

HEALTH CARE BACKGROUND

Minnesota is a national leader in health care. We have the lowest rate of uninsured individuals and one of the healthiest populations. We should be proud that we are ahead of the curve, but our health care system in Minnesota and the rest of the United States is far from healthy. The high cost of health care which leads to high health care insurance premiums is a significant concern for Minnesota employers. Employers have been faced with double-digit or near double-digit increases for several years. Health insurance premiums have increased significantly above the consumer price index and health plan spending per enrollee grew about 2.7 times faster than average wages, 2.3 times faster than per-capita income, and 5.6 times faster than inflation¹.

A majority of Minnesotans receive their health care benefits from their employer but it is becoming increasingly difficult for employers to continue to afford to offer this benefit. In Minnesota, group coverage dropped from 68.4 percent in 2001 to 62.9 percent in 2004². Many employers have been forced to make trade-offs between health care benefits and wage increases, not offering health care benefits, or asking employees to pay a greater share of their health care costs. In 2000, the average health plan enrollee out-of-pocket cost was approximately 10.1 percent of total spending per enrollee, in 2005 that number grew to 14 percent³.

Employers cannot and should not wait for a federal solution to address health care cost and access. Minnesota must take steps to address the cost of health care.

Several factors are contributing to the growing cost of health care.

Quality

We like to think that America's medical system is the best in the world. Yet, the Institute of Medicine reports that 20 percent to 30 percent of health care spending is the result of poor quality. The IOM study estimates that 50,000 to 100,000 people die every year of medical mistakes in hospitals. A RAND study found that only 50 percent of patients received recommended care regardless of socioeconomic status. Outright errors are just one component of poor quality. Underuse and overuse of medical technologies and services are also prevalent.

There is also significant variation in care. For example, diabetic care in Minnesota varies greatly by clinic. Clinics are being measured by the number of their patients who reach all D5 goals, a set of five treatment goals that, when achieved together, represent the gold standard for managing diabetes. Clinics ranged from 0 percent of patients meeting the D5 goal to 36.1 percent of patients reaching the goal. Reaching all five goals greatly reduces a patient's risk for the cardiovascular problems associated with diabetes, thus reducing the need for more costly care.

We are spending a lot of money on health care in the United States without demanding better quality. According to a report released by the McKinsey Global Institute in January 2007, our health care system is higher in cost and lower in quality than most other Organization for Economic Co-operation and Development (OECD) countries. We spend \$477 billion more than peer countries on health care, even after adjusting for our higher per-capita income.

Lack of consumer engagement

The McKinsey report points to the fact that our health care system does not provide incentives for patients and consumers to be value-conscious in their demand decisions as one of the main reasons for the high cost of health care in the United States. Services are provided and priced in ways that are unintelligible to consumers which prevents cost and quality comparisons in ways that would be meaningful. Consumers remain divorced from the cost of health care, mainly insulated by third-party payers.

Employer-based health insurance benefits, including first dollar coverage and prepaid coverage, insulate consumers from the true cost of care. When consumers are shielded from the true cost, it often leads

them to consume more services than they otherwise would and increases the overall cost of care. For example, consumers often have nominal or no out-of-pocket cost associated with routine office visits, diagnostic testing, prescription drugs and treatment. This tends to expand demand for these services.

To create a value-driven health care market, employees and consumers need information about the quality and cost of health care. Individual consumers of services also must be given sufficient incentives to be more cost and value conscious in their selection and utilization of services, and to reduce the need for such services through healthier lifestyles and preventive care.

In order to bridge the divide between price, quality and consumption, consumers and purchasers need information on price and quality of services. For consumers to begin to make sound economic and quality of care decisions, it is essential that they have information on how plans, clinics and hospitals compare on items such as price, quality indicators, patient satisfaction, cost control, disenrollment rates and grievance and appeals procedures. Employers are distinctively positioned to encourage consumer demand for safe, efficient, evidence-based health care by providing employees access to quality information and incentives for selecting "better" providers.

There is increasing evidence that public disclosure of provider performance is resulting in clinical quality improvements. For example, the New York state Cardiac Surgery Reporting Initiative has led to a 41-percent drop in risk-adjusted mortality in the state over three years. Internet-based tools that assist consumers in choosing a physician and a hospital based on quality and preference indicators are growing in popularity. Minnesota health care purchasers have taken a strong leadership role in promoting Leapfrog and patient safety reporting, standards and initiatives. The Minnesota Hospital Association, with support of the purchaser community and the Minnesota Department of Health, passed legislation during the 2003 Minnesota legislative session that initiates hospital patient safety reporting and lays the foundation for broad based reporting of patient safety events.

Employees should be encouraged to utilize existing measurement tools to access information about health care costs and quality, including the Community Measurement Program (www.mnhealthcare.org) and the State information website at www.minnesotahealthinfo.org.

