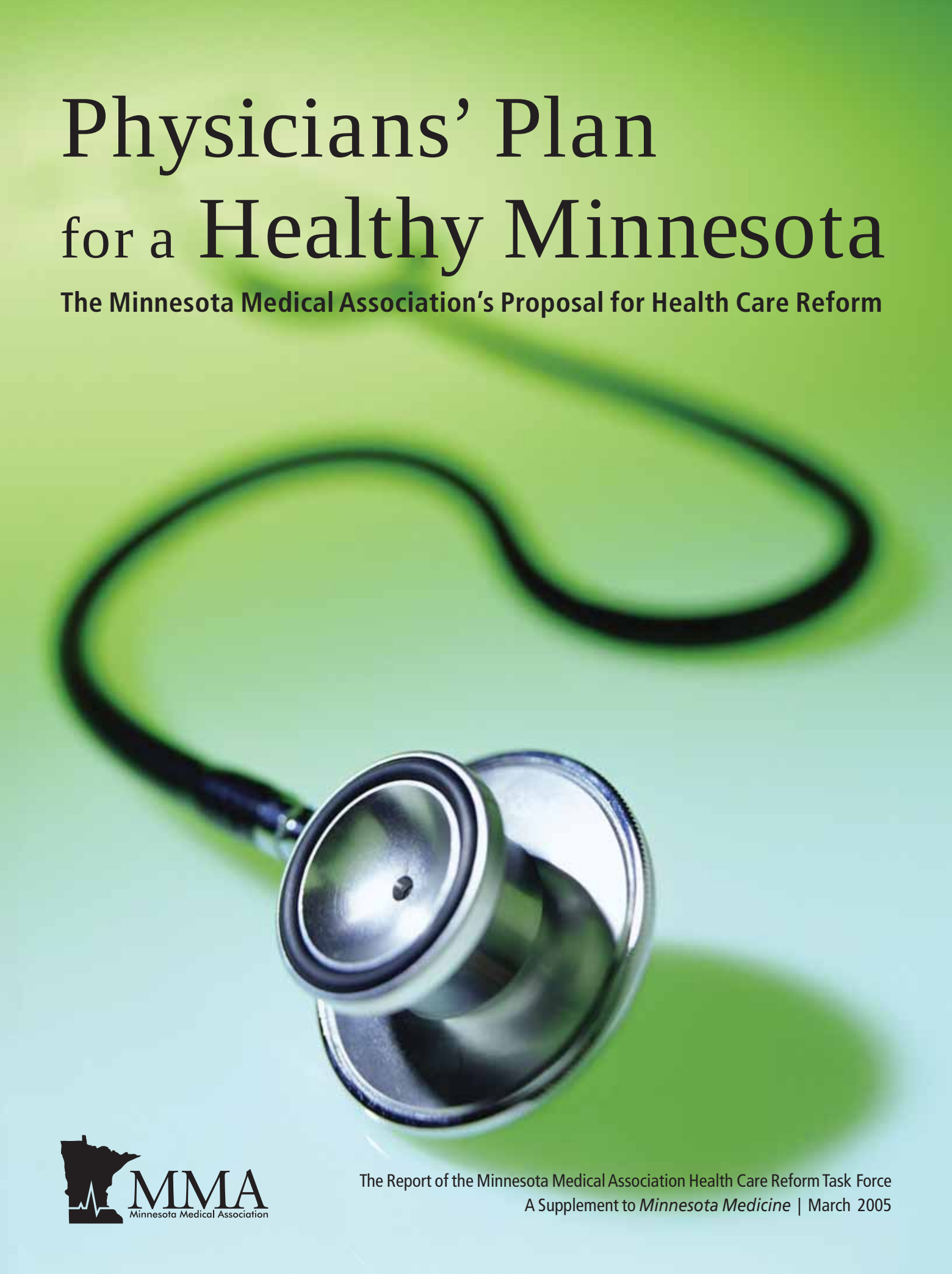
Physicians' Plan for a Healthy Minnesota

The Minnesota Medical Association's Proposal for Health Care Reform



MMA
Minnesota Medical Association

The Report of the Minnesota Medical Association Health Care Reform Task Force
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The Report of the MMA Health Care Reform Task Force

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J. Michael Gonzalez-Campoy, M.D. , Ph.D., F.A.C.E.
MMA President

G. Richard Geier, M.D.
Chair, Board of Trustees

Dear Colleagues:

It is a pleasure to present the report of our Minnesota Medical Association Health Care Reform Task Force. This report is the product of several months of work by task force members and MMA staff. To all of them, we are thankful. Not only was their collective wisdom critical in formulating this report, but their commitment to physician leadership and medicine as a profession carries through their recommendations. We especially wish to thank Judith Shank, M.D., who chaired the task force.

This report was approved by the MMA Board of Trustees at its Jan. 22, 2005, meeting. For many of you, the key features of the health care reform plan will be familiar. A preview was presented at the 2004 MMA Annual Meeting in Duluth last September, and the MMA has given several regional presentations. For others, this will be your first chance to read the recommendations. To all, we hope you'll see the value of this work, and will support your MMA.

Our Health Care Reform Task Force report gives a broad analysis of the state of medical practice in Minnesota. It also provides an outline of the steps that need to be taken to improve it. There is no other plan as comprehensive. This report calls for all players in the health care system to make changes, including physicians, patients, employers, the government, and third-party payers. The ultimate goal is for the current system of care to evolve into a patient-centered model that ensures participation by everyone. It focuses on promoting health and preventing disease. It calls for a medical home for every patient and a return to a strong doctor-patient relationship. It emphasizes ways to enhance quality while controlling costs, such as greater use of information technology and continuous systems improvement. But perhaps most importantly, it places physicians in a position to lead health care.

Our MMA has been careful to elicit feedback from all interested parties. Some of our colleagues have strong views about the inadequacy of the current system of care. Some have definite opinions about what constitutes the ideal model of care that should replace the one we have. And yet others stand behind the current models of care, highlighting their benefits and minimizing their faults. Clearly, there is never going to be a model that pleases everyone. What the task force has created is a collective vision of how medical care in Minnesota should evolve. This vision represents many compromises. It values the good things we have accomplished. But it challenges us to continue to improve what is currently recognized as the best health care in the nation.

Change is often difficult. Many of us feel complacent and fear change. But over time, our association has realized that change will come one way or another and that fighting it is fruitless. We have, by virtue of this report, asserted our right to move beyond merely being a part of the process and have placed the MMA in the lead. Our MMA is proud of its work and its leadership. Above all, our MMA is pleased to continue to be of value to our profession. We hope all of you will embrace the concepts in this report and become ardent supporters of the process of change that it will help bring about in Minnesota.

Sincerely,

J. Michael Gonzalez-Campoy, M.D., Ph.D., F.A.C.E. G. Richard Geier, M.D.

The Case for Reform

As health care costs continue to rise and exert pressure on families, physicians, businesses, and state and local governments, consensus is building that the health care system needs to be reformed.

- The United States spends twice as much per person on health care as any other country.
- In Minnesota, the average annual cost of health care per family is about $11,000—an amount that is expected to double by 2010. Wages are not growing fast enough to absorb such cost increases.
- At least 275,000 Minnesotans don't have health insurance.
- Opportunities to improve quality and reduce costs exist—especially in the treatment of chronic illnesses.

The MMA's Response

The MMA Board convened the Health Care Reform Task Force in January of 2004 after recognizing the growing momentum for a more fundamental debate about health care. The MMA's last major health care reform initiative was in 1992.

The 21-member task force met 11 times during a nine-month period to grapple with the complex problem of health care reform. The goal of every task force member was to make a set of recommendations that would result in bold and fundamental change. The report was unanimously approved by the MMA Board of Trustees on Jan. 22, 2005.

The task force members hope Minnesota's physicians will unite around this reform vision and use it to lead the state to a better and more affordable health care system.

Next Steps ...

Some of the recommendations in the Physicians' Plan for a Healthy Minnesota require long-term efforts and collaboration with other stakeholders. In the next several months, MMA staff and members will build support for the plan by holding about 200 meetings with health care stakeholders such as physicians, health plans, legislators, consumers, employers, the governor's administration, and community groups. The goal of these meetings is to refine the plan and fill in details.

Other recommendations, such as those below, can be undertaken immediately or are already part of the MMA's action plan:

- Advocate for stronger public health policies and systems
- Help physicians deliver evidence-based care
- Support a medical home for every Minnesotan through changes in administrative and payment policies
- Support efforts to improve care delivery and payment for patients with chronic and complex conditions
- Advocate for including behavioral health care as part of basic medical benefits
- Support an information infrastructure that would allow collection, reporting, and dissemination of the information needed to measure and improve quality and help patients make choices about cost and quality
- Advocate for reductions in administrative complexity
- Support a $1 per pack increase in the tobacco tax to help preserve Minnesota's health care programs and move toward universal insurance coverage
- Advocate for a statewide ban on smoking in bars and restaurants
- Explore legislative options regarding specific reforms such as an individual insurance requirement, an essential benefit set, and insurance market reform

Judith Shank, M.D., chair of the MMA Health Care Reform Task Force

The Right Plan at the Right Time

Former MMA President Judith F. Shank, M.D., led the 21-member MMA Health Care Reform Task Force through months of deliberations on how to reshape Minnesota's health care system. Shank is a strong believer in the vision of providing insurance for all Minnesotans and improving the quality of care—while at the same time holding down health care costs. Here are some of her thoughts about why Minnesota needs the Physicians' Plan for a Healthy Minnesota.

Q. Why is reform needed now?

A. The Legislature is grappling with budget shortfalls and finding that more and more of the state's budget is taken up by health care costs. Employers are seeing double-digit increases in the cost of their health care premiums. Employees' portion of health care costs is rising three times faster than wages. So there's recognition that health care is tremendously important to everyone and costing more and more every year.

Q. What is at the heart of the task force's vision?

A. The vision is essentially that all Minnesotans should have health care insurance [and that we] can improve quality because we have much more information to work with now.

Q. How could a new system promote quality and save money?

A. Hopefully, the new system would provide incentives for physicians to do more counseling and prevention and disease management. We know that 30 percent of the population uses 70 percent of health care dollars. And 5 percent of the population uses 50 percent of health care dollars. By giving both patients and physicians incentives to work on primary and secondary prevention and using better systems to manage chronic disease, we can keep more people healthy and out of these high-cost groups. Improving chronic disease management should improve quality of life and prevent expensive hospitalizations.

Q. Can you give an example?

A. We can improve quality by getting more patients to have colonoscopies in a timely fashion. Colon cancer, in most cases, is a preventable illness. So it would cost more for the colonoscopies, but you would save a lot of money on therapy and surgery later on. Another good example was a local project that used a team approach to help patients manage their congestive heart failure (CHF). Physicians collaborated with nurses, nutritionists, pharmacists, even physical therapists to provide care for a group of patients that had had numerous hos-

pitalizations for CHF. The result was a dramatic improvement in health status and thousands of dollars in savings. Right now, there is no way to finance such programs without a grant.

Q. How does public health fit into this vision?

A. There certainly needs to be more dollars spent on public health. We only spend about 5 percent of health care dollars on public health. For instance, if we could keep people from smoking, we could save lots and lots of dollars. Lung cancer and COPD are nearly always related to smoking, and they are very expensive to treat.

Q. Why reform the insurance market?

A. At present, insurance companies work very hard to prevent adverse selection. They don't want to be attractive to people who have medical problems and could cost them money. If everyone's [insurer] was required to provide health insurance for anybody [who wants it], it would stop that adverse selection and the inefficient cost shifting that goes with it.

Q. Why is an individual mandate necessary?

A. It is unfair for people who assume they are young and healthy to opt out of the program. The idea of insurance is to spread risk. And it should be spread as broadly as possible.

Q. Doesn't that create another burden for the poor?

A. There would have to be subsidies for people who cannot afford it. We're already subsidizing health care for many poor people. We think we could do that more efficiently with a different insurance market.

Q. Who will determine the essential set of benefits?

A. What we're proposing is that there be a community group led by physicians that determines the essential set of benefits. It would be evidence based where possible. There isn't a lot of evidence about some things. In those cases, it would have to be based on expert opinion and existing guidelines.

Q. Will it be a bare-bones set of benefits?

A. I don't think we envisioned bare bones. I think we envisioned a process where many of the things that are covered now would still be covered. We would not, however, advocate for big copayments for preventive services. We want to give people incentives to use preventive services.

Q. How would this work?

A. One example might be prescribing a generic drug versus a brand-name one. Probably, generic drugs for hypertension would be fully covered, but if you want a new high-tech, fancy drug you only have to take once a day, you might have to pay more for that one.

Q. How will prices be determined?

A. Physicians would set their own fees, presumably based on real costs. Insurance companies would determine what is a reasonable amount to pay for a service. Then, patients would be responsible for deciding whether or not they were willing to pay more for a specific procedure, physician, or hospital.

There also must be some mechanism to make sure that people without discretionary dollars still have adequate access to the services they need.

Q. Will this change the way the government buys health care?

A. Government programs set prices. Many of their prices are far below the cost of care, though some prices actually exceed the cost of care. That creates an incentive for hospitals to concentrate on profitable care and to minimize care that is poorly compensated. This is why we have so few psychiatric beds and so many cardiac centers. The other thing that happens is that the costs get shifted onto employers and other purchasers.

The MMA can't make the government do anything. But we would hope, through the power of persuasion and by employers recognizing how much of this cost they're bearing, we could end the discriminatory pricing.

Q. What needs to happen to make this plan a reality?

A. We need to get buy-in from employers. We need buy in from and we need to educate consumers. And we need the government to think more long term.

Q. How soon could change occur?

A. There are a lot of pieces that could happen quickly.

Q. Which ones?

A. It might take the Legislature a year or two to change the laws relating to insurance. That's a matter of will more than anything else. We can all start working on understanding what high-quality care is and developing systems to help with that.

Q. How significant is this plan?

A. It is very significant. Employers see health care costs are harming their ability to compete in a global market. They are eager for ideas about how to do a better job of providing better health care for their employees at lower costs. I think they are eager for something like this.

