DEPARTMENT OF HEALTH

Universal Health Care Financing System Study

REQUEST FOR INFORMATION (RFI)

3/19/2024 — 04/09/2024

Purpose

As required in Laws of Minnesota 2023, chapter 70, article 16, section 19, subdivision 3.b.,[1] the Minnesota Department of Health (MDH) is seeking public comments through this Request for Information (RFI) to inform the future procurement of one or multiple independent entities to conduct a cost-benefit analysis of a universal health care financing system as compared to the current health care financing system in Minnesota.

The information received through this RFI will assist MDH in identifying the requirements for the design, analysis, and deliverables of the future study and the necessary experience and expertise of potential vendors; it will help MDH prepare the Request for Proposals (RFP) to procure the needed professional services. Responses from all interested stakeholders – not just those that can provide the services required in the study - will be considered in the preparation of the RFP.

Study requirements

The Minnesota Legislature directed MDH to contract with an independent entity or entities to conduct a cost-benefit analysis of a legislative proposal for a universal health care financing system (i.e., the Minnesota Health Plan) in comparison to the current health care finance system.

As detailed in Attachment A[2]: Minnesota 2023, chapter 70, article 16, section 19, the study must analyze the performance of the proposed Minnesota Health Plan (Senate File No. 2740[3]) (House File No. 2798[4]) compared to the current public and private health care financing system over a ten-year period. The study must describe and quantify the effects of each system on:

- Insurance coverage and the number of people who are uninsured.
- Benefit design.
- Underinsurance and affordability.
- Timeliness and appropriateness of care, including emergency department utilization.
- Total public and private health care spending for medical, dental, and mental health savings and quantify savings or costs due to:

[1] Laws of Minnesota 2023, chapter 70 (https://www.revisor.mn.gov/laws/2023/0/Session+Law/Chapter/70/)
[2] Link to Attachment A in this document.
[3] Senate File No. 2740 (https://www.revisor.mn.gov/bills/bill.php?b=Senate&f=SF2740&ssn=0&y=2023)
[4] House File No. 2798 (https://www.revisor.mn.gov/bills/bill.php?f=HF2798&y=2023&ssn=0&b=house)

- Changes in the cost of administrative functions resulting from universal health care financing and savings from global budgeting for hospitals and institutional care instead of billing for individual services.
- Changes resulting from price negotiations conducted under the proposal for medical services and products and pharmaceuticals.
- Changes in service utilization, health outcomes and workplace absenteeism.
- Effect on capacity of medical facilities, equipment, and personnel, including emergency departments and variation by geographic areas.
- Effect on job losses or gains in the state due to any reduction in insurance and administrative burden on businesses.
- Impact on disparities in health care access and outcomes.
- Care coordination and case management, including care management conducted by health plan companies, to assess the cost of coordinating and navigating care for enrollees.

MDH must submit the final cost-benefit analysis report to the Governor and the Legislature in January 2026.

Related projects and relevance to the cost-benefit analysis

Minnesota state agencies have recently issued reports on topics that address related aspects of Minnesota's health care system. The MDH Health Economics Program (HEP) also publishes relevant and up-to-date data on the Minnesota health care market. Respondents might review these reports to inform and shape their responses to the RFI.

Public Option Report[5]: The 2023 Minnesota State Legislature directed the Minnesota Department of Commerce (Commerce) and the Department of Human Services (DHS), in consultation with the Department of Health and MNsure, to complete an actuarial and economic analysis of different public option models, including a public option that expands MinnesotaCare. The analysis conducted by Milliman, an actuarial firm, explores alternatives for a public option for Minnesotans who need affordable and dependable health care coverage and provides a needed framework to advance conversations with policymakers and stakeholders. Recommendations to the legislature and a comprehensive report were published in February 2024.

Study of HMO Conversions,[6] provides background information on changes to Minnesota's health insurance market. This is the first of two reports the Minnesota Department of Health (MDH) was directed to complete on the regulation of conversions, mergers, transfers of assets,

[5] Public Option Report (https://mn.gov/commerce-stat/insurance/industry/policy-data-reports/2024_public_option_report.pdf)
[6] Study of HMO Conversions (https://www.health.state.mn.us/facilities/insurance/managedcare/docs/hmostudyprelimreport.pdf)

and other transactions affecting Minnesota-domiciled nonprofit and for-profit Health Maintenance Organizations (HMOs).

Minnesota Health Care Markets Chartbooks,[7] provides convenient and up-to-date Minnesota statistics on health care spending, drivers of health care costs, access to insurance coverage, and health care provider trends.

Who should respond to the RFI?

