Transformative Health Care Reform in Minnesota

An overview of health reform from the 2008 Legislative session

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Overview

- ✶ Some context for the health reform discussion in Minnesota this year
- ✶ Commission and Task Force work
- ✶ Health Reform bill components
- ✶ Next Steps

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The Context for the Health Reform Discussions in Minnesota

- Rising health care costs in the state are unsustainable
- Our health care system creates poor value and has misaligned incentives
- Private insurance continues to erode, and the number of uninsured is rising
- Health care quality is low relative to the amount spent, and unevenly distributed across the population
- The way we pay for health care services leads to distortions in the types of health care that gets delivered

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Total Health Care Spending Growth in Minnesota

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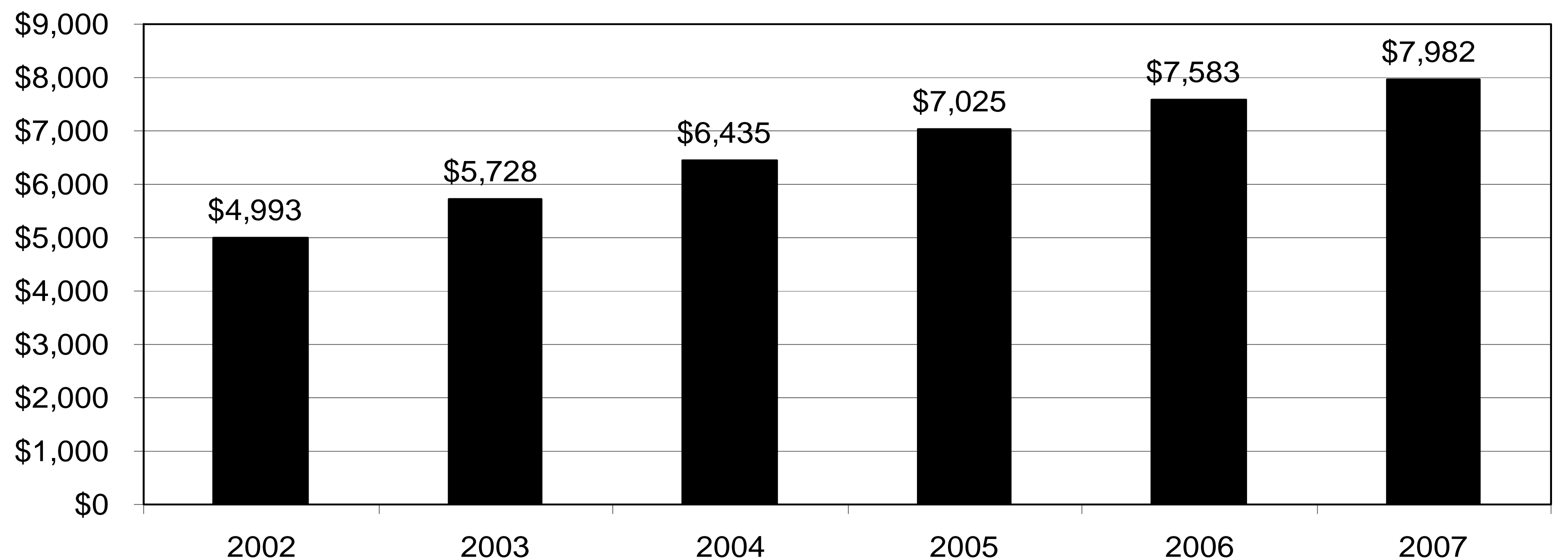
The Cost of Employer Health Insurance Continues to Climb