Health Insurance for All Minnesotans

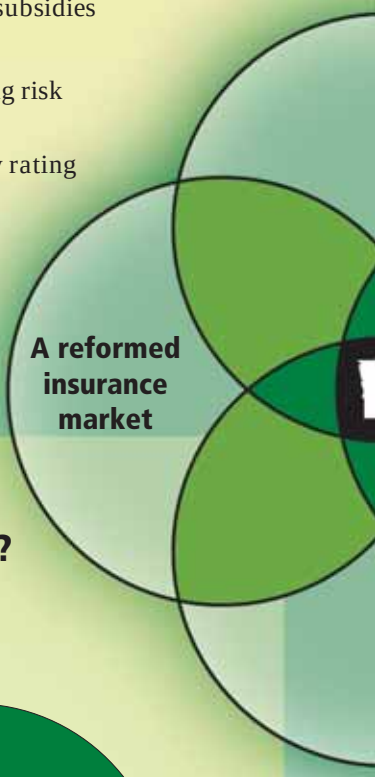
Achieving universal coverage is a key step to creating a better, more affordable health care system in Minnesota. Under the plan, all Minnesotans will be required to have insurance for essential health care services. A communitywide, physician-led discussion will lead to the creation of an essential set of benefits that will be continuously updated.

Under the proposal, all health plans will sell this essential benefit set. Pricing will be based on a community average, rather than an individual's age or health. People will be able to buy supplemental insurance for services outside the essential benefit set. The state will subsidize the cost of basic coverage for those who cannot afford it.

Universal insurance coverage will result in a healthier population and lower health care costs, as having insurance will encourage people to get preventive care and avoid more serious illness. Also, when everyone has insurance, the risk pool is broader and insurance is more affordable. Universal coverage will also eliminate inefficient cost shifting to employers and health care providers.

Recommendations

- Ensure universal coverage for essential benefits
  - Require that all individuals have insurance coverage.
  - Identify an essential benefits package that is adequate to protect health.
  - Ensure affordability through subsidies and targeted tax incentives.
- Build a fairer system of spreading risk and sharing cost
  - Require statewide community rating and guaranteed issuance for the essential benefits package.
  - Reinsure high-cost claims.
- Help employers make coverage options available.



Best of Both Worlds

Competition and Coverage

Minnesotans are divided. They want universal coverage, and they want a private health care system. The MMA proposal gives them both. The government will require all Minnesotans to have health insurance, but medical services will be delivered in a competitive market.

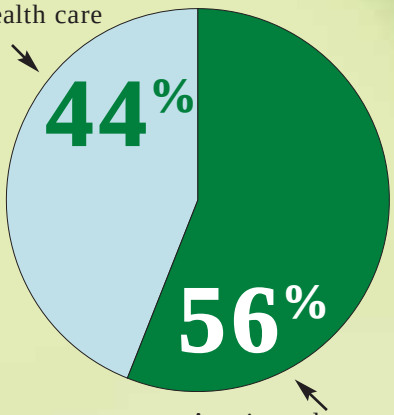
Under the plan, patients, not large payers or the government, will control health care spending. Physicians, not insurance companies, will set prices. Patients will have unlimited choice and a stake in getting the best value for their health care dollars. Overpriced health care providers will lose patients.

Health plans will compete by offering supplemental products covering additional services or reducing patients' out-of-pocket expenses.

A combination of universal health care coverage and a competitive market will slow rapidly rising health care costs, improve the quality of care, and result in Minnesotans receiving the best value for their health care dollar.

Which would you prefer?

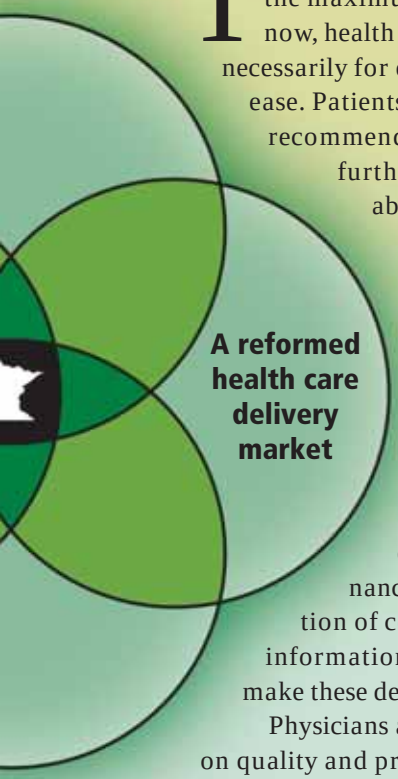
A private system that relies on individuals and employers to provide for their own health care needs.



A universal system in which the government ensures that everyone has coverage.

Source: Minnesota Citizens Forum on Health Care Costs

A Competitive Market that Improves Value and Engages Consumers



The task force concluded that Minnesotans are not getting the maximum value for their health care dollars. Right now, health care providers are rewarded for volume—not necessarily for delivering quality care or for preventing disease. Patients are often oblivious to costs. The task force recommends changing the current payment system to further engage patients and support physicians' ability to deliver the highest quality care.

Under the plan, patients, not large payers, will control health care spending. Patients will decide where to receive care and how much they are willing to pay for it. They can choose to pay extra to be cared for by higher-cost providers, to use a brand-name drug rather than a generic, or to receive care that is not needed but is preferred, such as frequent ultrasound examinations during an uncomplicated pregnancy or repeated imaging procedures for evaluation of common conditions. Patients will have more information available at the point of care to help them make these decisions.

Physicians and other health care providers will compete on quality and price. Physicians will set their own prices, and barriers to competition, such as limited networks, will be eliminated. Encouraging health care providers to compete on price will keep the price of services in line with value.

Health insurers will compete by helping enrollees make the best use of their money. They may also offer supplemental insurance that will limit out-of-pocket risk for patients and/or cover services outside the essential benefit set. Though everyone must have insurance, employers will still have an incentive to offer insurance benefits as a way to recruit future employees or to keep existing ones.

The state and federal governments will buy health care services the same way private purchasers do. Government will stop arbitrarily setting prices below actual costs because this results in inefficient cost shifting to the private sector. This will lead hospitals, physicians, and clinics to use their capital and resources more efficiently.

Recommendations

- Engage patients through greater accountability for medical decision making.
- Create a fundamentally different economic model for medical care service
  - End discriminatory government pricing policies.

What do Minnesotans want?

69% say health insurance should pay for any kind of medical treatment, regardless of the cost.

62% say our health care system should spend as much money as necessary to try to save a person's life.

But...

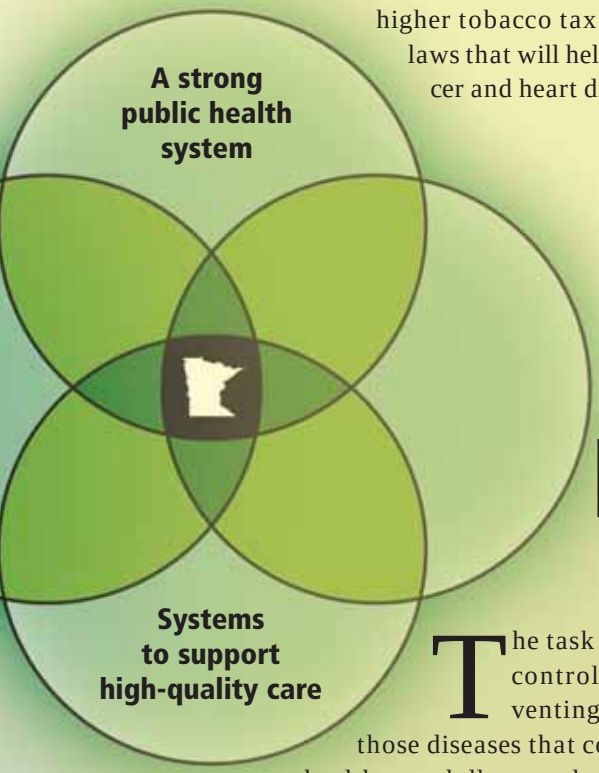
72% say the cost of treatment, along with the chance of success, is a factor that should be considered when making treatment decisions.

82% say people have the responsibility not to overuse health care services because it increases insurance costs for everyone.

SOURCE
Minnesota Citizens Forum on Health Care Costs

A Strong Public Health System

There should be more emphasis on preventing illness and strengthening our public health system. The public health system reduces risk factors for disease by protecting the food and water supply, ensuring highway and workplace safety, and promoting changes in social norms and behaviors such as reducing tobacco use. It also promotes immunization, controls disease outbreaks, and coordinates disaster response. Public health must be considered an integral part of the health care system. Minnesota should adopt policies such as a higher tobacco tax and clean-air laws that will help prevent cancer and heart disease.

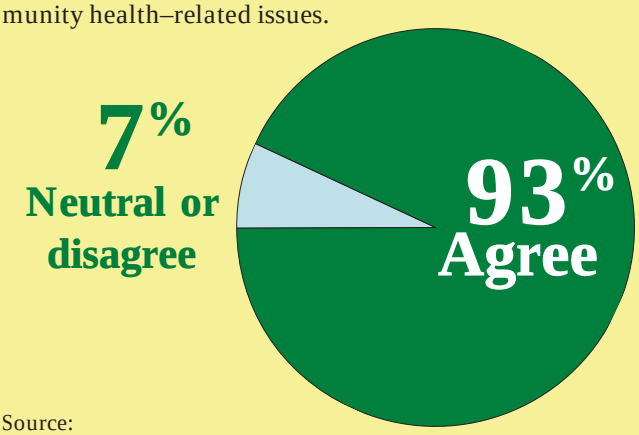


Recommendations

- Make public health more prominent.
- Coordinate action to address modifiable risk factors.

Do you agree or disagree?

I think it's a good idea that the government spends money on prevention, early detection of disease, and other community health–related issues.



Source:
Minnesota Citizens Forum on Health Care Costs

Promoting Quality

The task force found that attempts to control costs should focus on preventing and managing the care of those diseases that consume most of Minnesota's health care dollars, such as heart disease and diabetes. The emphasis will shift from trying to control costs in the generally healthy population to preventing and managing serious illness in the 30 percent of patients who generate 70 percent of health care spending.

The plan calls for policies and incentives that encourage the use of evidence-based guidelines, disease management, and preventive care. Investments should be made in electronic medical information systems that can improve care and eliminate errors. And the health care system should help each Minnesotan find a "medical home" with a personal physician. Behavioral health services will be covered in the same way as care for other illnesses. The task force supports initiatives that provide patients with cost and quality information they can use to make smart health care choices.

True or False?

The MMA is calling for a government-run single-payer health care system.

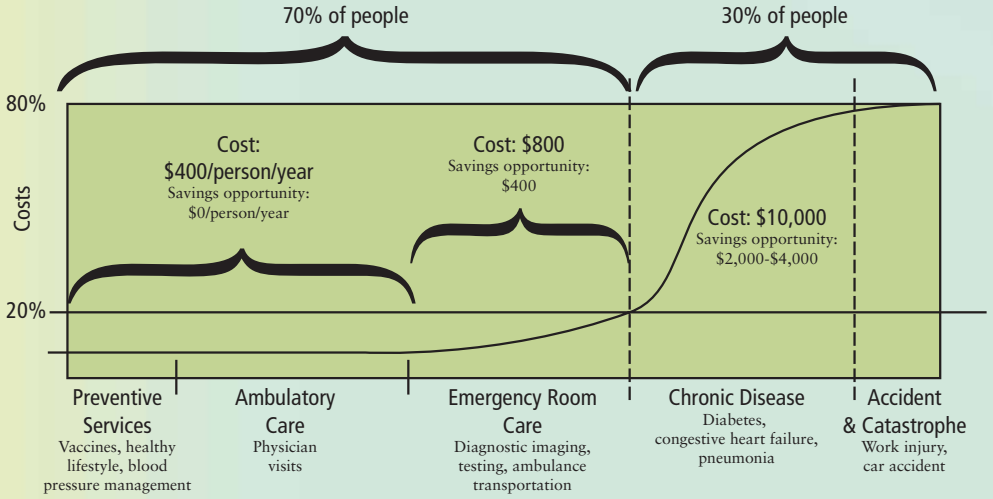
The essential set of benefits will be bare bones.

The plan encourages employers to stop providing health insurance.

The plan has no room for health savings accounts.

Health Care Costs

Only 5 percent of patients generate more than 50 percent of health care costs. Today's system tries to save money primarily by extracting deep discounts from primary care. This is counterproductive and discourages preventive medicine. Cost-control efforts should focus on chronically ill patients or those with complex diseases who generate the vast majority of costs.



Average annual per household health care costs in Minnesota: $11,000

Sources: Fischer M, Avorn J. JAMA 2004;291:1850-1856; McGlynn E, et al. New Engl J Med. 2003;348:2635-45; and Villagra VG, Ahmed T. Health Affairs 2004;23:255-266.

Health Care

False The MMA supports a more competitive, market-oriented health care system than exists today.

False Essential benefits will likely resemble those offered by employers today.

False Health benefits will still provide a powerful way for employers to attract and keep employees.

False The plan embraces a competitive market in which health savings accounts still make sense.

Recommendations

- Further increase the amount of effective care that is provided
  - Support physician-developed guidelines.
  - Support expansion of improved information infrastructure.
  - Support every Minnesotan having a medical home.
  - Place the emphasis for cost control where the greatest opportunity exists—chronic care
- Provide useful quality information
  - Support transparency in quality measurement and reporting of system capability.
  - Support simplified quality measurement and reporting transactions.
- Develop payment systems to support quality practice
  - Support payment processes that financially reward the implementation of guidelines, registries, and other efforts to improve quality of care.
- Ensure the safety and quality of health care
  - Leverage existing quality-improvement work.
  - Ensure the competency of heath care professionals and institutions.

