminate the shortage.
- IV-I5. By December 31, 2008, the Minnesota Department of Health should complete a study of state licensure requirements and other statutes and regulations to determine which inappropriately serve as barriers to providers entering markets or providing lower-cost, higher value services.
- IV-I6. By December 31, 2008, the Minnesota Department of Health should establish improved, uniform definitions and standards for administrative costs of health plans, and should begin disseminating more consumer-friendly reports on health plan administrative costs.
- IV-I7. By June 30, 2009, the Minnesota Department of Health and other state agencies should work with health plans to reduce regulatory compliance costs as much as possible.

J. Actions by Other Organizations

- IV-J1. By June 30, 2009, all health care plans should identify and eliminate or modify unnecessary or overly expensive administrative requirements imposed on health care providers.
- IV-J2. By June 30, 2009, the mechanism for reviewing new technologies established under Recommendation IV-D1 should begin issuing

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reports on the relative value of new technologies, and health plans should adopt those recommendations indicating that the new technologies should not be covered.

- IV-J3. By December 31, 2008, the Institute for Clinical Systems Improvement should begin convening providers, purchasers, and payers to develop and implement recommendations for reducing overutilization of services, similar to what was done with diagnostic imaging.
- IV-J4. By December 31, 2008, the Institute for Clinical Systems Improvement should convene health plans and providers to identify potentially duplicative health care improvement processes implemented by both health plans and providers and develop recommendations for eliminating the duplication.
- IV-J5. By June 30, 2009, health plans and providers should implement the recommendations for eliminating duplicative functions as recommended by the collaborative process established by ICSI.

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TRANSFORMATION PRINCIPLE V: INSURE EVERYONE.

All Minnesotans Should Be Able to Obtain Necessary Health Care at An Affordable Cost

What the Transformed Health Insurance System Should Look Like:

A. Insurers Who Offer Individual Health Insurance Policies Should Be Required to Sell Policies to Anyone Who Wishes to Buy One, and All Citizens, Including Current Minnesota Comprehensive Health Association (MCHA) Enrollees, Should Be Required to Obtain and Retain Health Insurance Coverage That is Affordable (Guaranteed Issue and Individual Mandate)

V-A1. It should be the responsibility of all citizens to obtain health insurance coverage unless (a) no insurance is available that meets the affordability standards established by the state, and (b) no subsidy is available to make available insurance policies affordable.

V-A2. The affordability of a health insurance plan should be defined based on the combined cost to an individual or family of:

- a. premiums;
- b. deductibles; and
- c. copays and coinsurance.

V-A3. The affordability standard under Recommendation V-A1 should be established based on a sliding scale up to 400% of the federal poverty guideline (FPG). A Minnesotan with a gross household income at or below 300% of FPG should not be expected to contribute more than 7% of their gross income for health care coverage and a Minnesotan with a gross household income at or below 400% of FPG should not be expected to contribute more than 10% of their gross income for health care coverage.

V-A4. For the first biennium corresponding to the effective date of the requirement set forth in Recommendation V-A1, the Governor should recommend and the Legislature should enact legislation providing a subsidy sufficient to allow all citizens to obtain health insurance coverage consistent with the affordability standard.

V-A5. Subsidies should be provided to individuals and families who cannot afford approved benefit plans based on the essential benefit set defined in Recommendation V-A8 to enable them to purchase such plans within the affordability limits under Recommendation V-A3. To the maximum extent possible consistent with the goal of reaching affordable coverage for all Minnesotans, the subsidy program should be designed and administered so that it does not encourage either employers or individuals to drop employer-based insurance. To the

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maximum extent possible, subsidies should be funded through the savings from reductions in health care costs achieved through Transformation Principles I-V.