Skewed Incentives

There is very little incentive in our health care system to reward excellence. Providers are paid based on how many procedures they do, not on the quality of the medicine they deliver. Mediocre providers are compensated the same way as top performing providers. Purchasers contribute to this problem by often making decisions solely based on price without examining plan and provider performance.

In addition, there are economic disincentives to improve care and no accountability for results. Today, bad outcomes can result in increased revenue for providers. Avoidable admissions generate revenue for doctors and hospitals. Complications require additional care generating additional provider income. In the current system, providers who invest in improvements in care actually face economic loss. For example, St. Mary's Duluth instituted a heart failure program that reduced heart failure hospitalizations by 82 percent, length of stay by 81 percent, and emergency room visits by 88 percent. They were rewarded with financial losses by our current system.

Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going toward health. Value-based purchasing focuses on incenting the use of health care resources to reduce inappropriate care and to identify and reward the best-performing providers. There are several ways that purchasers can reward providers including fees, volume, performance profiling, shared savings contracts, public recognition and selective contracting.

Government health care mandates and taxes

Minnesota imposes more mandates on health care coverage than every other state, with 63 mandates, far more than most other states⁴. Many of these mandates benefit only a handful of patients with costs borne by the rest of the enrollees.

Mandates are generally “cost-less” to state legislatures since they affect insurance policies paid for by employers and individuals and do not require a direct appropriation. The common tendency, therefore, is to keep adding mandates, resulting in a very generous package that costs more than most consumers are willing to pay. In fact, benefit mandates drive up the cost of health care and it is the premium payers, both employers and employees who actually pay for mandates, not the insurance companies.

Easing regulations concerning benefit mandates and coverage limitations could stimulate innovation and allow more competition between health plans. It also would encourage consumers to become more engaged in the market and allow the market to respond to current purchasing demands. The Minnesota Legislature should repeal existing mandates where the benefits do not outweigh the costs.

The state of Minnesota collects four different health care taxes (Minnesota Comprehensive Health Assessment, premium tax, provider tax, Medicaid surcharge) adding between 5.8 percent and 6.68 percent to health care premiums. Finding a broader funding source for health care taxes would eliminate the current inequitable tax treatment between purchasers of insured products and others.

- **The Minnesota Comprehensive Health Association.** MCHA is a state-created insurance risk pool for high-risk individuals. It is the largest such pool in the country. The purpose of this program is to serve as a “safety net” insurance plan for individuals denied coverage in the private market. Funding for MCHA comes from two sources: 1) premiums which can be no more than 125 percent of the average premium for individual policies sold in Minnesota, and 2) an assessment on commercial insurance premiums. Currently, this assessment is more than 2 percent of premiums. Premiums produce approximately 46 percent of MCHA’s funding. The assessment covers the remaining 54 percent, totaling an estimated \$91 million in 2003. State funds have sometimes been used to offset MCHA’s losses (1998, 1999, and 2001).
- **Provider tax.** The revenue collected goes into the Health Care Access Fund (HCAF) to support MinnesotaCare, a program to support low-income children and adults. From 1994 to 1997, the state taxed gross revenues for patient services at a rate of 2 percent. Between 1997 and 2003, the Legislature provided general fund offsets to lower the provider tax to 1.5 percent. The rate returned to 2 percent in January 2004.
- **Premium tax.** All indemnity insurers in the state must apply a 2-percent premium tax on the cost of health insurance premiums. This money is deposited into the general fund. Similarly, a 1-percent gross premium tax has been placed on nonprofit HMOs and Blue Cross/Blue Shield. These revenues are deposited into the Health Care Access Fund. Between 1998 and 2003 there was a surplus in the HCAF, and the Legislature chose to “blink off” this tax. It was reinstated at 1 percent in January 2004. Premium taxes are bad tax policy. A direct premium tax on insurance cannot be equitably applied to all Minnesotans and penalizes consumers and purchasers for buying health insurance.
- **Medicaid surcharge.** The MA surcharge was enacted with the support of Minnesota’s hospitals in 1992 as a way to enhance federal payments to Minnesota and avoid state cuts in payments to hospitals. However, after Minnesota enacted the MA surcharge, Congress passed legislation that undermined the intent of the Legislature’s 1992 law. As a result of this federal change, most Minnesota hospitals, nursing homes and health plans, are now net losers under the MA program and must make payments to the Department of Revenue in excess of any payments they receive. Hospitals are expected to pay more than \$50 million in MA surcharge taxes.

Health care mandates and many of the health care taxes only apply to the fully insured market, which is now only 27 percent of the market and getting smaller. This group is made up of mainly small and medium-size businesses and individuals that do not have the resources to self-fund. State-imposed mandates and taxes, with the exception of the provider tax, do not apply to the self-insured market.