Current and Future Stakeholder Roles in

	Patient/Consumer	Physician/Provider	Employer
Current	• Chooses plan based on coverage levels, provider access, premium price • Seeks service • Pays co-pay (if any) • Feels entitled to covered services • Pays nothing or full price (no discounts) if uninsured • Pays higher co-pays for behavioral health services • Chooses physicians based on referrals or word of mouth	• Provides service • Is paid primarily at negotiated (imposed) rate • Provides care to uninsured either charged at full rate or as uncompensated care (occasional individual arrangements negotiated with selected providers)	• Selects plan(s) and products • Determines contribution levels • Can restrict or opt out of behavioral health coverage
Future	• Chooses plan based on price, quality of administrative services, availability of information to support provider choice, shared treatment decision making, prevention, and care management • Seeks services from any provider with no plan restrictions • Chooses physicians based on quality and cost information (may face cost differentials based on level of coverage and physicians' prices)	• Advises patient on treatment options • Provides service • Sets same price for all patients (percent of bill paid by patient versus plan may vary among plans) • Strives to improve safety, effectiveness, efficiency of care • Competes on improved outcomes and expertise • Provides information about cost and quality	• Selects plan(s) to administer essential benefits • Chooses whether to offer additional coverage • Determines contribution levels • Provides incentives and programs for health risk reduction/wellness (eg, employer pays enrollee and physician to complete a health risk appraisal and rewards both for improvement over time) • Provides information to employees to help them maximize value for dollars spent

How the MMA Proposal Compares with

The MMA proposal includes many of the same recommendations made by Gov. Tim Pawlenty's Minnesota Citizens Forum on Health Care Costs (2004). That forum conducted numerous public hearings and a public opinion survey to chart a course for health care reform in Minnesota.

Recommendations	MMA Plan	Citizens Forum Plan
Allow patients to control payment and choose providers	Yes	Yes
Create payment systems that support preventive care	Yes	Yes
Encourage patients to choose treatments based on value	Yes	Yes
Disclose cost and quality information	Yes	Yes
Reduce costs through better quality	Yes	Yes
Change payment systems to reward quality	Yes	Yes
Strengthen public health efforts	Yes	Yes
Commit to universal coverage	Yes	Yes

Creating Value

Health Plan	Government
• Designs multiple benefit packages • Sets coverage criteria • Determines provider network • Effectively sets provider's price/payment • Is primarily concerned with control of unit prices • Supports independent behavioral health pricing, access and service limits, and co-pays	• Focuses on setting artificially low prices per unit cost • Shifts costs to other payers • Adds layers of regulation • Adopts benefit mandates
• Administers essential benefit set • Uses standard clinical guidelines • Does not define provider network but helps consumers find a medical home and maximize the value of their dollars • Negotiates payment rates to providers but doesn't limit provider prices • Shifts payment toward episodes of care or care for ongoing conditions • Provides information and other support for providers to improve care • Charges a community-rated premium for essential benefits • Continues to design and offer supplemental products • Participates in a statewide reinsurance pool for all its products • Provides information to enrollees to help them maximize value for dollars spent	• Ensures a well-functioning market • Protects against anti-trust violations • Provides tax incentives for coverage • Pays plans and providers a reasonable rate • Subsidizes coverage for people with low incomes and ensures access • Supports the information infrastructure with funding, incentives, regulations • Promotes streamlined reporting • Does not impose mandates for ineffective care • Ensures a strong public health system • Uses policy tools to reduce health risks

the Citizens Forum Plan

Recommendations	MMA Plan	Citizens Forum Plan
Require individuals to have health insurance	Yes	No
Use community average to price insurance	Yes	No
Develop an essential benefits set	Yes	Yes
Reduce the cost of overhead and administration	Yes	Yes
Eliminate cost shifting for uncompensated care	Yes	Yes
Persuade government to buy health care like private parties do	Yes	No
Provide incentives for healthy behavior	Yes	Yes

Note: For a more extensive comparison see pg 39.

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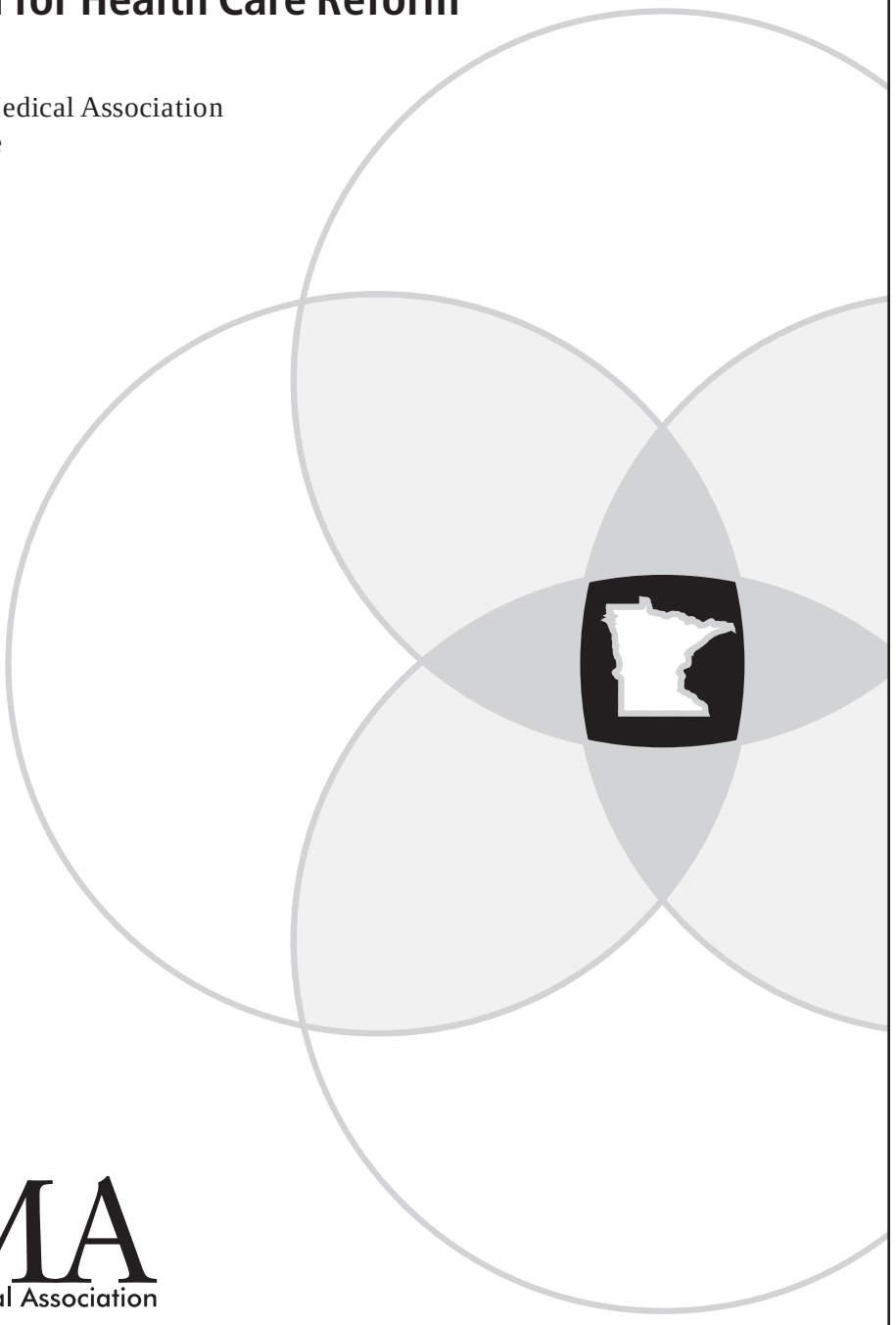

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Executive Summary

The health care system in the United States, according to some, is on the verge of imploding. The rapidly rising cost of services is causing more and more Minnesotans to forego needed care. At the same time, the increasing costs are placing additional pressure on families, businesses, and state and local government budgets. The Minnesota Medical Association's (MMA) Health Care Reform Task Force has proposed a bold new approach that seeks to ensure affordable health care for all Minnesotans.

The proposal is a roadmap to provide all Minnesotans with affordable insurance for essential health care services. In creating this plan, the task force strove to achieve three common reform goals: expand access to care, improve quality, and control costs. To achieve those ends, it has proposed a model built on four key features:

1. A strong public health system,

2. A reformed insurance market that delivers universal coverage,

3. A reformed health care delivery market that creates incentives for increasing value,

4. Systems that fully support the delivery of high-quality care.

The task force believes that these elements will provide the foundation for a system that serves everyone and allows Minnesotans to purchase better health care at a relatively lower price.

Why health care reform again?

The average annual cost of health care for an average Minnesota household is about $11,000—an amount that's projected to double by 2010, if current trends continue. Real wages are not growing fast enough to absorb such cost increases. If unabated, these trends portend a reduction in access to and quality of care, and a heavier economic burden on individuals, employers, and the government. Furthermore, Minnesota and the United States are not getting the best value for their health care dollars. The United States spends 50 percent more per capita than any other country on health care but lags far behind other countries in the health measures of its population.

A new model for Minnesota: Four interconnected features

1. A strong public health system

Health policy currently places far too little emphasis on populationwide prevention approaches that can help reduce risk factors for disease. Greater emphasis on communitywide public health measures that complement the work of the medical care system are needed.

Recommendations:

Provide leadership in making public health more prominent.
Supportive actions would include strengthening clean indoor air laws, increasing tobacco taxes, addressing the alarming trends in obesity rates, and providing immunization against preventable diseases. Such policy measures are powerful levers that can lead to healthier environments and healthier individuals.

Coordinate action to address modifiable risk factors.
Although many organizations have a genuine interest in supporting prevention, current activities across the state are fragmented. The MMA should urge the creation of a more coordinated and strategic action agenda to address the leading modifiable risk factors.

2. A reformed insurance market that delivers universal coverage

Minnesota needs a system in which all residents have continuous coverage for services necessary for the preservation and restoration of health and function. The current system, which rewards cost avoidance on the part of insurers and insulates consumers from the cost of the care and the consequences of behaviors, cannot be maintained.

Recommendations:

Ensure universal coverage for essential benefits.

- *Require that all individuals have insurance coverage.*
  The current voluntary health insurance system should be replaced by a system that requires continuous participation by all Minnesotans. Participation would be enforced through an individual mandate, which would be enforced in multiple ways and at multiple points (eg, tax filings, drivers' license applications, school registration, etc.). The mandate would be for essential services only—a "floor" of coverage.

- *Identify an essential benefits package that is adequate to preserve health.*
  A single, standardized set of health services, which are essential for the protection of individual and public health, should be developed. Behavioral health services would be covered on the same basis as any other clinical service. A physician-led, communitywide discussion that balances treatment expectations with affordability would be the basis for the development of the essential set of services. Unlike today, when covered benefits vary depending on one's employer or health plan, the single set of essential services would be applied consistently by all health plans in an open and transparent process.

  Insurance coverage for services beyond the essential package could be purchased in the market, but those services would not be subsidized by the broader community.

- *Ensure affordability through subsidies and targeted tax incentives.*
  In a mandated insurance system, financial subsidies will be necessary for persons of limited financial means. Cost-sharing models should provide people with more information about cost and strive to motivate them to seek value and improve their health behaviors. Cost sharing should not, however, create barriers to preventive services or needed and effective care, especially for those with low incomes and/or high need.

  The adoption of a communitywide essential benefit set should be used to trigger fundamental changes in health benefit tax policy such as limiting the tax deductibility of benefits to the essential benefit set. The savings from this policy could be used to help defray the cost of any expanded tax incentives that might be provided to individuals and/or small businesses.

Build a fairer system of spreading risk and sharing cost.

- *Require statewide community rating, guaranteed issuance, and a high-cost case reinsurance pool.*
  In the current system, health plans compete to a significant degree by seeking to avoid insuring the groups of people that have the highest medical costs through their product designs, underwriting criteria, and rating policies. To create a more stable and fair system, the task force calls for a return to statewide community rating for the essential benefits set. Plans would charge everyone the same premium for the essential benefit set regardless of their age or health status. The plan also calls for the creation of a mandatory reinsurance pool for all types of health plans and all products. Under the new model, policies would be available to all who wish to buy them—guaranteed issue.

Help employers make coverage options available.
Although an individual mandate is proposed, the task force recognizes that in the near-term, the employer-based system will remain the means by which most individuals obtain health insurance coverage. And employers likely will want to compete for workers as they now do by facilitating access to health insurance. The state should examine how models such as the Federal Employees Health Benefits Program could be made available to help employers efficiently offer multiple health plan choices. The state should also help employers make maximum use of worksite wellness programs.

3. A reformed health care delivery market that creates incentives for improving value

Recommendations:

Engage patients through greater accountability for medical decision making.
Today, the cost and possibly marginal benefits of a service are not significant factors in a patient's perception of value. In a reformed system, "health literate" patients will select services based on their condition and risk factors; the strength of evidence indicating the effectiveness of the proposed intervention; and the difference between the payment rate negotiated by that patient's insurance plan and the provider's price. The task force advocates a system in which patients, rather than purchasers and plans, make the choices.

A fundamentally different economic model for medical care services.
The current system creates powerful incentives for all parties to try to shift costs to someone else, which further distorts the economics of the system. Large purchasers need to be persuaded that a focus on real value will generate more savings than shifting costs to other players in the market. In the current system, large purchasers, such as businesses and government, often receive discounts by controlling the flow of patients. Such discounts are often unrelated to the cost of providing services. That often shifts costs to

individuals and small-group purchasers.

To help remedy the economic distortions, discriminatory pricing policy, particularly by government payers, must end. Currently, the government's payment policies for Medicare and Medicaid are often not fair, adequate, or aligned with the cost and value of services. Government should buy health care services on the same basis as the private market. The results of current government policy shift cost onto other payers, creating additional pressure in the system. For example, as prices rise for non-Medicare patients, companies provide fewer insurance options at greater cost and more people become uninsured or underinsured. By emphasizing value in its payment systems, government would be better able to manage the rising costs of care that are often volume- and supply-driven.

4. Systems that fully support the delivery of high-quality care

Recommendations:

Further increase the amount of effective care that is provided.