Source: Hewitt Associates, September 2007

Minnesota: 68% growth from 2000 to 2006; 3x per capita income; general inflation

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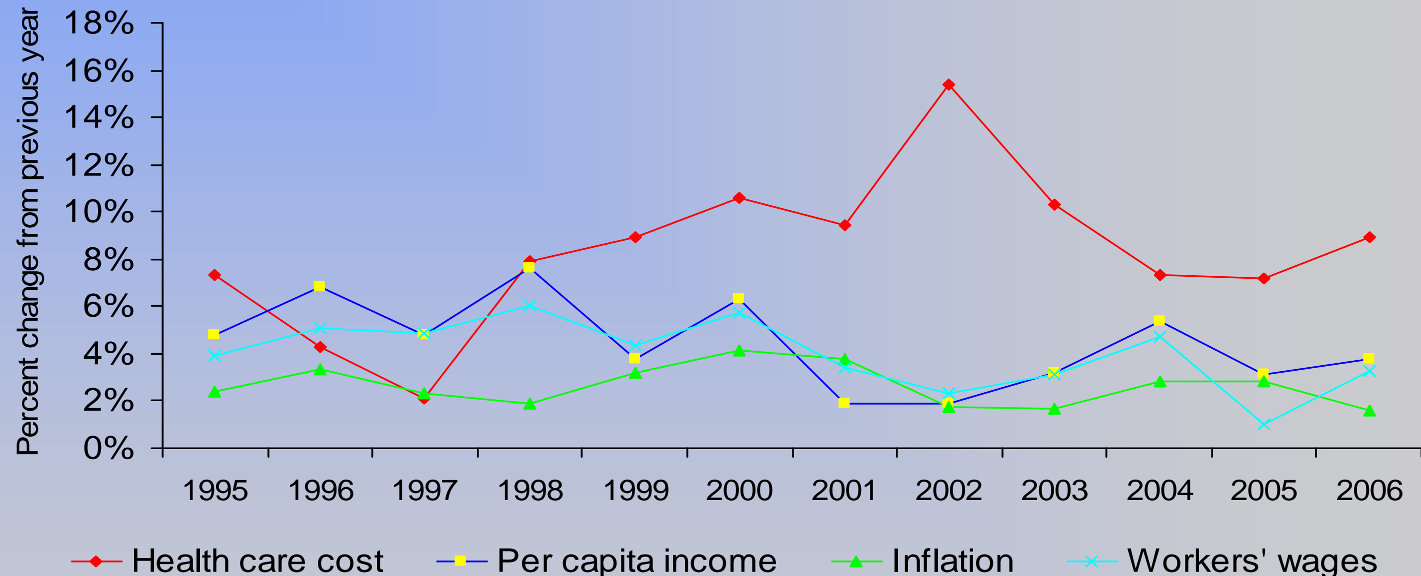
Health care cost growth in Minnesota continues to outpace growth of the overall economy



Notes: health care cost is MN privately insured spending on health care services per person, and does not include enrollee out of pocket spending for deductibles, copayments/coinsurance, and services not covered by insurance..

Sources: Health care cost data from Minnesota Department of Health, Health Economics Program; per capita personal income from U.S. Department of Commerce, Bureau of Economic Analysis; inflation data from U.S. Bureau of Labor Statistics (consumer price index); workers' wages from MN Department of Employment and Economic Development

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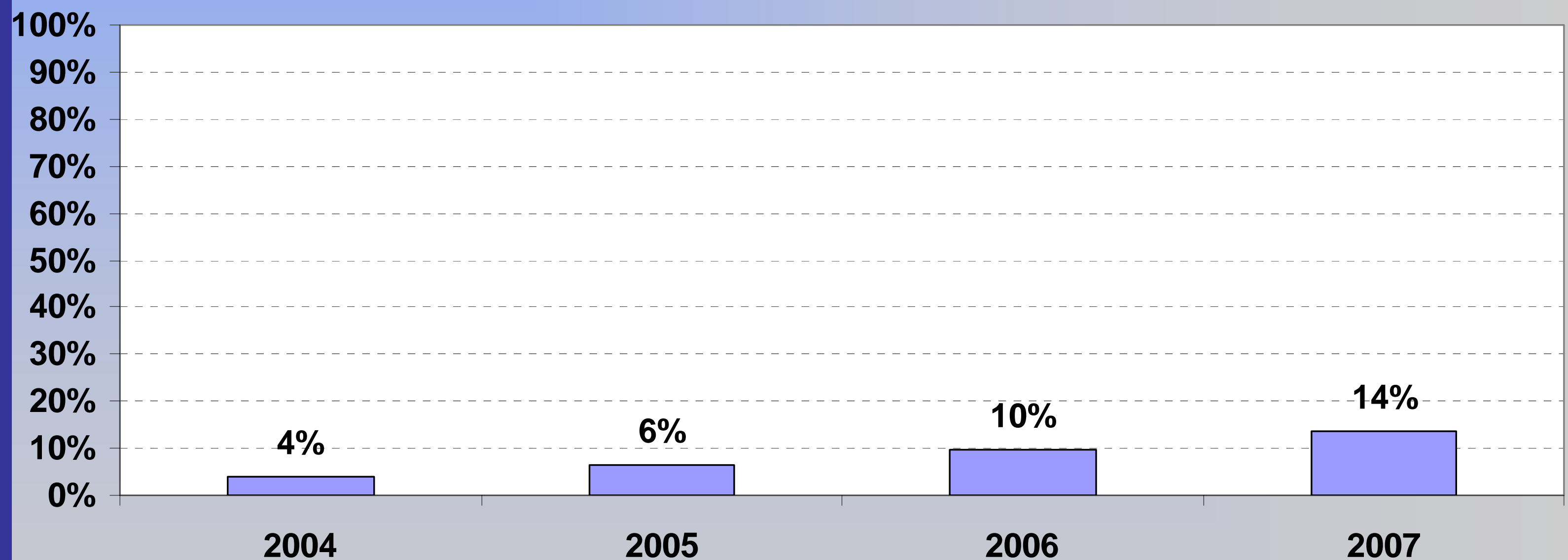
Minnesota diabetes care