- V-A6. At the same time that the requirement under Recommendation V-A1 takes effect, insurers who offer individual policies should be required to sell policies to anyone who wishes to buy one. To the extent that insurers can expand access to coverage sooner than this, they should be encouraged to do so.
- V-A7. MCHA as a mechanism for providing coverage should be phased out over time. (The funding currently raised through the MCHA assessment may need to be replaced or rechanneled in some fashion to help cover the costs of subsidies.)
- V-A8. The Governor should recommend and the Legislature should enact legislation establishing an independent board to define an essential value-based benefit set for health insurance. The members of the Board should be appointed by the Governor and the Legislature, and should not be in a position to directly benefit from their decisions. A significant proportion of the board members should have expertise in benefit design. The board should contract with the Institute for Clinical Systems Improvement (ICSI) to assemble existing scientifically-grounded evidence-based standards, and develop new standards where necessary, for purposes of benefit design. The board should seek public input, including input from the Legislature, before finalizing the essential value-based benefit set. The essential value-based benefit set will serve as the standard for determining subsidies to meet the affordability standard, as the minimum benefit set needed to satisfy the requirement that all citizens obtain health insurance coverage, and as a minimum benefit set for purposes of the Health Insurance Exchange established under Recommendation V-E. The benefit set should include ICSI-designated evidence-based preventive services without cost-sharing requirements. The benefit set should include ICSI-designated evidence-based outpatient care for asthma, heart disease, diabetes and depression with no cost sharing requirements or cost sharing requirements that do not impose an economic barrier to access to that care. The essential value-based benefit set should be reviewed on an ongoing, periodic basis and the benefit set should be adjusted to ensure a benefit design that is current, safe, effective, and scientifically-based. Following completion of the board's work, the Governor should recommend and the Legislature should enact appropriate amendments to current benefit standards to align them with the essential value-based benefit set.
- V-A9. The Health Insurance Exchange should utilize, and expand where appropriate, programs for public education and outreach to ensure that

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all citizens are aware of their responsibility to obtain health insurance coverage and the resources available to enable them to do so affordably.

V-A10. The Health Insurance Exchange should assemble existing research, and conduct additional research if necessary, on the reasons why individuals are not obtaining health insurance coverage, and implement or make recommendations for changes needed to address barriers or disincentives to achieving health insurance coverage for all Minnesotans.

B. The Same Health Insurance Policies Offered to Small Groups Should Be Available to Individuals, Unless Subsequent Analysis Indicates That This Would Cause Serious Problems (Merger of Small Group and Individual Markets)

C. The Variation in Premiums Across Population Groups Should Be Reduced. At Most, Premiums Should Only Vary Based On Age, Individual Health Behaviors (e.g., Smoking), and Geography (Modified Community Rating)

D. Risk Equalization Payments Should Be Made to Health Plans Based on the Relative Health of Their Enrolled Population

V-D1. Payments should be designed to eliminate incentives for “cherry picking” low risk patients and to reward plans that do a good job of managing care for sicker populations

E. A Health Insurance Exchange Should Be Established Through Which Individual and Small Group Insurance Products Would Be Sold

V-E1. Individuals and businesses should be encouraged to purchase insurance through the Exchange. An individual and small group insurance product may be purchased outside the Exchange, as long as the insurance product has the same premiums both inside and outside of the Exchange (not including any brokerage fees). If voluntary use of the Exchange fails to support an adequate individual and small group insurance market, use of the Exchange may need to be mandated.

V-E2. At least initially, there should be a limited selection of plans through the Exchange (e.g., 3 products per health insurance carrier at each benefit level; allowing variations on plan design that are actuarially equivalent).

V-E3. Policies should be offered with an essential benefit set as defined in Recommendation V-A8 that:

- a. Covers necessary, evidence-based care;
- b. Does not cover care that has been demonstrated to be ineffective; and

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- c. Covers other services that produce good outcomes at a reasonable cost.
- V-E4. Small employers should be encouraged to offer insurance through the Exchange by making it easier and more efficient for employers to use than purchasing health insurance outside the Exchange.
- V-E5. Large group policies would not be sold through the Exchange.
- V-E6. The governance structure for the Health Insurance Exchange should have public oversight.
- V-E7. The premiums for health insurance policies offered for purchase by individuals should be published in a consumer-friendly format by the Health Insurance Exchange.
- F. All Employers With More Than 10 Employees Should Be Required to Offer Section 125 Plans to Enable Pre-Tax Payment of Premiums**
- G. Incentives Should Be Provided to Encourage Employers That Currently Offer Group Coverage to Continue Doing So (Erosion Control)**

