MinnesotaCare®

A Comprehensive Summary of Health Care Reform 1992-1996

MinnesotaCare

A Comprehensive Summary of
Health Care Reform in Minnesota
1992-1996

Produced by the
Minnesota Department of Health

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Background

MinnesotaCare is a comprehensive strategy to improve the quality of health care services, increase access to health coverage for the uninsured and contain health care costs.

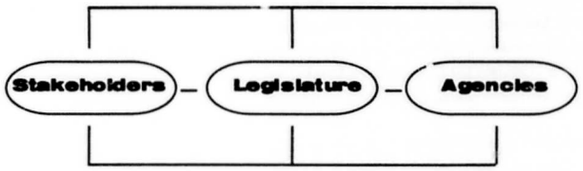
Minnesota's commitment to these three goals began in April 1992 with the enactment of the HealthRight (now known as MinnesotaCare) Law. The 1992 law was drafted by a bipartisan legislative team working in conjunction with Governor Carlson.

Among other initiatives, the first MinnesotaCare Law created the Minnesota Health Care Commission and charged it with developing a cost containment plan. The commission's cost containment plan, unanimously supported by its members, was released in January 1993 and formed the heart of the 1993 MinnesotaCare Law. Subsequent MinnesotaCare laws continue to move Minnesota toward higher quality and more efficient health care delivery system.

For general information on MinnesotaCare contact:

Minnesota Department of Health
Health Information Clearinghouse
(612) 282-6314 or (800) 657-3793

Minnesota is successfully undertaking health care reform to assure Minnesota's population is healthy. This has been done and continues through broad participation. Stakeholders, the legislature and state agencies have a role in shaping Minnesota's health care delivery system. Every Minnesotan contributes an important element to the success of MinnesotaCare.



Every initiative discussed in this summary brings Minnesota one step closer to improving the quality of health care services, increasing health coverage and containing health care costs, all of which helps to assure a healthy population.

Improving the Health of Minnesotans

Public Health

Health care reform brings new duties to the public health system and is further reshaping existing responsibilities. Changes in the health care delivery system encourage private-sector health care providers to take a greater role in improving the public's health. State and local governments must also undertake new duties necessary to support the efforts of the health care system and address the public health needs of the entire population.

The Commissioner of Health made recommendations to the legislature in 1995 on how to strengthen the local government public health system. In 1996, the legislature appropriated funds to the Department of Health for core public health functions including assessment, assurance and policy development.

Data Collection and Analysis

An essential element of Minnesota's health care reform is the development of a data system. The success of reform depends significantly on access to valid and reliable data that serves multiple purposes while ensuring encryption of patient identifiers to prevent identification of individuals.

For additional information on data collection, contact:

Minnesota Department of Health,
Data Analysis Program
(612) 282-5650

First, for the purpose of setting and adjusting expenditure limits, the state must be able to track total statewide spending to monitor system-wide success in limiting the growth in health care expenditures, and to form the basis of setting organization-specific limits. Secondly, the state and the public must be able to compare health plans and providers on the basis of cost, access and quality, so as to hold health plans and providers accountable for access to care and quality of care.

Minnesota's current data collection efforts are crucial as the information provides detailed, accurate, and timely information on our health care market, which will be invaluable to policy makers as they continue to study health care issues in Minnesota. Data collection and analysis contributes to all three goals of MinnesotaCare; improving the quality of health care, increasing access to health care and containing health care costs.

Minnesota Health Data Institute

The Minnesota Health Data Institute is a collaborative, public-private sector initiative to design and implement an integrated, statewide health care data system to support health reform in Minnesota. The Institute was created by the 1993 Minnesota Legislature as a partnership between the Commissioner of Health and the 20-member board of the Minnesota Institute for Community Health Information, a nonprofit organization representing health care plans, providers, consumers, and group purchasers.

Data Institute contacts:

(612) 228-4370
http://www.mhdi.com
Fax: (612) 222-3209

The Institute's overall functions and responsibilities are grouped into three major components: 1) performance measurement and improvement; 2) health information infrastructure; and 3) data privacy and access to data.

In October 1995, the Institute released the results of its first consumer survey. The survey was designed to provide statewide standardized measurement of health plan performance from the perspective of health plan enrollees. This survey represents the nation's first statewide effort to develop standardized, comparative information regarding enrollee perceptions of their health plans and medical care.