Source: **MN Community Measurement Health Care Quality Report**

Minnesota health status measures

Smoking: we've made some progress

- Since 1990, prevalence of smoking decreased from 28.7 percent to 18.3 percent of population where it holds steady

Obesity: we haven't

- Since 1990, prevalence of obesity increased from 10.2% to 24.7%
- 63% of adults are either overweight or obese

Binge drinking: is too high

- High prevalence (~18%) of binge drinking

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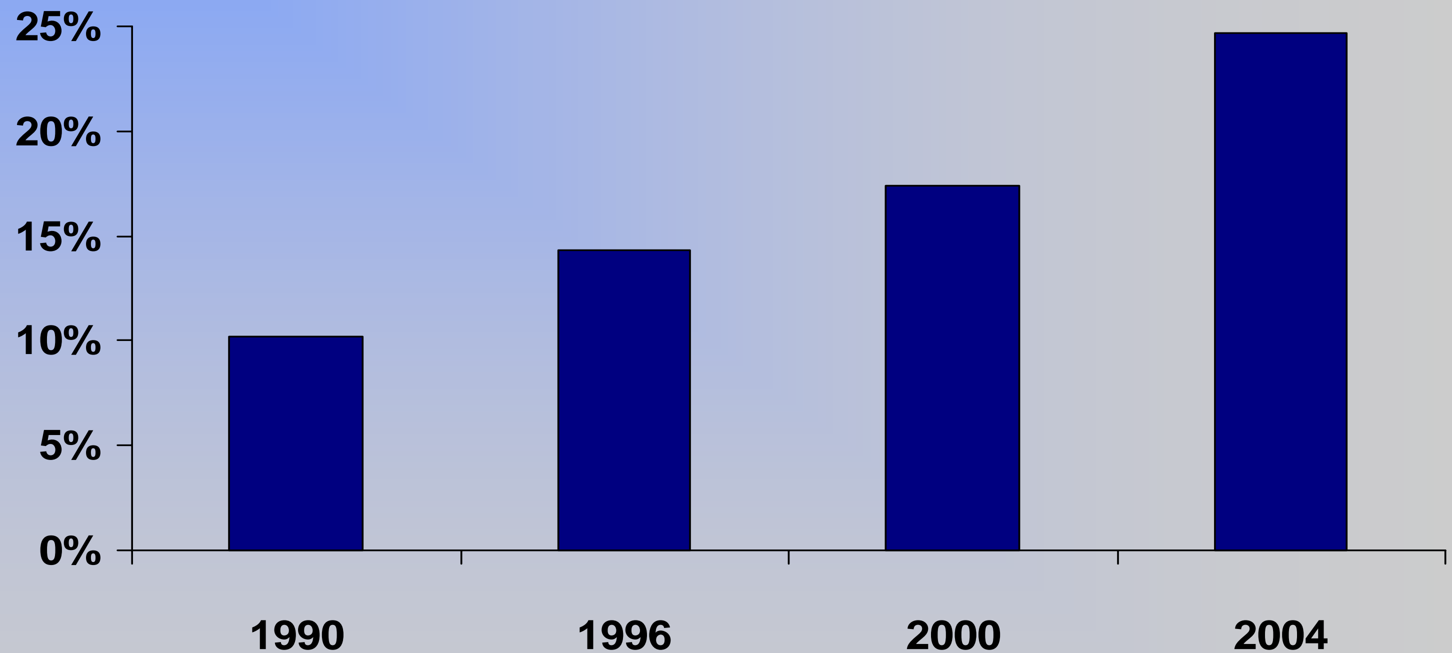
Percent of Minnesotans who are obese



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Source: Behavior Risk Factor Surveillance System

Erosion of Private Insurance

- Between 2001 and 2007:
  - Employer-Sponsored Coverage eroding
    - Percentage of Minnesotans with health insurance through an employer fell from 68.0% to 62.5%.
  - Uninsured increasing
    - Enrollment in public insurance programs rose from 21.1% of the population to 25.2%, yet the uninsurance rate also increased from 6.1% to 7.2%.

