

2008 Health Care Reform Summary

In 2008, Governor Pawlenty signed significant health care reform legislation into law. These reforms, which include recommendations of the Governor's Transformation Task Force and the Legislature's Health Care Access Commission, create a comprehensive health care package making significant advances for Minnesotans in the following areas:

Public health

- Establishes and funds a statewide health improvement program to reduce the percentage of Minnesotans who are obese or overweight and reduce the use of tobacco.
- Appropriates a total of \$47 million for this activity in fiscal years 2010 and 2011.

Health care coverage/affordability

- Provides MinnesotaCare coverage for an estimated 8,700 additional people by 2011.
- Expands MinnesotaCare eligibility for adults without children to 250 percent of federal poverty and parents with incomes up to \$57,000 annually.
- Reduces the MinnesotaCare sliding-fee premiums to increase affordability.
- Increases outreach for state health care programs.
- Streamlines access to applications for state public health care programs and requires further study to improve coordination between state health care programs and other assistance programs.
- Requires the study and development of a proposal to promote affordable access to employer-sponsored health insurance through the use of direct subsidies and/or tax credits and deductions.
- Requires employers that have 11 or more full-time equivalent employees and do not offer group health insurance to establish

and maintain a Section 125 Plan, which allows employees to purchase health insurance with pre-tax dollars. Employers have the opportunity to opt out of this requirement.

- Provides grants and tax credits to cover certain employers' cost of establishing Section 125 Plans.¹
- Agreement to establish a tax credit for the uninsured to purchase coverage through a Section 125 Plan.
- Creates a workgroup to make recommendations on the design of an "essential benefit set" that provides coverage for a broad range of services and technologies, is based on scientific evidence of clinical and cost effectiveness, and requires lower enrollee cost-sharing for certain services.

Chronic care management

- Promotes the use of "health care homes" to coordinate care for people with complex or chronic conditions.
- Requires DHS and MDH to develop and implement standards of certification for health care homes by July 1, 2009.
- Establishes standards for state certification of health care homes and evaluating outcomes. Health care homes will receive care coordination payments from public and private health care purchasers.

Payment reform and price/quality transparency

- Encourages quality improvement, by increasing transparency of quality and establishing a single statewide system of quality-based incentive payments to be used by public and private health care purchasers.



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- Creates a powerful set of tools to allow consumers and health care purchasers to compare providers on overall cost and quality of care. This information will be used to create incentives for health care providers to innovate on ways to deliver health care with higher quality and lower cost and it will also be used to create consumer incentives to use high-quality, low-cost providers.
- Promotes transparency and accountability by establishing “baskets” of health care services to allow consumers to more easily compare cost and quality of care across providers, and to promote provider innovation on cost and quality.
- Convenes a workgroup to develop strategies for engaging consumers in understanding the importance of health care cost and quality, specifically as it relates to health care outcomes, consumer out-of-pocket costs, and variations in cost and quality across providers.
- Provides for legislative oversight and establishes a Health Care Reform Review Council for stakeholder review and input on implementation of the payment reform provisions of the bill.

Administrative efficiency

- Enhances health care quality, patient safety and Minnesota’s ability to achieve interoperable electronic health records by ensuring that providers use nationally-certified electronic health record systems when available.
- Advances the use of health information technology by requiring that all prescriptions be ordered electronically by 2011.
- Requires a study and report on reducing claims adjudication costs for health care providers and health plans by adopting more uniform methods of processing claims.

Health care cost containment

- Requires health care cost savings to be measured against projected costs without reform.²
- Results in significant potential overall health care cost savings. Compared to baseline projections, the health care reforms in this bill are estimated to have the potential for cost savings of about 12 percent by 2015. This represents a potential savings of about \$6.9 billion compared to baseline projections.

Other

- Requires a study and report on health care workforce shortages.
- Requires a study and report on community benefit standards for nonprofit health plans.
- Requires a study and report on health care coverage for long-term care workers.
- Requires a workgroup to develop recommendations for the education and regulation of oral health practitioners.³

Endnotes

The health reform measures passed this session are included in the health care reform bill, Chapter 358, Senate File 3780, unless otherwise noted.

1. Omnibus tax bill
Chapter 366, House File 3149
2. Supplemental budget bill
Chapter 363, House File 1812
3. Omnibus higher education bill
Chapter 298, Senate File 2942