Continuing to add mandates increases the cost of health care insurance for businesses making it increasingly difficult for those who want to continue to attract and retain good employees by offering health care benefits.

A broader funding base is needed for the MCHA program. The same 27 percent of the market that is faced with increasing costs due to insurance mandates also bear the entire burden of the MCHA assessment. A broad-based tax would provide a more stable funding base for the MCHA program. This will ensure that the most vulnerable of Minnesotans who cannot obtain coverage in the private market will continue to have access to health care. The state also should explore alternative options to deal with high-risk individuals, including those within small employer plans.

Increased prescription drug costs

Rising prescription drug costs are a major contributing factor to rising health care costs. Total private insurance spending grew by 9 percent between 2002 and 2004 and prescription drugs accounted for 21.8 percent of that 9-percent growth⁵. Three factors contribute to the increase in drug expenditures: utilization accounts for 43 percent of the change, types of prescriptions used accounts for 36 percent of the change and increase in price accounts for 21 percent of the change. Utilization grew faster in Minnesota than nationally.

Prescription drug coverage has become the norm for employment-based coverage. According to the Kaiser Family Foundation, 98 percent of employers who offer health care insurance offer prescription drug coverage. As a result of employer-based coverage, people pay significantly lower out-of-pocket cost for drugs. This shift in insurer payment for prescription drugs has been an important factor influencing the growth in prescription use and expenditures. On the other hand, it may be the case that use of prescription drugs lowers health care costs as they frequently reduce or replace more expensive forms of medical care.

For those without access to prescription drug coverage, individuals can access many programs in Minnesota that help them pay for necessary prescriptions. The following programs currently provide prescription drug coverage to Minnesota's citizens: Medicaid, MinnesotaCare, GAMC, the Minnesota Prescription Drug Program (for seniors and the disabled), and Minnesota Comprehensive Health Care Association. In addition to these state programs, many pharmaceutical companies offer discount or coverage programs to Medicare enrollees. There are also private-sector discount programs available to eligible citizens. In addition, many pharmaceutical companies offer prescription medicines free of charge to patients who might not otherwise be able to afford needed medicines. In 2003, the Legislature created a clearinghouse program for prescription medications. The Minnesota Board on Aging administers the program called RxConnect. RxConnect will assist individuals in obtaining needed prescription medications through existing private-sector free, discount and coverage drug programs sponsored by pharmaceutical manufacturers.

Employers are reacting to increases in prescription drug spending. The percent of covered workers with tiered prescription drug benefit coverage increased from 28 percent in 2000 to 89 percent in 2005. The average co-payment for brand name drugs with generic substitutes increased from \$16 in 2000 to \$35 in 2005.

Cost shifting on to private market due to public policies

Cost shifting is a pricing structure that compensates for losses created by the under-reimbursement of services for some patients with higher rates for others. Health care taxes, state mandates and caring for the uninsured all contribute to cost shifting.

- ***Inadequate Medicare and Medicaid reimbursement:*** Nationally, Medicare payments to physicians and hospitals are 70 percent of private patient payments, and Medicaid payments to hospitals and physicians are 63 percent and 45 percent of private payments, respectively, according to the Congressional Budget Office. In 2000, Medicare patients provided 35.7 percent of the business conducted by Minnesota hospitals. The Minnesota Hospital Association notes that reimbursement rates for these patients averaged 11.2 percent below break-even cost of services.

Managed care reimbursement levels averaged 8.3 percent above cost, commercial/nonprofit rates averaged 27.3 percent above cost, and self-pay and other rates averaged 22.3 percent above cost. By 2003, the Congressional Budget Office estimates that \$108 billion will be shifted from Medicare and \$87 billion from Medicaid onto the nation's private sector if health care reform is not undertaken. However, the ability of providers to shift this cost onto the private market has been restrained in the past five years by changes in contract terms with health plans that have limited fee increases for providers.

- ***Caring for the uninsured:*** In 1991, the uninsured in this country caused \$20.3 billion to be shifted to paying patients. Without health care reform, the Congressional Budget Office estimates that figure will reach \$53 billion by 2007. Uncompensated care in Minnesota is estimated to be \$188 million. While Minnesota's per-capita expenditures were \$3,528 or 82 percent of the U.S. total of \$4,309 in 1999, insurance premiums over the past several years have been higher than the national average. Cost shifting has been a significant contributor to this trend.

New technology

Information technology is a critical enabler for high quality, high value health care. Health care lags in 21st century information technology. More than 90 percent of an estimated 30 billion health care transactions still are conducted by phone, fax or mail every year. Many records are primarily kept on paper, and most systems are unable to talk with each other. This adds complexity, duplication and bureaucracy to the health care system.