Administrative Simplification

A major component of the 1994 MinnesotaCare Law established a process to simplify administrative procedures for health care providers and payers. The law:

- Requires uniform claim forms for hospitals, clinics, dentists, pharmacies and other health care providers;
- Establishes unique health care identifiers for payers, providers and ultimately patients;
- Implements standards for the electronic transfer of health care data information;
- Creates the Minnesota Center for Health Care Electronic Data Interchange; and
- Specifies the standards for uniform health care identification cards.

Information Clearinghouse

While Minnesota consumers have some of the best health care in the world available to them, they also face an increasing number of health care choices. A key component in the successful reform of the health care delivery system involves wise decision-making on the part of the consumer. Wise decision-making involves understanding the real costs of health care, practicing a healthy life-style, asserting the consumer's role in shared decision-making and promoting healthy behaviors in the community. The Minnesota Health Information Clearinghouse was created by the 1993 MinnesotaCare Act to provide information that would aid consumers.

Clearinghouse contacts:

(612) 282-6314 or (800) 657-3793
clearinghouse@health.state.mn.us
FaxRequest: (612) 924-0014

Currently, the Clearinghouse has the following information available:

Health Plan Action Plans

One of the key components of health care reform in Minnesota is increasing available information concerning the quality, accessibility and cost of health care services. Accordingly, the 1994 MinnesotaCare Law requires health plan companies to file action plans, with either the Department of Health or Commerce depending on the agency that regulates them, which provide vital information to health planners, local policy makers and consumers concerning how their health plan company delivers services. The plans show practices and procedures and how these procedures impact the health of the whole community. In this way, the action plans will contribute to a health care system with public accountability.

Health Plan Collaboration Plans

Collaboration plans are required from managed care organizations. These plans describe the actions the managed care organizations intend to take to achieve public health goals for their service areas. Each plan is developed in collaboration with the local public health units, appropriate regional coordinating boards, and other community organizations providing health services within the same service area as the managed care organization.

Health Plan Atlas

This service assists individuals in their search for health care coverage. The Clearinghouse provides county-specific information about all health plan companies operating in Minnesota and serves as a resource for additional coverage options and educational materials for choosing health care coverage.

Recodification

In 1994, the Minnesota Legislature gave the Commissioners of Health and Commerce joint responsibility to recodify health plan company law to accommodate a two-tiered system of a Regulated All-Payer Option (RAPO) and Integrated Service Networks (ISNs). The need for recodifying law became obsolete in 1995 with the repeal of RAPO but he work from the recodification project was not without value. Consumer protection measures and standard term definitions were recommended to the 1996 legislature.

Health Technology Evaluations

The Health Technology Advisory Committee (HTAC) was established by the Minnesota Legislature as an advisory committee to the Minnesota Health Care Commission (MHCC). HTAC has 19 members that represent diverse sectors of the health care industry as well as different geographic areas of Minnesota.

For additional information on health technology evaluations, contact:

Minnesota Health Care Commission
(612) 282-6374

HTAC conducts evaluations of specific health technologies and their specific use for patients with given clinical characteristics or a given condition. In making a determination of appropriate use, HTAC takes into consideration safety, clinical effectiveness, ability to improve health outcomes and cost effectiveness.

Practice Parameters

The 1992 MinnesotaCare Law included authority for the adoption and application of practice parameters or guidelines for the purpose of promoting the consistent use of the most cost-effective quality health care in Minnesota. The outcomes research component of the MinnesotaCare Law is an indication of the importance of expanding the scope of knowledge about the relative cost-effectiveness of various treatment alternatives.

However, the Practice Parameters Advisory Committee was repealed in the 1995 MinnesotaCare Law.

Universal Standard Benefit Set

The 1994 MinnesotaCare Law directed the Commissioner of Health to make recommendations for a Universal Standard Benefit Set (USBS) to the legislature by January 1, 1995. However, after much legislative debate, the 1995 MinnesotaCare Law did not include provisions for a USBS.

The USBS was envisioned as one comprehensive, standardized set of health care benefits offered by all health plan companies in the state. It would not have replaced the myriad of products sold, but merely allowed consumers to more easily compare one product across the entire market.

Long Term Care

Minnesota Health Care Commission contact:
(612) 282-6374

The Minnesota Legislature directed the Minnesota Health Care Commission to examine the relationship between the acute and long-term care systems during its 1995 session. The commission was asked to address fragmentation and cost shifting between these two systems. The commission also was directed to prepare a *plan for a process* to better coordinate acute and long-term care so as to maximize quality, overcome cost shifting, and contain overall costs.