MDH welcomes responses from a wide variety of stakeholders, including individuals and organizations interested in understanding the potential costs and benefits of a universal health care financing system in Minnesota, but also Minnesotans who have perspectives on the functioning of the existing system. MDH invites input from researchers, health care advocates, policy makers, actuarial companies, medical practices and health systems of all sizes, insurance companies and brokers, and employers and entities that provide or pay for health services for Minnesotans. MDH also invites and encourages individuals and groups representing patients or family caregivers to share their perspectives on what MDH might consider in developing the study.

RFI questions

Please answer as many questions as you like; there is no need to answer all the questions.

Please note that this section refers to the independent entity or entities that will successfully respond to a future RFP and provide the future analysis as the "contractor."

1. **Purpose and focus of the RFI**
    a. The legislation outlines various measures/impacts that should be included in the cost-benefit analysis (see "Study Requirements" section above). Are there additional measures or impacts that MDH should consider to fully compare the performance of the two systems or assess the sensitivity of the study?
    b. What areas of expertise and/or experience should a contractor be able to demonstrate to conduct the cost-benefit analysis completely and accurately?
    c. What are the key federal rules/waivers that will need to be considered when pursuing the Minnesota Health Plan (e.g., Medicaid, Basic Health Program, and Qualified Health Plan funding)? What considerations should the cost-benefit analysis include, related to the role of this federal funding in Minnesota?
    d. Are there any data sources or research findings that a future contractor should be required to utilize and/or consider as part of their cost-benefit analysis? Please share why this research is important to consider and if there are any Minnesota-specific data sources that should be included.

[7] Minnesota Health Care Markets Chartbooks (https://www.health.state.mn.us/data/economics/chartbook)

e. How could MDH use the RFP to guard against actual or perceived biases of vendors? What biases should MDH be particularly concerned about? Is there any documentation or specific assurances MDH should require to ensure vendors can conduct the work in an unbiased fashion?

2. Components of the cost-benefit analysis?

a. Given the limited existing evidence base, how should the cost-benefit analysis assess administrative costs separately from other health care costs? What data could be used? What estimation approaches should MDH be open to consider acceptable? (NOTE: Administrative costs are all non-benefit health care spending. They pertain to health insurance carriers, providers, and employers and include, but are not limited to, costs required for eligibility determination, contracting, coding and billing, accreditation, quality reporting, and management).

b. Are there any additional, non-economic impacts and costs, such as those listed below, that should be required as part of the cost-benefit analysis (or sensitivity analyses) to assess trade-offs between models and drivers of change?

   i. Changes in utilization of state-funded social services.

   ii. Changes in access to and utilization of behavioral health services.

   iii. School absenteeism or effects on academic performance.

   iv. Worker retention and productivity.

   v. Impact on employee mobility and business creation.

   vi. Changes in confidence in receiving needed care, patient experience, and satisfaction with insurance coverage.

   vii. Employer and consumers' time spent navigating the health care system, including selecting, purchasing, and negotiating health care.

   viii. Other.

3. Necessary clarifications

a. What types of scenarios or benefit assumptions beyond those explicitly stated in the Minnesota Health Plan (e.g. health care services covered by a universal health plan) should MDH require the contractor to consider as part of their analysis? For example, should MDH require the contractor to include benefits covered by the State Employee Group Health Insurance Program and/or MNsure benchmark plan in its analysis? Where should MDH provide further specificity and where will a range of assumptions be helpful? What, if any, guidance should MDH offer on the types of long-term services and supports to include in the analyses?

b. What guidance should MDH provide to prospective contractors or require the contractor to consider, around how the Minnesota Health Plan will be paid for?

c. The Minnesota Health Plan is "designed to ensure all Minnesotans have health care coverage." What guidance should MDH provide to prospective contractors regarding the

populations to include in the analysis (e.g., undocumented residents, individuals who receive care through the Indian Health Service, the Veterans Administration or TRICARE).

d. What guidance should MDH provide to prospective contractors regarding the relationship between the Minnesota Health Plan and other existing public insurance or health care access options that will persist for eligible Minnesota (e.g., Indian Health Service, Veterans Administrations, TRICARE, the Federal Employee Health Benefit Plan)? How could Minnesota leverage those designs and what, if any, wrap-around services or financing should Minnesota consider to meet the intent of alternative system?

e. How should MDH assess whether the contractor/contractor team has all necessary expertise to perform all components of the analysis particularly where there doesn't seem to be a deep evidentiary basis?

f. How should other, recent health care system-related studies (e.g., Public Option Study) commissioned by the State of MN be considered in the contractor's analysis? How should the assumptions contained within those studies be used or considered?

g. The future analysis and the final report must document and clearly state all methodologies employed and assumptions used by the contractor. For example, some companies may offer proprietary tools to model impact on the health system or a broader economic impact across state businesses more generally. Are there any confidentiality concerns or trade secret limitations that MDH should be aware of at the outset? How can MDH mitigate this and ensure that all methodologies are shared?