Implementation Steps and Responsible Organizations

H. Actions by the State Legislature

- V-H1. By June 30, 2008, the Governor should recommend and the Legislature should enact legislation that:
 - a. establishes an affordability standard for the purchase of health insurance as described in Recommendations V-A1 and V-A2;
 - b. establishes an independent board to define an essential value-based benefit set for health insurance and provides it with the resources necessary to carry out its responsibilities effectively;
 - c. directs the Department of Health to analyze and recommend options for providing subsidies to individuals and families to bridge the gap between the cost of insurance with the essential benefit set and the affordability standard. The options should include, but need not be limited to, direct subsidies to individuals; expansion of current programs such as MinnesotaCare; and advanceable and refundable tax credits. The Department of Health should report its recommendations to the Governor and the Legislature by January 15, 2009.
- V-H2. By January 15, 2009, the independent board described in Recommendation V-A8 should establish an essential value-based benefit set for health insurance after obtaining input from the public and the Legislature. The independent board should review the essential value-based benefit set on a periodic basis and adjust the benefit set to ensure a benefit design that is safe, effective, and scientifically-based.

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- V-I3. By June 30, 2008, the Governor should recommend and the Legislature should enact legislation that:
- a. establishes the Health Insurance Exchange, and which requires that by January 1, 2011, all insurers offering small group and individual health insurance policies will do so in compliance with guaranteed issue and modified community rating requirements.
 - c. requires all employers with more than a minimum number of employees to offer Section 125 plans to their employees by January 1, 2010.
 - d. requires all Minnesotans to have health insurance by January 1, 2011, unless no policy is available which, with subsidies available from the state, meets the affordability standards established by the state.
- V-H4. By June 30, 2009, the Governor should recommend and the Legislature should enact legislation that establishes a mechanism for providing subsidies to make health insurance coverage that meets essential benefit standards affordable for individuals and families with incomes up to the limits established in Recommendation V-A3.

I. Actions by the State Executive Branch

- V-I1. By January 31, 2008, the Minnesota Department of Health should:
- a. Estimate the likely cost to a household of current "minimum benefit set" insurance policies, with the cost including premiums, deductibles, and copays and coinsurance.
 - b. Estimate the impact of having lower costs in the health care system and healthier consumers on the cost of a basic plan.
 - c. Compare that cost to (current and projected) distributions of household income for (projected) uninsured households to determine how many households would experience a cost that exceeded various percentages of income.
 - d. Calculate the subsidy needed to bring the cost to households within different potential ceilings of affordability (defined in terms of percentage of income).

J. Actions by Other Organizations

- V-J1. By June 30, 2009, the Health Insurance Exchange should establish a system for making risk equalization payments to health plans selling insurance through the Exchange.
- V-J2. By September 30, 2008, the Institute for Clinical Systems Improvement should assemble available scientifically-grounded evidence-based standards and provide them to the independent board for its use in establishing the essential value-based benefit set under Recommendation V-A8.

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TRANSFORMATION PRINCIPLE VI: IMPLEMENT RAPIDLY AND COMPREHENSIVELY. All of the Recommended Transformations – Health Improvements in the Population, Improved Quality and Reduced Cost of Health Care Systems, Restructuring of Payment Systems, and Health Insurance Reform – Are Essential to Each of the Others’ Success, and All Should Be Implemented No Later Than 2011

A. A New Private, Non-Profit, and Publicly Accountable Health Care Transformation Organization Should Be Established to Plan, Coordinate, and Report on Implementation of All of the Recommended Transformations

- VI-A1. The Health Care Transformation Organization should be a quasi-public body. The board should be appointed by the Governor and Legislature, and the majority of members should be individuals who do not have a direct financial interest in health care services, equipment, facilities, products, or medications. Board members should also include purchasers from state and local government and private employers; citizens; health care providers; health insurance plans; experts in health care practice and policy, and representatives of existing organizations responsible for improvement of health and health care systems. Consistent with Recommendation III-E3, the Board should include some individuals with expertise in health care payment but without conflicts of interest.
- VI-A2. The Health Care Transformation Organization should, to the maximum extent possible, utilize existing expertise and organizational capacity in Minnesota, including the capabilities of the Institute for Clinical Systems Improvement, Minnesota Community Measurement, the Health Information Exchange, the Smart Buy Alliance, health insurance plans, health care providers, and other organizations, and should avoid duplication of functions with these organizations.
- VI-A3. The Health Care Transformation Organization should issue annual reports on the extent to which health care costs have been reduced by 20%, the extent to which annual increases in health care costs have been reduced, the extent to which the quality of health care services has improved, and the extent to which all Minnesotans have access to quality, affordable health care. These reports should also specifically identify (a) the savings that have accrued and are likely to accrue to state government as a result of the transformation in the health care system and (b) the costs that the state has incurred or will need to incur in order to implement changes necessary to implementing and maintaining the transformation.