The commission made recommendations in 1996 with its overarching goals in mind: in order to provide appropriate, high quality care in the most cost effective manner, care systems should be reoriented and realigned to address the interrelated acute and long-term care needs of the disabled and elderly populations.

The commission's report set forth a broad framework of possible goals and principles that should guide the state's examination of acute and long-term care integration, and describes the major barriers to achieving integration. Moreover, it recommends what characteristics an integrated system should have, outlines a number of areas that merit further exploration, and identifies the possible resources or contributors to facilitate the integration process.

The Commissioner of Health is also responsible for monitoring long-term care costs and cost-shifting related to government health care program reimbursement rates.

Anesthesia Study

The 1994 MinnesotaCare Law required the Minnesota Department of Health to study anesthesia services provided in Minnesota health care facilities by certified registered nurse anesthetists (CRNAs) and anesthesiologists. The report, which was submitted to the 1995 legislature, recommended that anesthesia services continue to be provided primarily in a "care team" approach using both anesthesiologists and CRNAs, with current risk levels remaining very low. The market and demand for both CRNAs and anesthesiologists is changing and it is expected that flux will take place in this market for several years.

Expanding Access and Coverage

Universal Coverage

Minnesota is making good progress toward improving the quality, accessibility to, and affordability of health care for its citizens. As a result of the MinnesotaCare laws, Minnesota has already taken significant steps toward each of these three major goals of health care reform.

The 1993 law committed Minnesota to guaranteeing universal coverage by January 1, 1997. While the 1995 law repealed this implementation date, the law did state that universal coverage will be achieved when every Minnesotan has access to the full range of health care services, including preventive and primary care, and pays into the system according to their ability. It is, therefore, the goal of the state to reduce the percentage of uninsured residents to four percent by January 1, 2000.

Minnesota Health Care Commission contact:
(612) 282-6374

Uninsurance Rate

Each year, a number of surveys measuring health insurance coverage are conducted in Minnesota by various organizations. Since each of these studies employs a somewhat different methodology, the results vary and are not directly comparative. However, the conclusion of all surveys conducted show that Minnesota's uninsurance rate is below that of the nation's rate and in addition, Minnesota's rate of uninsurance has remained stable while the rest of the country has increased.

Issues surrounding the trend of uninsurance are complicated, as individuals in Minnesota and nationally receive insurance coverage from one or more of a number of sources. Changes in general economic conditions, public program eligibility, and employer-based offering of insurance can have impacts which simultaneously increase and reduce the percentage of Minnesotans with health care coverage. The Department of Health and Minnesota Health Care Commission continue to monitor the rate of uninsurance and the sources of insurance coverage for policy makers.

MinnesotaCare Health Plan

In response to the number of uninsured, the 1992 Minnesota Legislature created a health insurance program also called MinnesotaCare. The program is already providing health coverage to thousands of previously uninsured Minnesotans.

The program is open to all Minnesota residents who meet program and income guidelines. Currently, the program is available to families with incomes below 275 percent of the federal poverty level and to single adults and families with children whose incomes are below 135 percent (as of July 1, 1996) of the federal poverty level.

For additional information on MinnesotaCare Insurance:
Minnesota Department of Human Service,
(612) 297-3862 or
(800) 657-3672

Premiums are paid in part by the enrollees and in part by the State. The amount of the families premium is determined on a sliding scale based on income and family size.

As of July 1, 1996, over 92,000 previously uninsured Minnesotans receive insurance coverage through the MinnesotaCare program.

MinnesotaCare Waiver

In April of 1995, the Health Care Financing Administration (HCFA) granted Minnesota two waivers — the MinnesotaCare Waiver and the Long Term Care Options Project Waiver. These waivers provide two exemptions for Minnesota from federal Medicaid rules which will help the state give low-income children better access to preventive health care and help low-income seniors obtain health care with fewer hassles. The federal waivers will reduce red tape, improve health care access and quality, and make more efficient use of tax dollars.

The MinnesotaCare Waiver will also make it easier for the state to combine three public health care programs: MinnesotaCare, Medical Assistance (MA), and General Assistance Medical Care (GAMC). Streamlining three programs into one will make the system more flexible, responsive, and efficient.

The Long Term Care Options Project Waiver will give seniors enrolled in MA managed care plans the chance to choose a new health plan option which combines the full range of services now covered by both MA and Medicare. Currently, the system is fragmented, uncoordinated, and arbitrary, forcing seniors to obtain health care from several — and often the most expensive — sources.