Instructions for responding

Responses to the RFI can be submitted anonymously via the online form: https://forms.office.com/g/fDkW5Sjsjh.

If you would prefer to submit your information in a fillable PDF, please email universalhealthstudy.mdh@state.mn.us with the subject line *Universal Health Care Financing System Study RFI* or call 651-201-3557.

To ensure that MDH has adequate time to review and incorporate RFI comments into the final RFP, individuals and interested parties are strongly encouraged to submit RFI responses by **Tuesday, April 9, 2024.**

Feel free to email any questions regarding the universal health care system financing study, or request a meeting with MDH staff, to universalhealthstudy.mdh @state.mn.us. Responders are responsible for all costs associated with the preparation and submission of responses to this RFI. Even though not all information received through the RFI process will be published by MDH, all responses to this RFI will be considered public data and accessible to the public upon request.

Attachment A

Minnesota 2023, chapter 70, article 16, section 19[8]

SEC. 19

ANALYSIS OF BENEFITS AND COSTS OF A UNIVERSAL HEALTH CARE FINANCING SYSTEM

Subdivision 1.

Definitions. (a) For purposes of this section, the following terms have the meanings given.

(b) "Total public and private health care spending" means:

(1) spending on all medical care, including but not limited to dental, vision and hearing, mental health, substance use disorder treatment, prescription drugs, medical equipment and supplies, long-term care, and home care, whether paid through premiums, co-payments and deductibles, other out-of-pocket payments, or funding from the government, employers, or other sources; and

(2) the costs of administering, delivering, and paying for medical care, including but not limited to all expenses incurred by insurers, providers, employers, individuals, and the government to select, negotiate, purchase, administer, and provide coverage for health care, dental care, long-term care, prescription drugs, the medical expense portions of workers compensation and automobile insurance, and the cost of administering and paying for all health care products and services that are not covered by insurance.

(c) "All necessary care" means the full range of services listed in the proposed Minnesota Health Plan legislation for a universal health care financing system specified in subdivision 5, including medical, dental, vision and hearing, mental health, substance use disorder treatment, reproductive and sexual health, prescription drugs, medical equipment and supplies, long-term care, home care, and the coordination of care.

Subd. 2.

Initial assumptions. (a) When calculating administrative savings under the universal health care financing proposal, the analysts shall recognize that simple, direct payment of medical services avoids the need for provider networks, eliminates prior authorization requirements, and eliminates administrative complexity of other payment schemes, along with the need for creating risk adjustment mechanisms and measuring, tracking, and paying entities according to risk-adjusted or nonrisk-adjusted payment schemes.

(b) The analysts shall assume that, while gross provider payments may be reduced to reflect reduced administrative costs, net provider income would remain similar to the current

[8] Minnesota 2023, chapter 70 (https://www.revisor.mn.gov/laws/2023/0/Session+Law/Chapter/70/)

system. The analysts shall not assume that payment rate negotiations will track current Medicaid, Medicare, or market payment rates or a combination of those rates, because provider compensation, after adjusting for reduced administrative costs, would not be universally raised or lowered but would be negotiated based on market needs, so provider compensation might be raised in an underserved area such as mental health but lowered in other areas.

Subd. 3.

Contract for analysis of proposal. (a) The commissioner of health shall contract with one or more independent entities to conduct an analysis of the benefits and costs of a legislative proposal for a universal health care financing system and a similar analysis of the current health care financing system to assist the state in comparing the proposal to the current system. The contract must be designed to produce estimates for all elements in subdivision 6.

(b) The commissioner shall issue a request for information. Based on responses to the request for information, the commissioner shall issue a request for proposals that specifies requirements for the design, analysis, and deliverables, and shall select one or more contractors based on responses to the request for proposals. The commissioner shall consult with the chief authors of this section in implementing this paragraph.

(c) The commissioner is exempt from the requirements of Minnesota Statutes, chapters 16A and 16C, when entering into a new contract or amending an existing contract to complete the necessary analysis required under this section.

Subd. 4.

Access to information. (a) The commissioner may request that a state agency provide the commissioner and contractor with data as defined in Minnesota Statutes, sections 62J.04 and 295.52, in a usable format as requested by the commissioner at no cost to the commissioner.