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- VI-A4. To the extent that these goals have not been achieved, the Health Care Transformation Organization should make recommendations to the Governor and Legislature as to what additional actions should be taken to achieve success, and whether any deadlines for action should be modified in order to maintain a consistent schedule for all aspects of the transformation.
- VI-A5. A sunset review should be conducted no later than December 31, 2013 to evaluate the continued need for the Health Care Transformation Organization.
- B. All Health Care Providers, Health Insurance Companies, Private and Public Employers, and Citizens Must Commit to Making, and to Hold Each Other Accountable for Making, Significant Changes in Order to Implement All of the Transformations by 2011**
- VI-B1. The recommended plans and policies in Transformation Principles I, II, III, IV, and V are necessary but not sufficient to ensure success in reducing health care costs by 20%, limiting annual increases in health care costs, improving the health of Minnesotans, improving the quality of health care services, and providing all Minnesotans with access to quality, affordable health care.
- VI-B2. Health care providers must commit themselves to significantly reducing their costs and improving the quality of the services they provide.
- VI-B3. Health insurance companies must commit themselves to supporting the new payment system, reducing administrative costs, and providing health insurance to all citizens at an affordable cost.
- VI-B4. Private and public employers must commit themselves to supporting the new payment system, continuing to provide health insurance to their employees, and encouraging and supporting their employees to improve their health.
- VI-B5. All citizens of Minnesota must commit themselves to reducing and eliminating unhealthy behaviors, utilizing appropriate health prevention services, obtaining and retaining health insurance, and choosing and using high-value health providers and services.
- C. A Portion of the Savings From Health Care Transformation Should Be Used to Cover the Costs of Activities Needed to Support Transformation**
- VI-C1. With adequate commitment from all of the stakeholders described in Recommendation VI-B, the savings from reduced health care costs should be sufficient to cover the costs of the subsidies needed to implement the individual responsibility requirement in Recommendation V-A and the administrative and programmatic costs of other recommendations.

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- VI-C2. A mechanism needs to be established that will capture a portion of the savings from reduced health care costs in order to cover the costs of the subsidies needed to implement Recommendation V-A5, the costs of expanded health improvement programs as defined under Recommendation I-C10, and the administrative and other costs associated with other new programs and agencies established under Transformation Principles I-VI. The savings-capture mechanism should account for the reduction/elimination of the MCHA assessment consistent with Recommendation V-A7. Any savings-capture method will have to be based on projected costs and savings, and adjusted if necessary after the actual costs and savings in the system can be determined. All of the revenues from any method for capturing savings should be dedicated to offsetting costs that the state incurs for implementation of the actions needed for transformation, and the revenues and their use should be accounted for separately and publicly reported. One option for savings-capture would be for the MinnesotaCare tax (which is based on a percentage of health care providers' revenue) to be increased by an amount that will generate revenues equivalent to the state's net costs from the transformation of the health care system (i.e., the additional costs the state incurs for subsidies, for expanded health improvement programs, and for administrative costs associated with other new programs and agencies, less the savings the state achieves through lower costs in its employee health plan and public health care coverage programs), but with the increase in the tax rate set in such a way that the increased revenues from the tax are less than the total savings achieved system-wide, so that payers would still achieve net savings in health care costs after application of the increased MinnesotaCare tax to provider bills.
- VI-C3. A mechanism should be established to account for the savings which accrue to the state through lower costs in its employee health plan and public health care coverage programs, so that those savings can be re-dedicated to covering the costs of implementing the transformation recommendations.
- VI-C4. Since many of the costs needed to support transformation activities will occur before the savings are realized, creative financing mechanisms may need to be established.