- *Support physician-developed guidelines.*
  The appropriate use of evidence-based, clinical guidelines is important for clinical and shared decision-making. Although numerous guidelines exist, they must be developed in an open, multi-specialty process. All guidelines should also be readily available to patients so they can better understand how to approach common health problems and what to expect from physicians and other health care providers.
- *Support expansion of an improved information infrastructure.*
  Interconnected health information systems are needed to support more efficient care and to support a heightened commitment to measurement and improvement. To fully engage patients in making informed, value-based decisions, real-time benefit determination systems will be required. Building and sustaining such systems will require leadership by the federal and state governments and the active partnership of private-sector purchasers and health care providers.
- *Support a "medical home" for every adult and child in Minnesota anchored in a continuous relationship with a personal physician.*
  The relationship between patient and physician is the central leverage point for improving quality and value. If these relationships are allowed to continue long term without the disruption caused by health plan and network changes, the benefits of a medical home are further increased.
- *Place the emphasis for cost control where the greatest opportunity exists—chronic care.*
  More than 70 percent of health care costs are incurred by about 30 percent of patients. In fact, only 5 percent of patients generate more than 50 percent of all costs. Today's system largely tries to save money by extracting deep discounts for primary care. The task force believes that system is inefficient and counterproductive. It keeps physicians and other health professionals from investing the time and resources in prevention, health education, and care management, all of which can avert more expensive treatments in the future. The new system should focus cost-control efforts on chronically ill patients or those with complex diseases who generate the vast majority of the expenses.

Provide useful information about quality.

- *Support transparency and efficiency in quality measurement and reporting of system capability.*
  In order to make more informed decisions and use their resources wisely, patients need to know what they are buying and what it costs. In order to improve the way they deliver care, physicians, hospitals, and other health professionals need to know how they are performing. This means all parties must commit to measuring and reporting on quality and cost. The reporting system, however, must capture relevant, appropriate, and valid performance information. There also must be an effort to streamline today's redundant systems that often do not produce valuable data.

Develop payment systems to support quality practice.

- *Support payment processes that financially reward the implementation of guidelines, registries, and other efforts to improve quality of care.*
  In the future, patients will decide for themselves the value of health care services in terms of both quality and cost. For now, new payment models should be developed that reward near-term provider actions that would build their capacity and systems for efficient, effective care—the

installation of electronic medical records, computerized pharmacy-order entry systems, clinical decision-support systems, disease and case management, team-based care, etc. It is also reasonable, in the interim, to support models that appropriately reward process improvements (eg, documentation of appropriate recommendations made to patients). Given current methodological limitations, the task force does not support pay-for-performance models that link payment with patient outcomes.

Ensure the safety and quality of health care.

- *Leverage existing quality-improvement work.* A tremendous amount of quality-improvement activity is already underway in Minnesota. Enough money is being spent already to fund an aggressive quality-improvement agenda for the state. Much more could be accomplished if the activities were more efficiently organized and connected, and if duplicative efforts were reduced.
- *Ensure the competency of heath care professionals and institutions.* Current limitations in methods preclude the use of statistical quality measures at the individual physician level. Instead, physician competency is assessed by methods such as state licensure and board certification. Board certification, in particular, is undergoing significant transformation. More emphasis is being placed on ongoing demonstration of performance rather than knowledge alone. As the new market system evolves, the role of various stakeholders in assuring competency will need to be re-evaluated.

Financing the health care system

The task force found that generally there is enough money in the system to insure everyone and provide them with high-quality care. However, members also identified recommendations for improving the way health care is financed.

Pursue broad-based financing.
Given the fundamental public interest in improving health, financing for public health and health care services should be broad-based. The current approaches of indirect and selective taxation are not sustainable.

Achieve efficiencies and redirect expenditures.
Much of the money spent on health care now is wasted. Capturing those lost dollars will require administrative simplification in the insurance, billing, and claims adjudication processes. It will also require the elimination of the waste and extra expense created by overuse of resources and current variations in quality.

Invest where needed to build the system of the future.
Additional investments will be needed in order to build the required information infrastructure, enhance prevention efforts, and increase the amount of effective care delivered. To guarantee access and quality in the future, it is critical to find separate and sustainable funding sources for medical education and research. The task force recommends that the costs of medical education and research be separated from the costs of patient care.

Moving reform forward

The task force recommends a mix of strategies for advancing various ideas in this report. Some elements of the proposed model for reform are relatively developed and focus on areas where the MMA can lead through its own actions. These include controlling costs through quality improvement. In some areas, the task force recommends that the MMA advance ideas for discussion at a more conceptual level to increase the chances for broader consensus. These include ideas for a very different approach to benefit design and transformation of the economic incentives in the system.

The task force is recommending a set of bold ideas that are certain to generate controversy, as they would create fundamental changes affecting virtually all stakeholders in the health care system. The task force has provided a new vision for a reformed health care system; it is hoped that these ideas will help to stimulate a productive discussion and change the terms and boundaries of the debate.

According to a 2003 survey conducted by the Minnesota Citizens Forum on Health Care Costs, Minnesotans want a bold new approach to health care reform. The task force believes that the proposals in this report provide the foundation for such a system.

Task Force Charge and Process

Health care reform is back on the front burner of state policy. Although the issues of health care costs and access never really went away, the urgency and the scope of discussions about them did fade for a time. After the piecemeal dismantling of the MinnesotaCare reforms of the early 1990s, most of the legislative action has addressed parts of the problem rather than the whole problem, and changes have been incremental. Often, one step cancels another made previously. Momentum is now building for a broader and more fundamental debate about the future of the entire health system.

The MMA recognized that a new framework for debate about health care reform was needed, given changes in the environment and evolution of the issues over the years, and that it had an opportunity to step up its involvement and assume a more proactive role in shaping current health reform discussions. The MMA Board of Trustees chartered the Health Care Reform Task Force to develop a new set of principles and recommend future directions for the MMA's work in health care reform. (A copy of the charter can be found in Appendix A.)

More than 50 physicians responded to the memberwide call for volunteers to serve on the task force. G. Richard Geier, M.D., MMA board chair, selected members from diverse specialties and from various parts of the state. Former MMA President Judith Shank, M.D., was asked to chair the group. The task force met 11 times over the course of nine months.

The task force explored issues in depth and let its conclusions evolve during a number of discussions. From the beginning, members made it clear that they had no desire to reinvent the wheel, but sought to be informed by and build from good work that had previously been done in Minnesota and in the United States, notably the recent report from the Minnesota Citizens Forum on Health Care Costs and several recent reports by the Institute of Medicine. (Appendix B illustrates how the task force's primary recommendations relate to some of these reports.)

Throughout the discussions, task force members tried to put patients and the community first, believing that the health of the profession will follow from policies that improve the system for those it serves. Of critical importance to every task force member was simultaneously achieving consensus among different points of view and defining a set of recommendations that would result in bold and fundamental change. The task force hoped that its report would create a vision for reform around which the physicians of Minnesota could unite in order to provide the necessary leadership for change in their communities and statewide.

Key Assumptions

Over the course of its deliberations, the task force developed a number of assumptions that created the foundation for the specific recommendations it ultimately endorsed.

1. Regardless of the mechanism of financing (whether a competitive market model or a government-funded and regulated model), it is critical that the delivery of effective health care be improved, including reducing the utilization of services that are driven more by the preference of the patient and/or physician (preference-sensitive care), as well as those that are driven more by availability (supply-sensitive care), rather than by evidence of appropriateness.

2. The task force recognized that the current system of health care financing creates severe economic distortions for all users and that federal payment policy is a significant contributing factor. The current system of "administered pricing" by Medicare and Medicaid shifts costs to other users, thereby increasing costs for other consumers. Complete reform will require federal action, but it is possible for Minnesota, and neighboring states working with Minnesota, to make changes that will improve health care quality and value and slow the rate of increase in health care spending. The Institute of Medicine in its Leadership by Example report has suggested that there is a greater likelihood for reform when whole states or regions undertake efforts to improve health care quality and value. Minnesota has an opportunity to lead the nation in such efforts. The recommendations outlined in this report should serve as a blueprint for the combined efforts of physicians, other health care providers, consumers, payers, and government to move forward in a coordinated and effective manner.

3. The task force recognized that Minnesota is not an island and could not, even if we wished to, make fundamental changes in the nature of the current employer-based private insurance system absent federal policy changes. The task force did look briefly at other international models of health care financing and wondered whether, especially

given global economics, the role of employers might be changed in the future. Such questions ought to be considered at the national level and, possibly, studied by a group such as the Institute of Medicine.

4. The vast majority of task force members concluded that a private, competitive market model is preferable to a government-controlled model primarily because of its superior ability to promote innovation and advancement. Many task force members did, however, place a high value on the equity and potential administrative simplicity of a more centrally financed and managed system. Members generally agreed that appropriate health policy should strive to find the optimal mix of competitive and regulatory approaches, and the recommendations in this report do propose a balance of both.

The Case for Change

The health care system in America may be on the verge of implosion. Health care costs have risen more than twice as fast as general inflation for the last 40 years. Greater rates of increase in recent years have strained the economy at both the macroeconomic and microeconomic levels. As a result, health care costs are now seen by many economists as the greatest threat to both private-sector economic growth and government budgets. Rising health care costs constrain job creation and real wage growth. Increases in publicly funded health care costs are straining budgets at the federal, state, and local levels of government. At a micro level, the cost of health care for individuals is rising so fast that people are choosing to forego treatment recommended by physicians. Access to needed care is uneven and falling. Ensuring a uniformly high level of quality of care is a greater challenge than previously realized. The health care system is not creating value for those who use it or pay for it. And when it comes to the most basic bottom line, it turns out we aren't buying nearly as much health for the money we are investing as we should or could be.

Minnesota has achieved distinction by providing insurance and health care for more of its citizens than other states. The state's health care system generally provides better quality at a lower per capita cost and produces better health outcomes (eg, longer life span, better immunization rates, and lower mortality rates) than almost any other state in the nation. Nonetheless, as the recent report from the Citizens Forum on Health Care Costs documented, Minnesota is not immune to the larger pressures bearing down on the system. Minnesota is facing staggering increases in costs, pervasive patterns of disparity in the health of various populations, and threats to quality.[1]

Cost

Per capita health care costs have increased at an average of 3.6 percent per year since 1960, versus GDP growth of only 1.4 percent per year. The share of the national economy spent on health care, education, and defense was 6 percent for each in 1960. By 2003, education was still at 6 percent and defense had fallen to 4 percent, but health care was at 16 percent of all spending. The imbedded cost of health care in the goods and services produced by American companies puts us at a growing disadvantage with global competitors.[2] The average annual health care cost for a family in Minnesota is about $11,000, and this is projected to double by 2010 if current trends continue.[1] Real wages are not growing fast enough to absorb this cost increase. If unabated, these trends portend a reduction in access to and quality of care, and adverse economic effects for individuals, companies, and government.

Thanks to improvements in databases and analytic methods, we now are able to understand much more clearly what is driving health care cost increases. We can begin to answer questions about how much of the increase is attributable to increases in the price of services and how much is attributable to an increase in volume. How much is due to increases in technological capability, to sheer demographics, and to changes in the profile of diseases, especially those caused by lifestyle choices and environmental factors?

A recent study by Thorpe et al. in *Health Affairs* broke down the component parts of the cost increase for the 15 health conditions that account for the majority of the health spending increase from 1987 to 2000. The researchers found that for about half the conditions total cost increases were driven principally by increases in the cost per case (ie, the increased intensity of care), which were driven in turn by new technologies and new treatment approaches. For the other conditions, an increase in the number of people being treated was the main factor. Notably, two of the top cost drivers in this analysis are diabetes and pulmonary diseases, the causes of which are environmental or related to personal behaviors (especially smoking and obesity) and are almost entirely preventable.[3]

The task force concluded that it is critical to look more deeply at the separate drivers of cost increases because different parts of the problem need different kinds of solutions.

Access

The United States is alone among developed nations in failing to guarantee universal health care coverage to its people. During the booming economy and tight labor markets of the 1990s, employer-provided coverage grew, although even then about 15 percent of people, most of whom were employed, were left without coverage. After a decade of fairly steady progress toward insuring more people, coverage levels are falling in the nation and in Minnesota, as employers have a harder time offering coverage, employees have a harder time affording it even when offered, and government programs tighten eligibility requirements as budgets are cut. Forty-five million Americans are uninsured on any given day of the year, and 82 million are uninsured at some point in the year.[4] The last official estimate for the number of uninsured Minnesotans was 275,000, although new data are expected soon that will likely show an increase.[5] Given cost trends and projected budget deficits, the number of uninsured is likely to continue to increase, absent policy changes. For thousands of other Minnesotans, high-deductible policies or limited coverage options may limit access to necessary and appropriate medical care.

Given that health care providers work hard to provide charity care and that public policy requires that people not be refused care for inability to pay, public opinion hasn't always equated lack of insurance with lack of needed care. The evidence is now clear, however, that coverage correlates strongly to health, productivity, and even mortality. Approximately 18,000 people die each year in the United States because they are uninsured, according to the Institute of Medicine. Others suffer unnecessary consequences of their disease and lack of treatment, and the indirect costs to the economy in lost productivity (including both absenteeism and impaired performance of people who continue to work despite their illness and limitations) are increasing.[6]

Besides barriers to access imposed by inadequate insurance coverage, limitations in public health resources and other infrastructure problems contribute to unequal access to health care.

Quality

Quality of health care is now understood to be highly variable. An estimated 30 percent of all health care spending nationally goes for care that is either not indicated, not effective, or not up to current community standards. A 2003 study by McGlynn et al. published in the *New England Journal of Medicine* constitutes the most thorough review to date of actual care received against well-accepted clinical standards. The researchers reached the startling conclusion that Americans receive effective care (defined as appropriate care based on medical evidence and practice guidelines) for acute and chronic conditions only about half the time.[7] Dartmouth researchers (Fisher et al.) reported in the *Annals of Internal Medicine* that for the Medicare program, the highest quality of care is actually delivered in the lowest-cost regions of the country.[8] Medicare data show Minnesota to be a low-cost, high-quality state. But current Medicare payment policy essentially penalizes rather than rewards this.

The evidence is mounting that "more care is not always better care" and that sometimes, in fact, more care is downright dangerous. The seminal Quality Chasm series from the Institute of Medicine not only documents the impact of suboptimal care on the public's health but suggests a blueprint for solutions.[9] Although many analyses suggest that Minnesota performs significantly better than national averages, there are also clear indications that quality variation is an issue and an opportunity here as well. These sources include the Institute for Clinical Systems Improvement, Stratis Health (the Medicare Quality Improvement Organization), and the recent results from the Council of Health Plans' Community Measurement Project. The task force is convinced that the Institute of Medicine and the Citizens Forum had it right: Higher-quality care need not always cost more; in fact, when it comes to cost containment, quality improvement is a big part of the answer.