Recent studies conclude that an electronically connected health care system would save nearly \$350 billion over the first 10 years and \$112 billion every year thereafter. The Minnesota Department of Health has estimated the savings to be \$140 billion per year. The Agency for Healthcare Research and Quality reports that implementing bar-code technologies nationwide would result in annual savings of \$15.3 billion. E-Health Initiative estimated that in 2005, e-prescribing could prevent more than 2.1 million adverse drug events and 190,000 needless hospitalizations nationwide each year.

On April 27, 2004, President Bush signed an executive order calling for widespread deployment of health information technology within 10 years to facilitate substantial improvements in safety and efficiency. The Office of the National Coordinator for Health Information Technology was established to build collaboration among the public, private and nonprofit sectors. Federal policy solutions include Regional Health Information Organizations, a national health information network, and a strategy to promote adoption of electronic and personalized health records by providers and consumers. In January 2005, the Minnesota Department of Health issued its roadmap and preliminary recommendations for Minnesota's e-Health Initiative.

An interoperable health information technology infrastructure would:

- Deliver relevant personal data, clinical guidelines and administrative information to providers and consumers.
- Foster quality improvement and reduce medical errors.
- Decrease costs by improving efficiency, reducing medical errors and coordinating care.
- Advance consumerism.
- Connect all caregiver settings.
- Assure patient privacy.

Administrative costs

Administrative costs account for 10.1 percent of health plan commercial spending in Minnesota⁶. This does not include administrative expenses incurred by providers, which also are excessive and add to the cost of care. Improving the integration and efficiencies of our health care systems could help lower costs.

Improvement in the way health care is delivered, paid for and used can occur through more uniform and standardized means to communicate customer and consumer expectations. Employing standardized

value-based purchasing specifications and requiring common system applications could help eliminate redundancy in care delivery and administrative costs.

Adopting state-of-the-art information technology such as standardized electronic health records and smart card technologies will help reduce health care costs and improve quality of care. Research by the Markle Foundation estimates that the United States could save \$125 billion just by adopting technology that eliminates unnecessary paperwork. Using computerized order entry has been shown to reduce error rates by 55 percent in less than a year.

Wellness

Chronic diseases are among the most prevalent, costly and preventable of all health problems and account for approximately 80 percent of total annual health care spending. Prevention of chronic diseases presents a huge opportunity to lower health care expenditures. Chronic diseases are attributed to three main risk factors:

- **Obesity:** Annual direct medial costs of modifiable health risk = 1.31 billion in Minnesota.
- **Tobacco:** Annual direct medial costs of modifiable health risk = 1.98 billion in Minnesota.
- **Physical Inactivity:** Annual direct medial costs of modifiable health risk = 495 million in Minnesota.

Employers are playing an increasingly large role in wellness by instituting wellness programs in the workplace. Wellness programs are focusing on smoking cessation, physical activity and nutrition in order to prevent obesity and other chronic diseases. These programs should be promoted and expanded in the community. A competitive marketplace has developed around wellness and with continued education and a proven return on investment for wellness programs, this market should continue to grow and thrive.

Limits on managed care

New laws restricting what health plans can do to manage costs and the public appetite to relax managed care practices have increased utilization and costs. As consumers face new issues in the health care coverage debate due, in part, to the growth of managed care, there has been increased pressure on legislators to respond to these changes with more regulation. Many of these proposals contain new requirements and mandates that could have a significant impact on premium costs if enacted. Only purchasers of insured products are affected by the passage of “consumer protections” due to federal ERISA laws. These are often the companies and individuals least able to afford additional cost increases.

An aging population. Older Americans consume a greater share of the health care dollar. As the American public continues to age, the cost of meeting its health care needs will correspondingly rise.

In order to re-establish a health care system that provides access to affordable health care coverage for all Minnesotans, we need to minimize state-imposed costs on the health care system, improve marketplace competition and expand product options, and re-engage consumers in health care quality and cost decisions.

¹ Minnesota Department of Health, Health Economics Program, “Health Insurance Premiums and Cost Drivers in Minnesota, 2006,” October 2007.

² Minnesota Department of Health, Health Economics Program, “Health Insurance Coverage in Minnesota: Trends From 2001 to 2004,” February 2006.

³ Minnesota Department of Health, Health Economics Program, “Health Insurance Premiums and Cost Drivers in Minnesota, 2006,” October 2007.

⁴ Council for Affordable Health Insurance, “Health Insurance Mandates in the States, 2007.”

⁵ Minnesota Department of Health, Health Economics Program, “Trends in Private Health Insurance Premiums and Cost Drivers, 2004,” August 2005.

⁶ Minnesota Department of Health, Health Economics Program, “Trends in Private Health Insurance Premiums and Cost Drivers, 2004,” August 2005.