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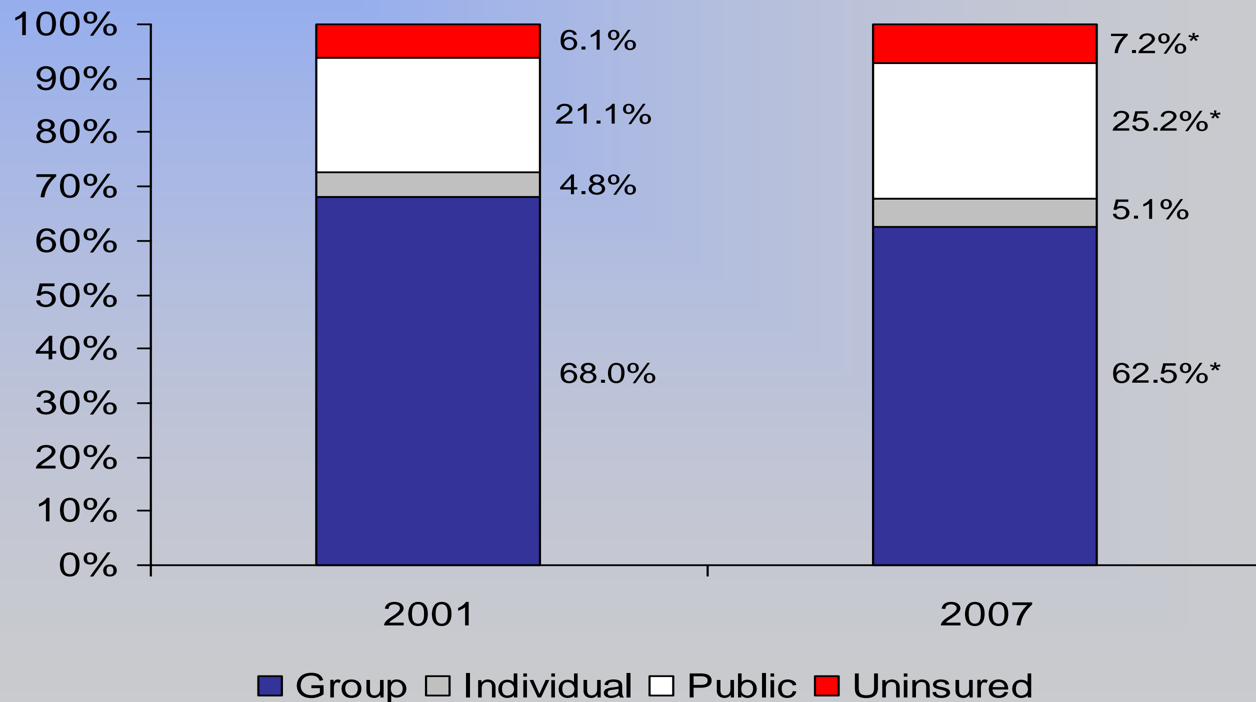
Sources of Insurance Coverage in Minnesota, 2001 and 2007