Health status

It is increasingly clear that despite spending twice as much or more per capita than most other countries on health care, the United States lags far behind them on broad measures of population health. The World Health Organization ranks the United States as 29th in life expectancy. The United States has fallen in the rankings on such basic measures as both male and female life expectancy and infant mortality in the last 20 years.[2] The reasons for the disparity in spending and outcome are complex. Indeed, researchers believe that differences in access to medical services per se account for perhaps 10 percent of those gaps. The most powerful determinants of population health are personal behaviors and the physical, economic, and social conditions of the communities in which people live.[10]

For example, Costa Rica spends less than 10 percent of what the United States does per capita for medical care. Yet, life expectancy in both countries is virtually identical. Some of the reasons: Costa Rica has one-half the rate of tobacco use, and a four-times lower lung cancer death rate than the United States; a fraction of the car ownership rate, which results in fewer accidents and more exercise; dramatically different dietary patterns; and much less obesity, diabetes, and heart disease. Stress levels and the attendant ailments

are quite different in that society as well.[11] Some might suggest that this comparison is much too simplistic. But it does raise a provocative challenge: Shouldn't the health we are producing for our population for the dollars we invest be the truest measure of our health policy?

From a state standpoint, part of Minnesota's past performance on measures of health care cost and quality come from its historically strong public health system and the relatively healthier habits of the population. More recently, however, local health behavior trends should give us cause for alarm. Smoking rates, for example, have not fallen in Minnesota as rapidly as in the nation as a whole. Youth smoking rates increased more rapidly during the years we were not funding aggressive prevention efforts, and obesity rates are increasing faster in Minnesota than in some areas. Despite the high health status rankings of the majority population, some key health status measures among African Americans and American Indians are worse than their counterparts in other states.[12] Public health research suggests that the causes of these disparities have a great deal to do with social and economic conditions in the communities in which minority populations are concentrated. Given the forecasted growth of these populations in coming decades, these disparities are even more significant.

Broad solutions across all sectors are needed

The medical profession should step up and acknowledge that it can and will make improvements in the areas it can influence. However, addressing the root causes of these deep challenges lies far outside the capability of individual physicians, hospitals, or health care delivery systems. Health care costs and quality are determined by the financing systems and market conditions in which health professionals do their work. The determinants of public health have everything to do with public policy choices in the spheres of economics, community design, and the like. Policy solutions are needed across a broad range of issues, if we want to see results.

Although the U.S. health care system has been predicted to be on the brink of collapse more than once over the last several decades, the health system has found ways to respond to the political pressures of the moment and avoid fundamental change. For instance, "the Hillary effect," was coined by some health economists to explain the rather significant slowdown in cost growth in the mid 1990s.[i] Many health policy experts decry the current state of affairs; they say the nation and the state have already tried the major alternatives—government control, market competition, and voluntary efforts from the health sector itself (although the rigor of the attempts can be debated). Many experts believe that the policy discussion is bereft of big, new ideas and, therefore, they expect continued tinkering at the margins and lack of fundamental progress.

This task force, however, has looked at the factors and trends in health care and sees reason for hope. The system clearly can do better—if we can build a system that supports, rather than undermines, doing what we already know works.

Note: The task force reviewed a large number of articles and reports in the course of its deliberations, the majority of which are cited in the bibliography (see Appendix D).

[i] The term is a reference to then-First Lady Hillary Clinton's efforts to reform health care at the national level.

Vision for a New Health System

The task force began its deliberations with each member articulating his or her own views of the most essential features of a new system. The resulting attributes were ranked by the group, and the following statements, written as a proposed vision to guide the MMA's future efforts, express the most central issues prioritized in that process:

- *The MMA envisions a system in which all Minnesotans have affordable coverage for essential health benefits that allows them to get needed care and preventive services in a timely and effective manner.*
- *Strong patient-physician relationships, unimpeded by third parties, will restore citizen trust in the system and professional satisfaction with the practice of medicine.*
- *Affordability for individuals, employers, and society will be improved by a renewed commitment by physicians to deliver high-quality effective and efficient care, patient responsibility for personal health behaviors and cost-conscious choices, and incentives that reward all parties for a greater focus on prevention and enhanced health.*
- *The ideal health system will deliver significantly greater returns in improved health status for the dollars invested and will deliver equity for all in access, treatment quality, and outcomes.*
- *Whatever the design of the system, the funding provided to the public health and health care delivery systems must be broad-based, stable, and adequate to meet the health needs of the state.*
- *In order to achieve this higher-performing system, we need a fundamental change in the financing approach to and market dynamics of health care. The MMA believes that the uncontrolled growth in health care costs can best be mitigated by replacing the current price and volume incentives that result from a system in which payers artificially control prices with a patient-centered market system in which incentives are aligned to encourage the use of preventive services and effective care without subsidizing the consumption of services of minimal clinical value. In the current system, large purchasers and health plans have the ability to impose prices and shift costs to smaller purchasers or individuals because they control the flow of patients. In the new system, the price of care will be determined by patients' determination of the value they receive from the services provided.*

Principles for Reform

Health policy debates are often framed in terms of competing claims of "rights." The task force believed that the discussion can be more productively focused around an interconnected set of mutual responsibilities. The task force suggests that as members of the community of all Minnesotans, we all have a set of critical responsibilities to each other.

A. The community has a responsibility

1. *To ensure affordable access to basic care.*
2. *To broadly share the risk and cost of medical needs.*
3. *To assist the population in using health care resources wisely.*
4. *To provide the conditions and environment in which people can be healthy and make healthy choices.*
5. *To maximize the proportion of health spending that goes to effective care for all who need it.*
6. *To secure the future capacity of the health care system to provide sustained high-quality and affordable health care through investments in prevention, medical education, and medical research, and improvements in the system's infrastructure.*

B. Individuals have a responsibility to the community

1. *To participate financially in sharing the cost of the system that benefits all.*
2. *To use the system wisely and draw on collective resources judiciously.*
3. *To take personal responsibility for their own health behaviors and reduce their own health risks.*
4. *To become more health literate (eg, educated about prevention, selection of plans/providers, wise use of resources, and the clinical decision-making process).*

C. Physicians and other clinicians have responsibilities to individual patients and to the broader community

1. *To accurately assess patient needs and recommend appropriate and effective care.*
2. *To advocate honestly for needed and effective care for their patients.*
3. *To help individuals achieve measurable improvements in health.*
4. *To exercise stewardship over collective health care resources.*
5. *To participate in care management as members of an effective multidisciplinary health care team.*
6. *To foster health literacy among patients and the broader population.*
7. *To create and foster continuous learning environments in the organizations in which they practice.*

D. Group purchasers (private-sector employers and government) have responsibilities as members of the community

1. *To set expectations for health plans to focus on the delivery of efficient care and health improvement by engaging patients and supporting providers.*
2. *To emphasize prevention strategies (including those with longer-term payoff) in benefits design.*
3. *To share in the needed investments in improvements to the infrastructure of the health system.*
4. *To move the health care system toward affordable, universal coverage for all, not just people employed by large companies or covered through publicly sponsored health care programs.*

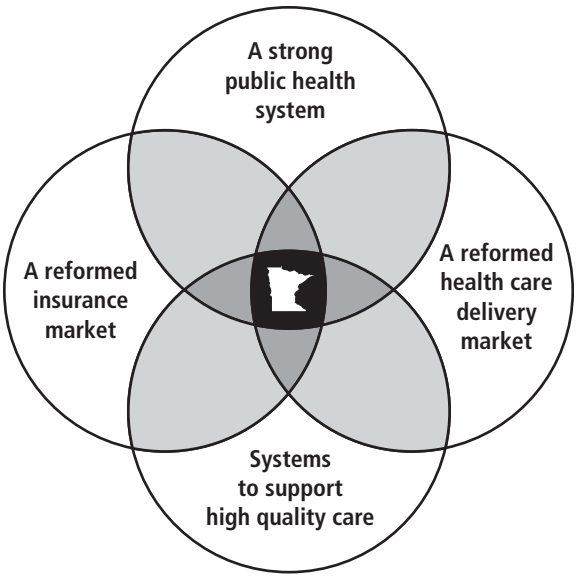
E. Health plans/insurers have responsibilities as members of the community

1. *To create payment systems that foster efficient care and improved health.*
2. *To coordinate care management systems with physicians and care teams and to provide the needed information and infrastructure supports for high-quality programs.*
3. *To correct business practices that lead to health care fragmentation, such as carved-out behavioral health benefits.*
4. *To minimize the complexity of the system and the cost of administration, and to assist patients/members in navigating the system.*
5. *To share in the needed investments in prevention strategies and infrastructure improvement.*
6. *To provide tools and resources and foster an environment to help beneficiaries achieve and physicians deliver desirable results.*
7. *To create and foster continuous learning environments for the improvement of health care administration and delivery.*

The task force believes that these principles could engender agreement among all stakeholders. At first glance, they may seem noncontroversial and perhaps not terribly new or noteworthy. A closer look at and comparison with how each stakeholder currently acts in today's system, however, shows a very different picture. For instance, today most purchasers and plans feel little responsibility for funding the needed infrastructure improvements in the delivery system or for funding prevention programs with long-term benefits to the community as a whole rather than their own bottom lines. Most patients do not think about health care resources as something to be conserved and shared. Most physicians do not yet practice in the kind of interdisciplinary care teams that are needed to manage complex and chronic conditions.

The task force believes that health reform debates usually skip too quickly past this first step of articulating and agreeing on parties' fundamental underlying assumptions and beliefs. Mutual understanding and agreement at this level helps to shape expectations for a positive outcome in a policy debate. It also can provide a common place for all parties to return to when negotiations break down. Therefore, the task force recommends that the MMA invest time and effort in conversations with leaders from key stakeholder groups using this "mutual responsibilities" framework. This discussion about underlying values should guide reform and identify where common ground can be forged.

A Model for a New System



This model depicts four key, interconnected features. These features taken together would address the fundamental challenge of producing greater value in the health system—ie, better health for all Minnesotans for the dollars invested. All four components are critical; no one part alone is the "silver bullet" for reform. The narrative describes each part of the model in turn:

1. *A strong public health system*
2. *A reformed insurance market that delivers universal coverage*
3. *A reformed health care delivery market that creates incentives for increasing value*
4. *Systems that fully support the delivery of high quality care*

1 • A strong public health system

Despite the overwhelming influence of environmental factors and behavioral choices on personal and population health status, the nation spends only about 5 percent of its total health budget addressing these issues.[10] The vast majority of this health budget is devoted to individual clinical interventions, which often occur after illness is already present. The state and the nation need to invest much more heavily in primary and secondary prevention efforts both to intervene in the process of disease and to reduce costs. Primary prevention—those efforts undertaken long before there is any clinical evidence of disease—can provide long-term benefits that are difficult to measure in short economic horizons. Intervention to prevent the worsening of a condition undertaken after disease is present (secondary prevention) can show more dramatic results in the short term and more quantifiable economic results. For example, it is known that individuals who are overweight or who have hypertension use about 30 percent more resources each year than people with normal weights and blood pressure levels. Lifestyle modifications to eliminate tobacco use and effective use of drugs to prevent recurrent heart attacks and heart failure can reduce the need for hospitalizations and expensive interventions such as angioplasty and stenting. Limiting smoking in public places and reducing tobacco use can curb the incidence of asthma and cardiovascular events, even in the very short term for patients with existing disease.

The primary prevention efforts of the public health system aim to prevent illness and injury by systematically reducing risk factors in the environment (eg, through protecting the food and water supply, and promoting highway and workplace safety), and by promoting changes in social norms and behaviors (eg, reducing tobacco use). The clinical and public health systems share responsibility for containing infectious diseases through strategies such as immunization and outbreak control. They also must respond to other public health emergencies such as natural and man-made disasters. Although harder to quantify in cost/benefit terms (especially over the short-term horizons of most public- and private-sector decision-making processes), primary preven-

tion strategies are largely responsible for the majority of the phenomenal gains in lifespan during the past century.

A stronger public health system can help do several critical things:

1. *Manage communitywide threats to health from a variety of sources;*
2. *Protect the capacity of the medical system by helping to reduce demand, which will be especially critical given the growing needs of an aging population;*
3. *Moderate long-term health care costs; and,*
4. *Improve population health status.*

None of these can be accomplished without stronger public health efforts to address communitywide conditions and reduce the risk factors that cause so much preventable disease. Without a strong public health system as its complement, the medical care system cannot succeed in controlling health care costs or improving health outcomes. Unfortunately, attention to and investments in public health have been short-term and episodic. In a sense, public health is the victim of its own success; when it works well, it is largely invisible and quickly forgotten.

Recommendations:

Lead in making public health more prominent. Prevention generally fails to generate the advocacy support that groups dealing with more visible and current problems can muster. As a professional association, the MMA is in a unique position to provide leadership in the area of public health. The MMA can and should tie its positions on public health issues such as the tobacco tax, clean indoor air laws, and obesity prevention to broader health care cost and access proposals and legislative strategy. Policymakers have an obligation to use the policy tools that they uniquely control, just as providers and other stakeholders are expected to do their parts to control costs and improve quality. The public health system and public health policies ought not to be considered as separate from the health care cost and system reform debate.

Coordinate action to address modifiable risk factors. Although many organizations, including employers and health plans, have genuine interests in supporting prevention, activities across the state are currently fragmented. The MMA should urge the creation of a more coordinated and strategic action agenda to address the leading modifiable risk factors for all Minnesotans.

2. A reformed health insurance market

For most of the last decade, policymakers have tried to ensure universal "access" to care—meaning insurance is available for those who can afford it, and emergency care is available even if you don't have insurance. Federal and state health policy has become increasingly complex as a variety of voluntary coverage plans and a range of cross-subsidization schemes have been developed, overlaying inconsistent laws that require some provision of emergency and other charity care. The resulting patchwork quilt of coverage creates a host of problems: unnecessary administrative complexity; poor care coordination for most people; too many uninsured and under-insured people; and, unnecessarily high costs for intensive care caused by lack of basic preventive and primary care. Most important, it produces unnecessary illness, disability, and death.