Implementation Steps and Responsible Organizations

D. Actions by the State Legislature

- VI-D1. By June 30, 2008, the Governor should recommend and the Legislature should enact legislation that establishes the Health Care

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Transformation Organization and invests it with all of the powers needed to carry out its responsibilities.

VI-D2. The Health Care Transformation Organization should utilize every means possible to get organized quickly and begin planning and implementing the actions needed to successfully implement all of the transformations no later than 2011.

VI-D3. By June 30, 2010, the Governor should recommend and the Legislature should enact legislation establishing a mechanism that will capture a portion of the savings to cover the additional costs involved in implementing the transformation, consistent with Recommendation VI-C2.

VI-D4. By June 30, 2008, the Governor should recommend and the Legislature should enact legislation establishing a mechanism to account for the savings which accrue to the state through lower costs in its employee health plan and public health care coverage programs.

E. Actions by the State Executive Branch

VI-E1. The Minnesota Departments of Health, Human Services, and Employee Relations should begin immediately to plan and begin implementing the changes in their policies, procedures, and behaviors needed to implement all of the transformations by 2011.

F. Actions by Other Organizations

VI-F1. Health care providers, health insurance companies, private employers, and citizens should begin immediately to plan and begin implementing the changes in their policies, procedures, and behaviors needed to implement all of the transformations by 2011.

Appendix B: Basis of Savings Estimates

The table on page 18 shows baseline projected spending (i.e., the projected level of spending in the absence of any policy changes) in 2011 and 2015. In the absence of any other changes, health care spending in Minnesota is expected to reach about \$43.9 billion in 2011 and \$57.4 billion in 2015.¹⁴ 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.¹⁵
 - 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.¹⁶ The concept of paying for episodes of care, like the Level 3 payment reforms

Appendix B: Basis of Savings Estimates

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 3.0% in 2011, rising to 5.7% in 2015 as more aggressive targets are achieved.

The Task Force has also recommended specific strategies to reduce the amount of unnecessary or unproven care, such as patient-centered decision-making and technology assessment. The table on page 18 includes an estimated 0.1% savings associated with implementing patient-centered decision-making, and potential savings of 1.0% and 1.3% associated with technology assessment in 2011 and 2015, respectively. These figures are based on savings estimates published by the Commonwealth Fund.¹⁷

The largest 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. Other sources of potential administrative cost savings include lower costs of underwriting for health plans, lower cost of contracting for both health plans and providers, and lower costs of debt collection. Based on currently available data, these savings do not appear to be large; in addition, they would be offset by increases in some administrative costs, such as the costs associated with more extensive quality measurement and reporting.

The table on page 18 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 2011 is estimated at about \$866 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 in 2011 would be over \$1.3 billion (with

Appendix B: Basis of Savings Estimates

state government cost of about \$816 million after enrollee premiums and federal contributions). More precise estimates of the cost of various coverage and affordability proposals, including the thresholds of 7% of income and 10% of income at 300 and 400 percent of federal poverty guidelines, are currently under development; potential costs of the subsidies could exceed \$100 million.

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Appendix C: Legislative Charge to the Task Force

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

Appendix C: Legislative Charge to the Task Force

- (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

¹ Minnesota Department of Health, Health Economics Program

² Minnesota Department of Health, Health Economics Program

³ Minnesota Department of Health, Health Economics Program

⁴ Banthin et al., “Financial Burden of Health Care, 2001-2004,” *Health Affairs*, January/February 2008.

⁵ Minnesota Department of Human Services

⁶ 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.

⁷ 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.

⁸ Minnesota Community Measurement website, accessed December 17, 2007.

⁹ Minnesota Community Measurement website, accessed December 17, 2007.

¹⁰ 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.

¹¹ Kenneth E. Thorpe et al., “The Impact of Obesity on Rising Medical Spending,” *Health Affairs*, October 2004.

¹² Minnesota Department of Health, data from Behavioral Risk Factor Surveillance System.

¹³ Blue Cross Blue Shield of Minnesota, Center for Tobacco Reduction and Health Improvement, “Health Care Costs and Smoking: The Bottom Line,” March 2005.

¹⁴ 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.

¹⁵ Fisher et al.

¹⁶ 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.

¹⁷ Commonwealth Fund Commission on a High Performance Health System, December 2007, pages 19 and 22.