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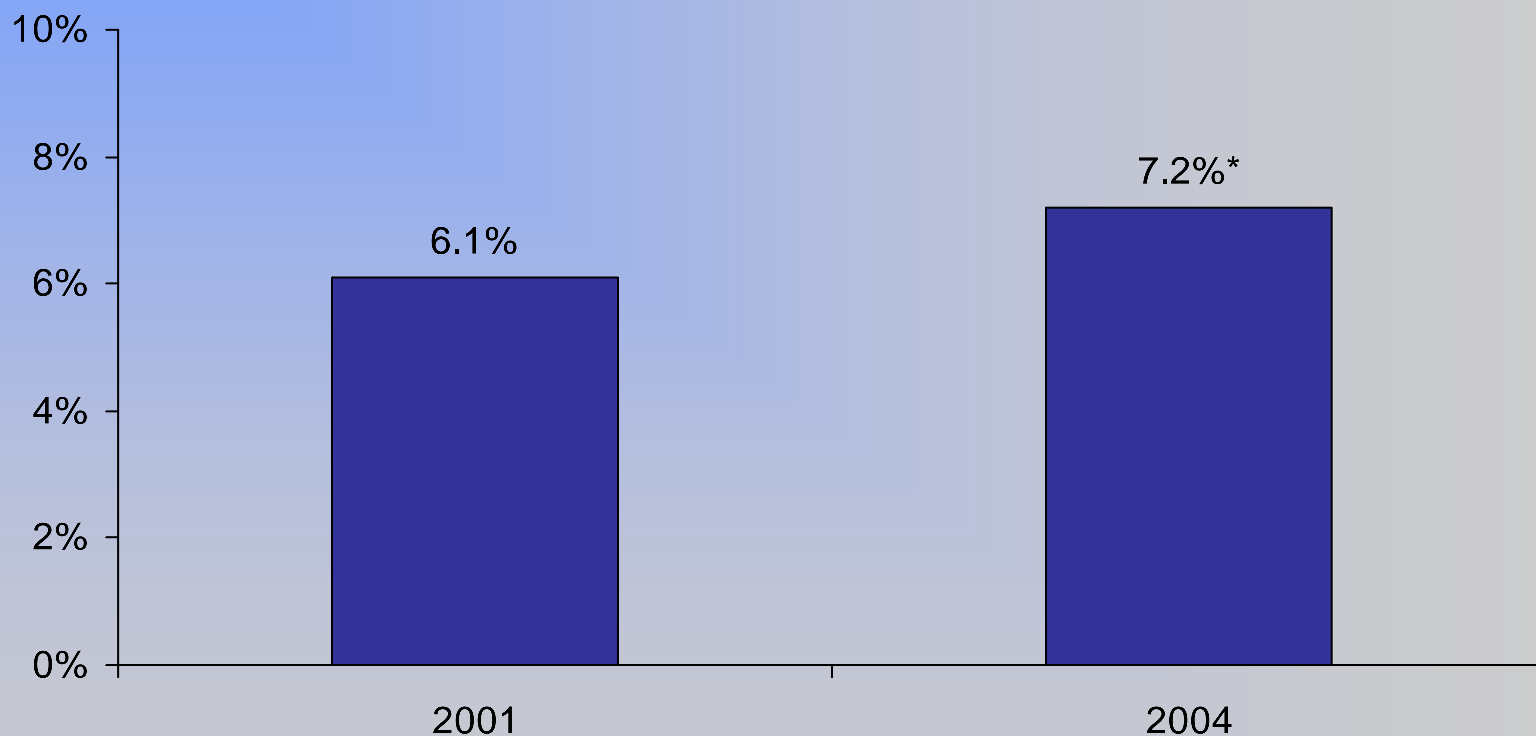
Source: Minnesota Health Access Surveys, 2001 and 2007 (preliminary). Estimates that rely solely on household survey data differ slightly from annual estimates that include both survey and administrative data.

Uninsurance Rate Trends in Minnesota



*Indicates statistically significant difference (95% level) from prior survey year.
Source: 2001 and 2007 Minnesota Health Access Surveys

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Task Forces and Commissions study health reform

- 2007 Legislature gave charges to two different commissions/task forces
  - Legislative Commission on Health Care Access:
    - Develop a plan to achieve the goal of universal coverage
    - by January 1, 2011, all Minnesota residents have access to affordable health care
  - Governor's Health Care Transformation Task Force
    - See next slide

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Governor's Transformation Task Force

- Develop statewide action plan for transforming the health care system to improve affordability, quality, access, and the health status of Minnesotans.
  - Develop recommendations to:
    - Reduce health care expenditures by 20% by 2011
    - Reduce rate of growth of health care spending to CPI +2%
    - Increase affordable health coverage options to ensure all Minnesotans have health coverage by 2011
    - Actions to improve quality and safety of care
    - Improve the health status of Minnesotans
    - Change health care purchasing strategies
    - Promote the appropriate and cost-effective investment in new facilities, technologies, and drugs
    - Actions to reduce administrative costs

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Recommendations

- ✶ Both groups produced recommendations in the late fall/early winter
- ✶ Both reports included recommendations to:
  - – Improve population health
  - – Better coordinate care
  - – Make advances in coverage
  - – Improve transparency
  - – Lower administrative cost
  - – Reform how we pay for health care