Employers who voluntarily elect to pay for health insurance are saddled with often unmanageable cost increases and are at a growing competitive disadvantage in both domestic and international markets. Today's insurance marketplace is characterized by more and more segmented risk pools and selective marketing of experience-rated products. In such a market, health plans economically prosper by attracting those who need and consume the least amount of care, not by best serving those who need the most.

The task force concluded that universal access will never get us to a fundamentally more effective and efficient system. The task force advocates a return to what was once law in Minnesota, but was regrettably repealed—a commitment to achieve universal coverage. Minnesota needs a system in which all residents have continuous coverage for services necessary for the preservation and restoration of health and function. The current system, which rewards cost avoidance on the part of insurers and insulates consumers from the cost of care and the consequences of behaviors, cannot be maintained.

The task force's recommended new model is fundamentally different. It would not guarantee anyone full coverage of everything possible but rather would ensure for everyone coverage of all needed and effective care. The task force advocates moving away from a market in which consumers respond to the system that is designed for them and toward a market in which consumers have more direct control over their choices. In this system, consumers also have more responsibility, including responsibility to participate in the system by purchasing at least a minimum level of coverage. The task force also advocates fundamental insurance reform to end cost shifting and more equitably distribute the high cost of care for the sickest people.

An important design feature of this reform model is that the market would still offer supplemental coverage. It would allow consumers to choose products that further limit their out-of-pocket expenses or add coverage for services broader than the core set. But such coverage would not be mandated, subsidized, or tax-preferred. The task force does not expect that the essential benefit set would be a "bare bones" kind of package. The goal would be coverage for those things that are the most essential to protecting individual and population health. However, the task force also recognizes an essential dilemma—it is not possible to precisely determine "what's in and what's out" until there is a greater degree of societal consensus on what we are individually and collectively willing to pay for health care. Although the task force does not advise that the MMA seek legislation to promote these changes on its own, the specificity of the recommendations will allow the MMA to lead discussions and to challenge others to respond accordingly. The recommendations to reform the insurance market are detailed below.

Recommendations:

Ensure universal coverage for essential benefits.

- *Require that all individuals have insurance coverage.*
  The task force believes that in order to maximize the health of individuals and the entire population, as well as to create a more functional health insurance system, the current voluntary health insurance system should be replaced by a system that requires continuous participation by all Minnesota residents (an individual mandate). The mandate would be enforced in multiple ways and at multiple points (eg, tax filings, drivers' license applications, school registrations, etc.). The mandate would be for essential services only—a "floor" of coverage. Additional supplemental coverage should be available in the market.

- *Identify an essential benefits package that is adequate to protect health.*
  A single, standardized set of health services, which are essential for the protection of individual and public health, should be identified and established as the required floor of coverage for all individuals (the required level of coverage for the individual mandate). Services beyond the standardized set should be available in a competitive market but would not be subsidized by the broader community (either directly or through tax policy). The design of the benefits floor should not be based on either a catastrophic policy with a high deductible or on first-dollar coverage with a simple dollar cap for coverage. Essential benefits should be based on health status impact and evidence of effective interventions. Age-appropriate health risk assessment should be provided for all patients. Behavioral health services should be covered on the same basis as any other clinical service.

- *Ensure affordability through subsidies and targeted tax incentives.*
  In a mandated insurance system, financial subsidies will be necessary for persons with limited financial means. The task force supported the basic principle that "everyone pays something." Economists and advocates will need to address what constitutes "realistic" affordability for low-income populations. Cost-sharing models should strive to motivate people to seek value and improve their health behaviors. Cost sharing should not, however, create barriers to preventive services or needed and effective care, especially for those with low incomes and/or great need.

  The adoption of a communitywide essential benefit set should be used to trigger fundamental changes in health benefit tax policy. The task force believed that a cap on the tax deductibility of benefits should be imposed and limited to the essential benefit set. The savings from this policy could be used to help defray costs of any expanded tax incentives that might be provided to individuals and/or small businesses.

Build a fairer system of spreading risk and sharing cost.

- *Require statewide community rating and guaranteed issuance for the essential benefits package.*
  In the current system, health plans compete to a significant degree not over their ability to manage costs or improve health but by seeking to avoid the groups of people that generate the greatest cost through their product designs, underwriting criteria, and rating policies. To create a more stable and fair system, each insurer or health plan should set one statewide community rate for the benefit package. The community rate set by each plan would not vary from one market segment to another (the rate for the benefit package would not vary whether sold to a large employer, a small employer, or an individual). There should be no adjustments for age or

other factors to the community rate. The only allowed variation should be for health-improvement incentives (eg, discounts for positive behaviors). In a mandatory universal coverage system, all insurance products must be available to all who wish to buy them—guaranteed issuance of policies.

- *Reinsure high-cost claims.*
  Because costs are so highly concentrated in a relatively few number of cases, all insurance plans (and all products sold by those plans) should be required to participate in a single reinsurance pool. There will likely be a need for further risk adjustments beyond the reinsurance mechanism to protect plans from adverse selection.

Help employers make coverage options available.
Under the model envisioned by the task force, employers would not be required to offer coverage or contribute any set portion to the cost. Employers, however, likely will want to compete for workers as they now do by facilitating access to health insurance. The state should examine how models such as the Federal Employees Health Benefits Program could be made available to help employers efficiently offer multiple health plan choices. The state should also help employers make maximum use of worksite wellness programs.

3. A reformed health care delivery market

The dominant payment methods in the current health care system offer health systems, hospitals, physicians, and other clinicians a higher profit for some services and limited payment for others, without clear regard for the overall effectiveness or importance of the service in terms of health impact. Unfettered utilization of health care services, new drugs, and technology are encouraged by the prevailing incentives, with no incentive for patients to be cost-conscious or for providers to encourage cost-effective alternatives. The ideal future system should, instead, reward cost-effective care and evidence-based treatment. The system should not reward or subsidize ineffective services or inefficient delivery.

Effective care, defined as care that is based on solid evidence and guidelines, is not delivered as often as it should be. If more effective care were delivered, it is reasonable to expect that at least some costs would initially rise as more services are provided to those who currently are underserved. In the long run, though, future costs will be avoided.

Researchers have described two distinct categories of care that contribute significantly to the variation in rates of service use and cost across the country and within market regions: preference-sensitive and supply-sensitive care.[13]

Preference-sensitive care, defined as care obtained by patients or ordered by physicians on the basis of personal preference rather than on the basis of available evidence or guidelines, contributes to increased health care costs. For example, use of frequent ultrasound examinations in uncomplicated pregnancy or repeated complex imaging procedures for evaluation of common conditions increase overall costs without providing specific clinical value. Sometimes, preference-sensitive care decisions are based on legitimate concerns or may be made where there is not yet good evidence to guide practice. Providing such care may yield important information and inform future choices. For example, rigorous use of clinical trials or analysis of large claims databases to which all physicians and hospitals would submit data as a condition of payment for the service. The task force recommends the development of new tools and strategies to provide patients with the information and, ultimately, the incentives to make choices that will reduce the overall utilization of unneeded preference-sensitive care.

Supply-sensitive care is care that is driven by the availability of services rather than by scientific evidence or guidelines. It also increases overall costs. Fisher et al. have demonstrated that the difference in Medicare costs between Minneapolis-St. Paul and Miami is related to the greater supply of intensive care and medical specialty resources in the latter, with no difference in patient need or outcomes.[8] From a patient care standpoint, it is not necessary that every hospital in a relatively small geographic area have a cardiac surgical program, an orthopedic program, a high-risk obstetrical program, and a comprehensive cancer program, each with marginal patient volumes. Such a diffusion of capacity is economically inefficient and undermines quality as well. The current situation is driven in large part, the task force believes, by the artificial payment system now used by Medicare and others in which the price for services is often unrelated to the clinical value delivered and to the cost of providing the service. Government program payments now are vastly below cost for many clinical services but also are significantly above cost for others. The task force believes that the recommendations for a reformed health care delivery market that are proposed below would lead hospitals, physicians, clinics, and health systems to better allocate capital and resources.

In the current system, large purchasers or health plans control the ability of patients to select their physicians and other providers. In return for the ability to restrict patient

choice only to the plan's network, plans (on behalf of purchasers) effectively set prices and demand discounts unrelated to either the cost of delivering care or the value that care represents to the ultimate customer—the patient. Health plan enrollees generally feel entitled to receive all possible services without much regard to cost. Many presume that having paid a premium for an insurance package ensures coverage (sometimes after a deductible and/or copayment) for virtually all the care that is available as long as it is "medically necessary," although the decision processes that determine medical necessity are controlled by health plans and are usually far from transparent.

Under the task force model of universal coverage, a standard definition of the core services would be set and kept up to date by a physician-led process and would not vary from plan to plan. The core services would include evidence-based prevention and treatment but generally would exclude services classified by guidelines as not indicated.

Health plans would no longer control patient access via predetermined networks, nor would they determine the price charged by the care system, hospital, physician, or other health professionals. Although health plans would still negotiate payment arrangements and patients could still keep their out-of-pocket costs lower by using those providers with the most preferential contracts, plans would no longer dictate total provider prices. It would be up to patients to decide whether additional services or the use of higher-cost providers are worth the added cost. Patients could pay extra to receive care from higher-cost providers, use a brand-name drug rather than a generic, or otherwise opt for a more expensive alternative when multiple choices exist. The choice is the patient's. This model moves the consumer away from simply asking about what is covered to a more balanced set of questions such as, What are my options? How much does each cost? What is the value to me? The model also shifts the nature of health plan competition. Plans will help consumers maximize the value for their dollars and make the best choices among providers, treatment options, and health improvement strategies.

Recommendations:

Engage patients through greater accountability for medical decision making.

Today, the cost of a service and the possible incremental or marginal benefit of that service are not significant factors in determining patients' perception of value. In a reformed system in which patients have access to information and are more health literate, patients will select health care services of value based on three things: 1) the patient's condition and risk factors; 2) the strength of the evidence on the effectiveness of the proposed intervention; and, 3) any difference between the payment rate negotiated by that patient's insurance plan and the provider's price.

A fundamentally different economic model for medical care services.

In the current system, large purchasers (businesses and government, directly and through health plans) essentially set prices by controlling the flow of patients and commanding discounts often unrelated to the cost of providing services. These actions shift additional costs to other buyers, especially individual and small-group purchasers. In the new system, consumers would make the choices about where to receive care and how much they are willing to pay for it. Health systems, hospitals, physicians, and other health professionals would compete at a new level (essentially disease by disease) to add value. The task force proposes having a system in which patients make choices directly, rather than the current system in which purchasers and plans generally make decisions on their behalf. The current system creates powerful incentives for all parties to shift costs to someone else; this further distorts the economics of the system. Large purchasers need to be persuaded that a focus on real value will generate more savings than shifting costs to others.

- *End discriminatory government pricing policy.* Government should buy health care services on the same basis as the private market. It does not cost providers less to provide care for Medicare beneficiaries than it does to provide the same care for non-Medicare beneficiaries. Government should not set arbitrary prices that may be less than actual cost in some situations and vastly higher than cost in others, nor should government use payment policy that promotes increasing the volume of service rather than delivering value. The results of current government policy shift cost onto other payers, creating additional pressure in the system. For example, as prices rise for non-Medicare patients, companies provide fewer insurance options at greater costs, and more people become uninsured or underinsured. By emphasizing value in its payment systems, government would be better able to manage the rising cost of care that is volume- and/or supply-driven. Geographic inequities in payment rates should also be ended by the same mechanisms. If government does not make a shift to value purchasing, additional pressure on government budgets will mean a reduction in eligibility criteria. The result will be a further increase in uninsured and vulnerable

populations. The task force believes this recommended reform model is worth pursuing even if only the private sector market takes it up and government payers do not. However, private purchasers should understand the degree to which current public program payment approaches are distorting the market and should join in advocacy efforts to get the federal government to adopt the same value purchasing approach.

New market dynamics—a few key differences

The following table highlights some of the differences between the current system and the task force's desired future system. A more detailed chart can be found in Appendix C.

CURRENT SYSTEM	FUTURE SYSTEM
Predefined benefit coverage levels variable from plan to plan	Communitywide agreement on a set of essential services that are updated through a standard process and uniformly applied by all health plans; consumers can buy supplemental coverage
Patients feel entitled to whatever plan covers; choose physicians or other providers based on referrals or word of mouth	Patients have more information, are more knowledgeable, and make decisions based on cost and quality and other value-based variables; have variable cost responsibility
Plans compete to enroll members in limited provider networks	Plans compete by helping consumers maximize the value of their dollars; patients can choose any provider but face cost differentials
Plans and purchasers reduce costs for themselves, in part, by shifting the costs elsewhere	Providers reduce costs for payers and patients by improving care processes; plans and purchasers reduce costs by helping consumers stay healthy and maximize value for dollars invested

4. Systems that fully support the delivery of high-quality care

Analyses of claims costs at both the national and state level and by various health plans all confirm that health care spending is highly concentrated in a small percentage of patients. The task force found the visual display of costs and savings opportunities (see Figure 1, p. 30) to be very helpful in understanding the opportunities for cost control in the system. The graphic portrays both the type of care and the potential for cost savings at various points along the spectrum.

In general, the task force concluded that cost-control efforts should be concentrated where the costs actually are (far right-hand side of graph), which is quite different from today's focus, which tends to place unproductive controls on the lower-cost parts of the system. Most current cost-control methods add to the frustration of both patients and physicians and, ironically, may contribute to the system's failure to prevent the progression of patients into the higher-cost areas of care.

The task force concluded that the greatest opportunity for significant and immediate savings is in better management of chronic diseases, especially those that result in hospitalization. The savings opportunities in the outpatient setting are more limited. Indeed, by increasing the delivery of effective care, we should expect to increase spending for office-based care. Significant per-case savings are possible by helping physicians to provide the best in science-based care for complex and chronic conditions, and by changing payment systems to reward team-based care in any setting. A more robust health information infrastructure will be needed to support these improvements. The public health strategies recommended earlier will also help to moderate the numbers of people presenting to the system with problems caused or exacerbated by preventable risk factors, ranging from infectious diseases to chronic conditions to accidents and injuries. The recommendations to improve quality are detailed below.