(b) The commissioner may request from a state agency unique or custom data sets. The agency may charge the commissioner for providing these data sets at the same rate the agency would charge any other public or private entity.

(c) Any data submitted to the commissioner shall retain their original classification under the Minnesota Data Practices Act in Minnesota Statutes, chapter 13.

(d) The commissioner, under the authority of Minnesota Statutes, chapter 62J, may collect data necessary for the performance of assigned duties and shall collect this data in a form and manner that ensures the collection of high-quality, transparent data.

(e) The commissioner of human services shall make available to the vendor selected under subdivision 3 any relevant findings from:

(1) any actuarial and economic analysis for a MinnesotaCare public option implementation plan and waiver; and

(2) any analysis of a direct payment system.

Subd. 5.

Proposal. The commissioner of health, in consultation with the commissioners of human services and commerce, shall submit to the contractor for analysis the legislative proposal known as the Minnesota Health Plan, proposed in the 93rd Minnesota Legislature as Senate File No. 2740/House File No. 2798, that would establish a universal health care financing system designed to:

(1) ensure all Minnesotans have health care coverage;

(2) cover all necessary care; and

(3) allow patients to choose their doctors, hospitals, and other providers.

Subd. 6.

Proposal analysis. (a) The analysis must measure the performance of both the proposed Minnesota Health Plan and the current public and private health care financing system over a ten-year period to contrast the impact of these approaches on:

(1) coverage: the number of people who are uninsured versus the number of people who are insured;

(2) benefit completeness: adequacy of coverage measured by the completeness of the coverage and the number of people lacking coverage for key necessary care elements such as dental services, long-term care, medical equipment or supplies, vision and hearing, and other health services. The analysis must take into account the variety of benefit designs in the commercial market and report the extent of coverage in each market segment;

(3) underinsurance: whether people with coverage can afford the care they need or whether cost prevents them from accessing care. This includes affordability in terms of premiums, deductibles, and out-of-pocket expenses;

(4) system capacity: the timeliness and appropriateness of the care received and whether people turn to inappropriate care such as emergency rooms because of a lack of proper care in accordance with clinical guidelines; and

(5) health care spending: total public and private health care spending in Minnesota under the current system versus under the Minnesota Health Plan legislative proposal, including all spending by individuals, businesses, and government. Where relevant, the analysis must be broken out by key necessary care areas, such as medical, dental, and mental health. The analysis of total health care spending must examine whether there

are savings or additional costs under the universal health care financing system established by the legislative proposal compared to the existing system due to:

(i) changes in the cost of insurance, billing, underwriting, marketing, evaluation, and other administrative functions for all entities involved in the health care system, including savings from global budgeting for hospitals and institutional care, instead of billing for individual services provided;

(ii) changes in prices for medical services and products, including pharmaceuticals, due to price negotiations under the proposal;

(iii) the impact on utilization, health outcomes, and workplace absenteeism due to prevention, early intervention, and health-promoting activities;

(iv) shortages or excess capacity of medical facilities, equipment, and personnel, including caregivers and staff, under either the current system or the proposal, including the rate of inappropriate emergency room usage. The analysis must break down capacity by geographic differences such as rural versus metropolitan, and disparate access by population group;

(v) the impact on state, local, and federal government non-health-care expenditures. This may include factors such as reduced crime and out-of-home placement costs due to the availability of mental health or substance use disorder coverage and other factors identified by additional analyses;

(vi) job losses or gains within the health care system, related to any changes in health care delivery, health billing, and insurance administration;

(vii) job losses or gains elsewhere in the economy under the proposal due to any reduction in insurance and administrative burdens on businesses;

(viii) impact on disparities in health care access and outcomes; and

(ix) care coordination and case management, including care management conducted by health plan companies, to assess the costs of coordinating and navigating care for enrollees.

(b) The commissioner may provide interim reports and status updates, and shall issue a final report by January 15, 2026, to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy. The findings and recommendations of the report must address the feasibility and affordability of the proposal and the projected impact of the proposal on the variables listed in paragraph (a). The report must also include:

(1) clear documentation of the technical assumptions made to conduct the analysis;

(2) a comprehensive description of the methodological approach used;

(3) the sensitivity of results to variations in the assumptions; and

(4) the data sources and the robustness of the information used.

EFFECTIVE DATE.

This section is effective the day following final enactment.

Minnesota Department of Health
Health Economics Program
PO Box 64882
St. Paul, MN 55164-0975
651-201-4520
universalhealthstudy.mdh@state.mn.us
www.health.state.mn.us

03/19/2024

To obtain this information in a different format, call: 651-201-4520