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Session Discussion

- ✶ Session produced much discussion on the issue of health reform
- ✶ General agreement on issues to be tackled; a lot of discussion on the right approach(es) to address the issues
- ✶ Ultimately led to passage of a health reform bill that included many of the elements of the TTF and HCAC recommendations

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Health Reform

- Governor Pawlenty signed health reform bill in May 2008
- Bill includes recommendations of Governor's Transformation Task Force and Legislature's Health Care Access Commission
- Bill is a comprehensive health care package making significant advances for Minnesotans

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Overview of Health Reform Bill

- Public health
- Health care coverage/affordability
- Chronic care management
- Payment reform and price/quality transparency
- Administrative efficiency
- Health care cost containment

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Public Health

- Establishes and funds a statewide health improvement program (SHIP) to reduce obesity and tobacco use in Minnesota
- $47 million appropriated for SHIP for fiscal years 2010 and 2011
- Grants to community health boards and tribal nations to implement evidence-based strategies to improve our health
  - 10% match required

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Health Care Coverage and Affordability

- Expands eligibility for MinnesotaCare for adults without children to 250% FPG
- Increases outreach for and streamlines access to state health care programs
- Requires improvement of coordination between state and other assistance programs
- Requires development of proposal to promote affordable access to employer-sponsored health insurance through use of direct subsidies and/or tax credits and deductions
- Requires employers with 11+ FTE employees who do not offer group health insurance to establish and maintain a Section 125 Plan
- Provides grants to cover certain employers' cost of establishing Section 125 Plans
- Agreement to establish a 20% tax credit toward the purchase of individual health coverage for the uninsured purchasing through a Section 125 plan
- Creates a workgroup to design of an "essential benefit set"

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Chronic Care Management

- ✶ Promotes use of “health care homes” to coordinate care for people with complex/chronic conditions
- ✶ Requires MDH and DHS to develop and implement standards of certification for health care homes by July 2009
- ✶ Health care homes meeting certification standards will receive care coordination payments from public and private health care purchasers

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Payment Reform and Price and Quality Transparency

- Encourages quality improvement, by increasing transparency of quality and establishing a single statewide system of quality-based incentive payments
- Creates a set of tools for consumers and health care purchasers to compare providers on overall cost and quality of care
  - Transparent and public information provided to the market about the relative cost, resource use, and quality of health care providers
- Promotes transparency and accountability by establishing "baskets" of health care services to:
  - Allow consumers and other purchasers to compare cost and quality of care across providers
  - Promote provider innovation on cost and quality

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Payment Reform and Price and Quality Transparency

- ✶ Gives the Commissioner of Health the authority to continue to work with private market stakeholders to discuss and develop new additional models of payment
- ✶ Convenes workgroup to engage consumers in understanding importance of health care cost and quality, as it relates to:
  - Health care outcomes
  - Consumer out-of- pocket costs
  - Variations in cost and quality across providers
- ✶ Provides legislative oversight and establishes a Health Care Reform Review Council for stakeholder review and input

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Administrative Efficiency

- ✶ Enhances quality, patient safety and state's interoperable electronic health records by ensuring providers use nationally-certified electronic health record systems
- ✶ Advances use of health information technology by requiring all prescriptions be ordered electronically by 2011
- ✶ Requires a study and report on reducing claims adjudication costs for health care providers and health plans by adopting more uniform methods of processing claims

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Health Care Cost Containment

- ✶ Requires health care cost savings to be measured against projected costs without reform
- ✶ Results in significant potential overall health care cost savings
  - – Estimated to have the potential for cost savings of about 12 percent by 2015 or about $6.9 billion

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Other Topics Covered

- ✶ Requires a study and report on:
  - – Health care workforce shortages
  - – Community benefit standards for nonprofit health plans
  - – Health care coverage for long-term care workers
- ✶ Requires a workgroup to develop recommendations for education and regulation of oral health practitioners

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Next Steps

- ✶ Implementation of the various components of the bill will occur over the next twelve to 36 months
- ✶ Will involve a large amount of work group, advisory group, and stakeholder input and advice
- ✶ MDH examining the timeline for implementation and beginning work of identifying the critical next steps to implementation of this historic reform package

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We'll be working closely with all of you to implement this transformational legislation!!

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- ✶ For more information on health reform legislation:
- ✶ http://www.health.state.mn.us/divs/opa/08reformsummary.pdf

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