Recommendations:

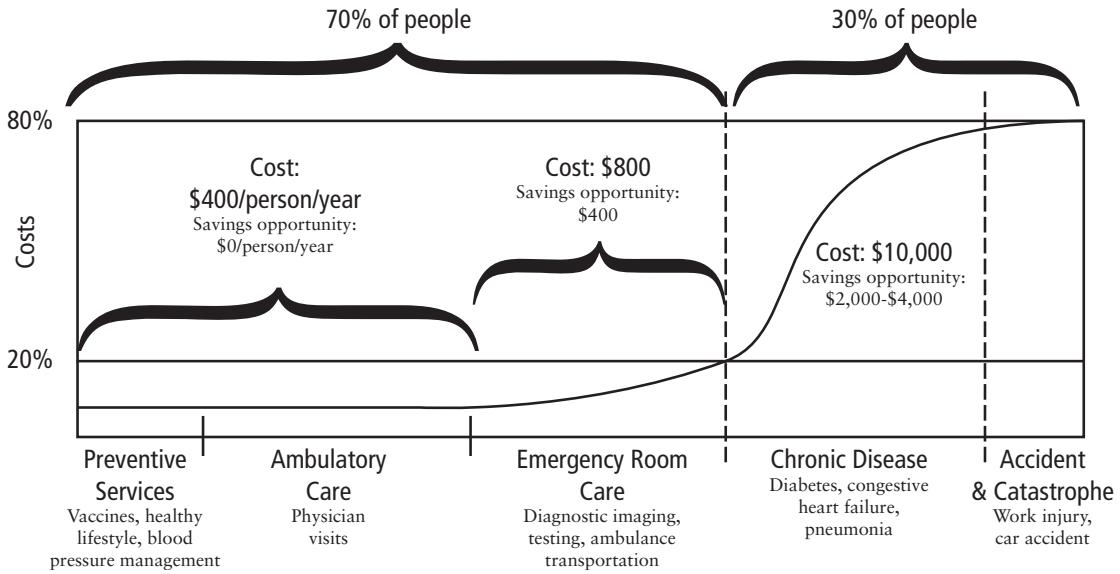
Further increase the amount of effective care that is provided.

- *Support physician-developed guidelines.* The appropriate use of evidence-based, clinical guidelines is an important tool for clinical and shared decision-making. Although numerous sources of guidelines exist, guidelines must be developed in an open, multispecialty process. Closed, proprietary models for guideline development are unsupportable. The task force urges the MMA to support efforts to develop and

Figure 1

Health Care Costs

Average Annual per Household Health Care Costs in Minnesota: $11,000



Sources: Fischer M, Avorn J. JAMA 2004;291:1850-56; McGlynn E, et al. New Engl J Med. 2003;348:2635-45; and Villagra VG, Ahmed T. Health Affairs 2004;23:255-66.

implement guidelines by working with the Institute for Clinical Systems Improvement and others. All guidelines should also be readily available for patient use. Patients need to understand how they should approach common health care problems and how to better understand what to expect from physicians and other health care providers.

- *Support expansion of an improved information infrastructure.*
  Support statewide implementation of electronic health records that provide, at a minimum, for the exchange of summary report information that can be used for treatment decisions. The task force urges the MMA to support creation of state incentives to help establish and expand the state's electronic health care infrastructure. A public-private partnership should be created to ensure that the roles of each sector in creating, expanding, and linking information and systems are complementary.

- *Support every adult and child in Minnesota having a "medical home" anchored in a continuous relationship with a personal physician.*
  To promote continuous healing relationships and to better coordinate care through continuity of person, place, and information, every Minnesotan should have a medical "home." Physician practices that are organized for easy patient access will facilitate greater patient use of the medical home as opposed to emergency or urgent care centers. In collaboration with others, the task force recommends that the MMA work to educate patients and payers about the importance of this concept. Significant evidence shows that having a personal physician improves quality, improves health outcomes, and controls costs. Employers, government, and plans should be encouraged to adopt payment plans and enrollment policies that increase the likelihood that patients can identify and sustain a relationship with a personal physician. Payment methods must be built to support the functions provided by a medical home, such as patient education and case management. Those services would be covered as part of the essential set of services.

- *Place the emphasis for cost control where the greatest opportunity exists—chronic care.*
  More than 70 percent of health care costs are incurred by about 30 percent of patients. In fact, only 5 percent of patients generate more than 50 percent of all costs. Today's system largely tries to save money by extracting deep discounts for most primary care. The task force believes that system is inefficient and counterproductive. It keeps physicians and other health professionals

from investing time and resources in prevention, health education, and care management—all of which can avert more expensive treatments in the future. The new system should focus cost-control efforts on chronically ill patients or those with complex diseases who generate the vast majority of the expenses.

Provide useful quality information.

- *Support transparency in quality measurement and reporting of system capability.*
  In order to give all Minnesotans the kind of information they need to play a much more active role in their own health care decisions, public reporting of changes and improvements in various dimensions of the health system's performance is needed. As we seek to improve the available information over time, however, it is critical that patients, payers, purchasers, and health care providers understand the meaning of various measures and the limitations of measurement tools.

  Within the health care system, there are three levels at which performance could be assessed: 1) at the population level; 2) at the facility level —clinic, hospital, nursing home, system; and, 3) at the individual clinician level.

  Performance measurement tends to evoke strong reaction from many physicians and for good reason. The implications of measurement and public reporting can be significant both in terms of business/economic impact and professional reputation. In addition, it is no easy task to explain the value and limitations of performance measurement at each of the three levels (ie, population, facility, and individual). The selection of appropriate measures is critical. Appropriate performance measures must be statistically valid, and they should measure things over which the object of the measurement has some control. Given both the large number of patients needed to meet statistical standards and the environmental influences on health status (ie, factors often outside of the physician's control), outcome measures should only be used to assess progress in whole populations of people.[ii] Process measures are appropriate for evaluating a clinic, hospital, or health system's performance (assuming adequate patient population size). For example, process measures could assess whether a clinic has systems in place to ensure that immunizations, screening tests, or hemoglobin A1Cs for diabetics are offered and tracked.

  Given the need for statistical validity and the limitations of current measurement techniques, performance or quality measures cannot be used at the individual physician or clinician level. Rather, the performance or competency of physicians and other clinicians must be evaluated through other means discussed below.

  The task force suggests that the MMA take a leadership role in working with stakeholders to identify and disseminate appropriate outcome and process measures that can be used for system improvement and to aid in improved decision making by all stakeholders. In general, the task force suggests the following:

  - Consumers should help to articulate what their information needs are. There should be public reporting of appropriate measures that consumers would find useful to help them make better decisions;
  - Measures useful to provider systems for purposes of quality improvement should be fully disclosed and reported back to them;
  - Organized medicine and individual medical groups should be consulted in the development of measures for accountability and improvement;
  - The role of government should be to partner with the private sector in the use of measurement for purchasing and to support measurement at a communitywide level through incentives and regulation; and
  - Criteria to be used for selection of measures should include whether good evidence exists and whether an opportunity for savings or other societal benefit exists if performance improves on a measure.

ii. Methodological challenges are real; consider this telling example from David Eddy: "The low frequency of certain outcomes has big implications for the sample size needed to measure a meaningful difference in outcomes across plans. If breast cancer mortality were to be used as a measure of breast cancer screening, a population of about 2 million women would be needed to find that size difference in mortality. The median-size health maintenance organization (HMO) has fewer than 10,000 women over age 50, which makes this measure impossible to use for comparing the quality of breast cancer care." (Eddy D. Performance Measurement: Problems and Solutions. Health Affairs. 1998;July/August:7-25.)

- *Support simplified quality measurement and reporting transactions.*
  It is important to eliminate duplicative reporting and measurement efforts. Data should be collected only once in the process of clinical care, measurement, and reporting. A single, common data set for quality measurement should be adopted. The MMA should work to facilitate the transition from manual to electronic chart abstracting.

Develop payment systems to support quality practice.

- *Support payment processes that financially reward the implementation of guidelines, registries, and other efforts to improve quality of care.*
  Significant national and local attention is being paid to the notion of "pay for performance." The intent of this concept is to financially reward those health care providers who are delivering care (for some subset of selected diseases or conditions) above some level identified, generally by health plans or purchasers. The task force notes that despite the rush to adopt such techniques, there is little or no evidence to indicate whether they will achieve the desired improvements in quality that all seek.

  The task force believes that its model for the future will eventually make the concept of pay-for-performance moot because patients will decide for themselves about the value offered in terms of performance and cost. However, in the short-term, employers and third-party payers appear to see the need to make value-based decisions on behalf of consumers and are moving to adopt some pay-for-performance models. Until the desired health care system that is described in this paper is achieved, the task force recommends that the MMA advocate for pay-for-performance models that reward near-term provider actions that would build their capacity and systems for efficient, effective care—the installation of electronic medical records, computerized pharmacy order-entry systems, clinical decision-support systems, disease and case management, team-based care, etc. The task force also believes that it is reasonable for the MMA, in the interim, to support models that appropriately reward process improvements (eg, documentation of appropriate recommendations made to patients). Given the limitations outlined earlier, the task force does not believe that the MMA should support pay-for-performance models that link payment with patient outcomes.

Ensure the safety and quality of health care.

- *Leverage existing quality-improvement work.*
  As the Minnesota Citizens Forum on Health Care Costs report documented, there is a tremendous amount of quality improvement activity already underway in Minnesota. Enough money is being spent already to fund an aggressive quality improvement agenda for the state. Much more could be accomplished if the activities were more efficiently organized and connected. Elimination of duplicate efforts would reduce wasteful spending on administrative functions and allow these precious resources to be better spent for direct patient care or funding of more critical needs. The task force believes that the MMA could serve an important function in integrating the various activities and in identifying those efforts that would benefit from MMA involvement.

- *To protect the safety of patients, the competency of heath care professionals and institutions must be ensured.*
  As discussed above, at the present time, statistical quality measures cannot be fairly applied at the individual physician level. Instead, physician competency is assessed by methods such as state licensure and board certification. Board certification, in particular, is undergoing significant transformation. More emphasis is being placed on ongoing demonstration of performance rather than knowledge alone. The task force believes that the MMA could serve as a resource for ensuring physician competency and should consider supporting uniform disclosure of physician training and competency, as well as the disclosure of facility capability. As the new market system evolves, the role of various stakeholders in ensuring competency will need to be re-evaluated.

Financing the Future System

The task force believes that the recommended model for reform would eventually produce a more efficient system at all levels. However, up-front investments will be needed for covering the uninsured; building the information infrastructure; directly financing medical education and research; and creating new capacity for consumer education and support. The task force suggests some ideas both for the redistribution of current expenditures and for raising new revenues. Some of these ideas are existing MMA policy (eg, raising the tobacco tax); others deserve further study and debate. The task force suggests that as this reform proposal or key elements of it begin to gain traction, full cost and savings estimates be done by qualified researchers. In the meantime, financing ideas such as the following, which are offered for discussion purposes and not as specific recommendations, could be part of the community discussions:

- *In general, the financing mechanisms must be broad-based, including reliance on progressive taxation systems.*
- *The cost of financing the needed subsidies for low-income Minnesotans could be partially recovered by capping the tax deductibility of health benefits at the essential benefit set level.*
- *Much more transparency in the system is needed to track where savings are being generated and captured.*
- *Cost savings from quality and efficiency improvements could at least partially be redirected into expanded access, system infrastructure needs, and prevention efforts with much longer-term payoff.*
- *Competition among health insurers could redirect some administrative spending into investments to improve care processes and system infrastructure.*
- *Government could redirect some of its current investments in capital improvement to prioritize building the information infrastructure.*
- *Although the issue was discussed only briefly, most task force members expressed more support for market influences determining the distribution of supply rather than regulatory forces.*
- *Mechanisms to directly and adequately fund the costs of medical and other health professional education and medical research, must be developed. The cross-subsidies and market disadvantages are now borne disproportionately by certain health systems that we rely on to provide these essential public goods. The more competitive market model advocated by the task force will exacerbate these problems unless a new financing method is developed.*
- *Taxes on products with correlations to health risks could be raised (eg, tobacco, alcohol, snack foods, fast food). Such taxes not only generate revenue but also create price disincentives for use or overuse and help consumers to appreciate the connection between their own behavioral choices and the cost of health care.*

Issues Outstanding and Needing Development

Although the task force addressed numerous issues in the course of its deliberations, it did not have time to fully explore all of the important issues that affect the current health care system. Some of these issues are long-standing concerns, and others are questions prompted by the new model itself.

- *The mechanics of the new payment model(s) for physicians, facilities, and other providers. Much more specific work is needed to translate the task force's general ideas on what to do differently into how to do it. This will be of major concern to other stakeholders.*
- *Implications of the model on underserved communities, including low-income and vulnerable populations. How will access be ensured for these groups? Even in a competitive system, physician prices will always be too high for some simply because the demand is high, supply is limited, and the need is immediate. The task force talked generally about requirements that could be placed on plans and/or providers to ensure that care would be available to these populations, but this issue needs to be addressed with other stakeholders from the outset.*

- *Identify and address the unique issues facing rural communities. The implications of the proposed changes in insurance and care delivery markets must be evaluated. For example in rural (and also in inner-city) areas, where retention of providers and delivery systems is an issue, payers should provide stable support. The MMA should work with payers to prevent the creation of artificial competition that would drive providers from markets because of new payment systems.*
- *Long-term care financing merits attention. In general, the systems of acute and long-term care cannot remain as artificially separated as they are today if the goal is to create a system that better meets the needs of an aging population facing greater burdens of chronic disease.*
- *An improved and better-coordinated health care transportation infrastructure, including recent efforts to develop a trauma system for Minnesota, is needed to improve care delivery and remove barriers to access to care. The MMA could explore ongoing issues of concern, including payment policies that require transportation to the nearest medical facility.*
- *Identify separate and distinct funding streams for health professional education, research, and patient care. The MMA's prior work in this area should be updated and specific recommendations developed. The urgency of this problem is growing.*
- *Consider specific cost drivers such as pharmaceuticals. The task force discussed pricing and other national policy issues; but at the state level attention should be focused on ways to support appropriate prescribing and patient education.*
- *The appropriate standards of care at the end of life need to be discussed by the broad community, especially as technology marches on.*

Recommendations for Moving Reform Forward

Communicating vision and building consensus for a new model

Pursuing fundamental change will take years and will not be accomplished by the MMA in isolation. The best chance for success is to share and communicate the vision articulated in this report and invite others into the conversation. Rather than advance all of the concrete proposals immediately, the MMA should work to make sure the concepts it wants to get across are clear. It should then embark on a campaign to build enthusiasm for the possibilities, position the MMA as a leader and a resource to the community, and recruit partners. Some of the specific tasks to be undertaken include the following:

- *Convene discussions on the mutual responsibilities/principles framework.*
- *Convene discussions on how the proposed new model would change the role of key constituencies (physicians, care systems, professional organizations, health care consumer/advocate groups, employers, health plans, government, patients).*
- *Further explore the essential benefit set concept in partnership with others. Study emerging literature on the topic, talk to other states, etc. Explore how such a model could be built and kept updated through a physician-led discussion.*
- *Build coalitions to press for the needed fundamental changes.*
- *Seek waivers of federal laws that impede reform (ERISA, etc.) and seek changes in federal government tax and payment policy that distorts the market (includes Medicare geographic equity).*

Immediate MMA action

A number of recommendations contained in this report can be undertaken immediately by the MMA. Among the recommendations upon which the MMA can focus and work to provide leadership are the following:

- *Increase emphasis on prevention and health maintenance by strengthening public health policies and systems.*
- *Educate consumers and assist them in playing a more central role in decision-making and participating in care management.*
- *Assist physicians and other providers in delivering evidence-based care.*
- *Support the establishment of a medical home for every Minnesotan through changes in administrative and payment policies.*
- *Build the information infrastructure to allow collection, reporting, and dissemination of the information needed to measure and improve quality and equip patients to make cost and quality choices (this should connect clinical with claims data for all clinics, hospitals, doctors, and insurers).*
- *Develop payment systems to support quality practice.*
- *Leverage existing quality-improvement work.*
- *Make behavioral health care a part of basic medical benefits. Change health care contracts, consolidate medical and behavioral health networks, put behavioral health claims in the medical health adjudication system, support behavioral health providers giving care in the general medical sector, etc.*
- *Support efforts to improve care delivery and payment for patients with chronic and complex conditions (eg, team-based care models, payment for nonvisit care).*
- *Reduce administrative complexity and cost.*

Conclusion

The members of the MMA Health Care Reform Task Force are pleased to submit this report and the recommendations for reform to the MMA Board of Trustees. The central premise of this report is that fundamental changes in the shape of the insurance market and the economics of care delivery are needed in order to change the incentives for all parties so they are encouraged to increase value in the system. Leadership by the MMA is needed to broaden the terms of the health reform debate so that critical issues, such as covering all Minnesotans for essential services, improving quality to help control long-term costs, and ensuring maximum prevention of avoidable health risks in the broad population are addressed.

Summary of Recommendations

A strong public health system

1. Lead in making public health more prominent.
2. Coordinate action to address modifiable risk factors.

A reformed health insurance market

1. Ensure universal coverage for essential benefits
   a. Require that all individuals have insurance coverage.
   b. Identify an essential benefits package that is adequate to protect health.
   c. Ensure affordability through subsidies and targeted tax incentives.
2. Build a fairer system of spreading risk and sharing cost
   a. Require statewide community rating and guaranteed issuance for the essential benefits package.
   b. Reinsure high-cost claims.
3. Help employers make coverage options available.

A reformed health care delivery market

1. Engage patients through greater accountability for medical decision-making.
2. Create a fundamentally different economic model for medical care services
   a. End discriminatory government pricing policies.

Systems that fully support the delivery of high-quality care

1. Further increase the amount of effective care that is provided
   a. Support physician-developed guidelines.
   b. Support expansion of an improved information infrastructure.
   c. Support a "medical home" for every adult and child in Minnesota.
   d. Place the emphasis for cost control where the greatest opportunity exists—chronic care

2. Provide useful quality information
   a. Support transparency in quality measurement and reporting of system capability.
   b. Support simplified quality measurement and reporting transactions.

3. Develop payment systems to support quality practice
   a. Support payment processes that financially reward the implementation of guidelines, registries, and other efforts to improve quality of care.

4. Ensure the safety and quality of health care
   a. Leverage existing quality improvement work.
   b. Ensure the competency of heath care professionals and institutions.

Appendix A

Health Care Reform Task Force Charter

January 24, 2004

MMA Board of Trustees

Summary

There is consensus that many aspects of our health care system are broken and need reform. The Board of Trustees believes the Minnesota Medical Association (MMA) should take a leadership role in addressing these issues of health care reform. Although the MMA tackles many aspects of reform on an ongoing basis, changes in the external environment (increased focus on cost, delivery, and quality/safety) and member input point to the need for an increased focus at this time. It is hoped these efforts will not only contribute to health care system reform but also strengthen MMA influence, build coalitions, and engage members and consumers.

Charge

A Health Care Reform Task Force will be created to:

Develop and recommend a set of principles to guide the MMA's positions/actions on health care reform.

Recommend next steps for MMA involvement in health care reform.

The task force should define reform broadly and deliberations should include a discussion of health care financing, costs, delivery, access, demand/supply, insurance reform, quality, manpower, technology, and disparities across local, state, public, and private sectors.

Scope of work

Phase I

Understand current MMA policies and previous reform work.

Understand AMA policies and reform work.

Understand external viewpoints/data/recommendations on reform.

Create a vision of the desired future to help create a common understanding of the goals for reform.

Develop principles to guide the MMA.

Phase II

Recommend next steps, including

What MMA health care reform principles should be prioritized for additional policy development and advocacy?

In what areas should we lead current and future reform efforts?

With whom should we collaborate?

What current MMA policies should be changed and/or adopted?

Should the MMA develop a full reform proposal?

How should MMA principles be communicated to physicians/patients?

What education of physicians and/or patients should occur?

Task force membership

12 to 14 MMA members

Task force members (including the chair) will be selected by the chair of the MMA Board of Trustees in consultation with officers, trustees, and MMA staff. It is anticipated that task force members will need to spend a minimum of four hours per month in meetings during 2004 with additional time spent in preparation.

Communication

The task force will provide regular updates to the board, prepare a report for the 2004 MMA House of Delegates, and complete work prior to the end of 2004.

Authority

The task force does not have the authority to set MMA policy or direct action. Task force recommendations will be reviewed by the board.

Appendix B

Task Force Recommendations Compared with Other Proposals

Health Care Reform Task Force	1992 MMA Principles for Health Care Reform	Report of the Minnesota Citizens Forum on Health Care Costs (2004)	Institute of Medicine (various reports)
Quality and Measurement			
Preference-sensitive and supply-sensitive utilization and variation addressed through new model		Reduce variation	
Support appropriate transparency in measurement and reporting		Report quality	Collect data and publish reports (including national quality report)
New economic model rewards quality and value improvement (detailed work on payment systems needed)		Reward quality	New committee working on pay for performance
Patient Choice and Responsibility			
New model is fundamentally more patient-based with no limits on selection of physician/clinics	Multi-payer system better supports patient choice	Put Minnesotans in the driver's seat	
Sophisticated approach to cost-sharing by condition and evidence of effective intervention, as well as provider price	Appropriate cost sharing	Consumers need an economic stake in decisions	
Health behavior incentives allowed as adjustment to community rate; medical home supports education and decision-making	Increase incentives for healthy behavior	Incentives to promote healthy choices	
Relevant cost and quality information available to patients		Full disclosure of costs and quality	
Public Health			
Strengthen communitywide approaches to reduce risk factors	Significantly increase education on health risks and prevention	Strengthen public health approaches	Focus on the ecological model of health: behaviors, social, and economic conditions (Future of the Public's Health in the 21st Century)
Reaffirm support for public health policy positions and point out the connection between health care cost and access debates	Reduce tobacco use		Need for a strong infrastructure for emergency preparedness

Appendix C

Current and Future (Potential) Stakeholder Roles in Creating Value

	Current	Future (Potential)
Patient/Consumer	• Chooses plan based on coverage levels, provider access, premium price • Seeks service • Pays co-pay (if any) • Feels entitled to covered services • Pays nothing or full price (no discounts) if uninsured • Pays higher co-pays for behavioral health services • Chooses physicians based on referrals or word of mouth	• Chooses plan based on price, quality of administrative services, availability of information to support provider choice, shared treatment decision making, prevention and care management • Seeks services from any provider with no plan restrictions • Chooses physicians based on quality and cost information (may face cost differentials based on level of coverage and physicians' prices)
Physician/Provider	• Provides service • Is paid primarily at negotiated (imposed) rate • Provides care to uninsured either charged at full rate or as uncompensated care (occasional individual arrangements negotiated with selected providers)	• Advises patient on treatment options • Provides service • Sets same price for all patients (percent of bill paid by patient versus plan may vary among plans) • Strives to improve safety, effectiveness, efficiency of care • Improves outcomes and develops expertise on which to compete • Provides information about cost and quality
Employer	• Selects plan(s) and products • Determines contribution levels • Restricts or opts out of behavioral health coverage	• Selects plan(s) to administer essential benefits • Chooses whether to provide additional coverage • Determines contribution levels • Provides incentives and programs for health risk reduction/wellness (eg, employer pays enrollee and physician to complete a health risk appraisal and rewards both for improvement over time)
Health Plan	• Designs multiple benefit packages • Sets coverage criteria • Determines provider network • Effectively sets provider's price/payment • Is primarily concerned with control of unit prices • Supports independent behavioral health pricing, access and service limits, and co-pays	• Administers standard benefit set • Uses standard clinical guidelines • Does not define provider network, but assists consumers in finding a medical home and in maximizing the value of their dollars • Negotiates payment rates to providers but doesn't limit prices • Shifts payment toward episodes of care or care for ongoing conditions • Provides information and other support for providers to improve care • Charges a community-rated premium for essential benefits • Continues to design and offer supplemental products • Provides information to enrollees to help them maximize value • Participates in statewide reinsurance pool for all its products
Government	• Focus on setting artificially low prices per unit cost • Shifts costs to other payers • Adds layers of regulation • Adopts benefit mandates	• Ensures a well-functioning market • Protects against anti-trust violations • Provides tax incentives for coverage • Pays plans and providers a reasonable rate • Subsidizes coverage for people with low incomes and ensures access • Supports the information infrastructure with funding, incentives, regulations • Promotes streamlined reporting • Does not impose mandates for ineffective care • Ensures a strong public health system • Uses policy tools to reduce health risks

Appendix D

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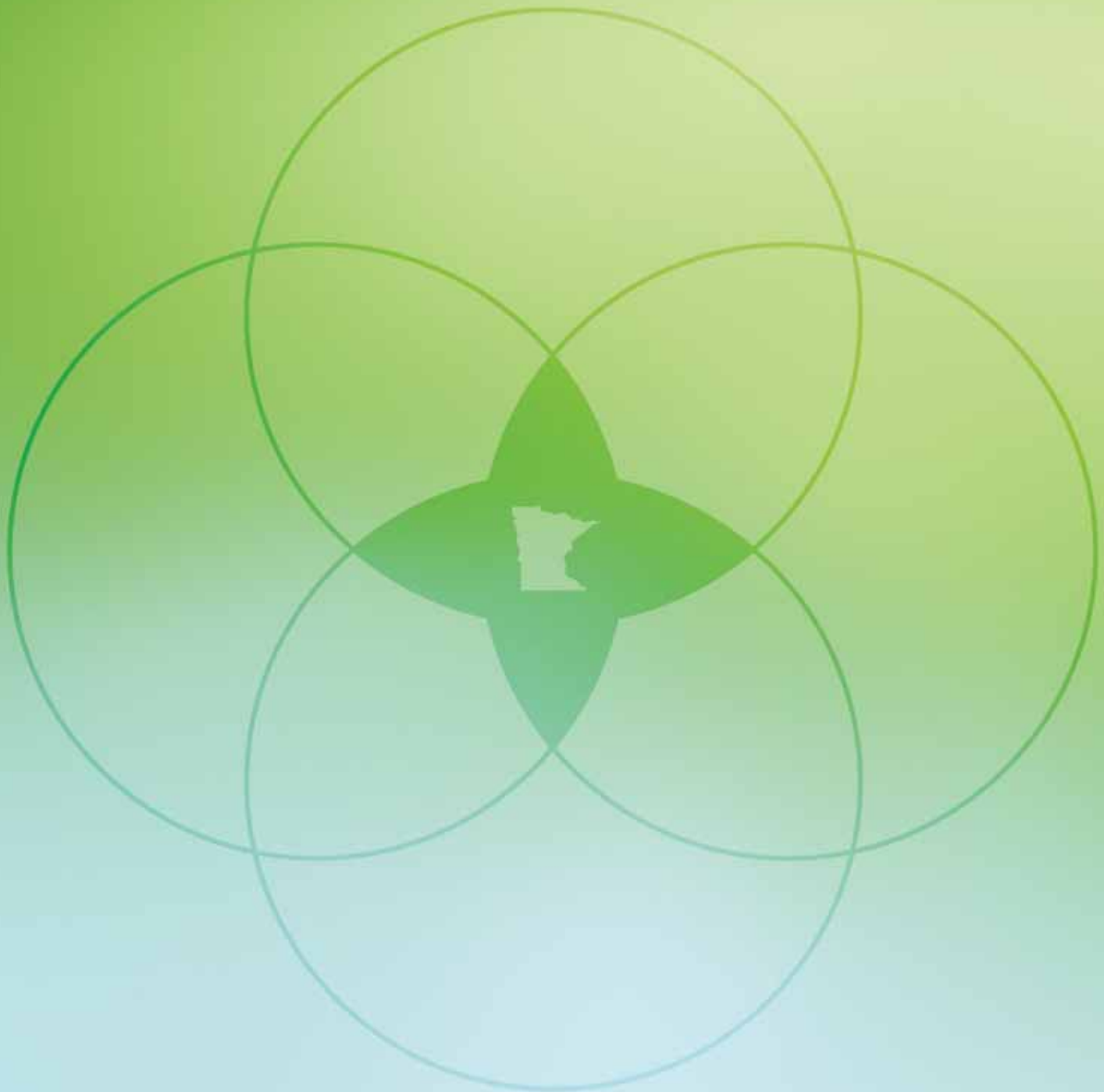

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