Small-Group and Individual Market Insurance Reform

The 1992 law featured substantial insurance reform in the small employer (fewer than 30 employees) and individual markets. The 1994 MinnesotaCare Law then extended these reforms to include employers with 2 to 49 employees as of July 1, 1995.

In adopting the small employer and individual insurance reforms contained in MinnesotaCare, the Legislature determined that existing underwriting and rating practices in the individual and small employer markets for health care coverage created substantial hardships and unnecessary administrative costs. For example, in the past, small employers have only been able to obtain group coverage if all their employees and dependents were generally healthy. Further, if employees were able to obtain coverage, rates varied widely due to gender, age and health of employees. Changes in law were made in 1992 and 1993 to improve access to health coverage at affordable rates.

The 1992 law also promotes access to health coverage by creating a new, more affordable health insurance product in the small employer market. The 1992 law requires that carriers offer at least two "small employer plans" to any small employer who wishes to purchase coverage in that market. The plans provide a more basic benefit package than is otherwise mandated under Minnesota insurance laws. One plan utilizes deductibles, the other copayments. The small employer plans provide inpatient and outpatient hospital services, physician and nurse practitioner services, X-rays and lab tests, ambulance services, durable medical equipment, maternity and prenatal care, and some chemical dependency, mental health, and prescription drug coverage. However, they do not require other mandated coverages that add to the cost of health insurance beyond the means of some small employers. The Department of Health produced an informational guide regarding the small group insurance market.

For a copy of the small group insurance market guide, call:
(612) 282-6314 or
(800) 657-3793

The insurance reforms in the 1992 law also helped to discourage insurers from denying coverage to high-risk groups and individuals, and prohibited such denials in the small employer market. These reforms — effective July 1, 1993 — required that:

- Health plan companies may not refuse to issue coverage to or renew a small employer group ("guaranteed issue" and "guaranteed renewal") and may not

refuse to renew an individual policy;

- Health plan companies may not carve out high-risk individuals from a covered group;
- Health plan companies may not base premium rates on gender;
- Premium rates for all small employer products and individual products must be no more than 25 percent above or 25 percent below an index rate and divergences from the index rate may be based only on experience and health status (an additional divergence from the index rate of up to 50 percent may be based on age);
- Health plan companies may not limit coverage based on pre-existing conditions for longer than 12 months and an insured who has already been subject to a pre-existing condition limitation may not be subjected to a new limitation for the same condition upon changing health plan companies; and
- Health plan companies increase the limiting age to 25 for full-time students.

During the 1996 legislative session, an additional measure was passed to increase access to health care; individuals no longer need to notify their health plan company about new dependents under their policy.

Minnesota Comprehensive Health Association

Even before the enactment of the 1992 Law, Minnesota already had a well-established high-risk pool that guarantees coverage to those people who have been turned down by health carriers. The Minnesota Comprehensive Health Association (MCHA) was founded in 1976 as the nation's first high-risk pool and now covers over 35,000 Minnesotans.

For additional information on MCHA contact:
(612) 593-6909

MCHA is funded partly through enrollee premiums and partly through assessments on all licensed insurers, including HMOs and non-profit health plans. MCHA remains an important part of Minnesota's strategy for promoting access to coverage, by insuring high-risk individuals who are self-employed, retired, or employed by firms that do not provide insurance. However, the MinnesotaCare insurance reforms should significantly reduce Minnesota's reliance on MCHA as the insurer of last resort.

Purchasing Pools

The 1992 MinnesotaCare Law sought to improve access to health coverage for employees through the Minnesota Employees Insurance Program (MEIP). This program enables private sector employers of any size, to pool their purchasing power in order to get better premium rates and spread the risk of high cost employees. The program, based on a successful existing program for public employers (counties, municipalities, and school districts), is administered by the state, but is not otherwise subsidized by the state.

For information on purchasing pools contact:
Department of Commerce
(612) 296-2488

For information on MEIP contact:
Department of Employee Relations
(612) 851-5601 or (800) 829-5601

The 1994 MinnesotaCare Law gave employers, groups and individuals the opportunity to voluntarily form purchasing pools to negotiate and purchase health care coverage from health plan companies for members of the pool. All participants in a purchasing pool must live within a common geographic region, be employed in a similar occupation, or share some common factor as approved by the commissioner of Commerce.

Risk Adjustment

The 1994 MinnesotaCare Law created a risk adjustment program for both private and public health care programs. The goals of risk adjustment are to:

- Achieve a more equitable, efficient system of health care financing;
- Remove current disincentives in the health care system to insure and provide adequate access for high risk and special needs populations;

- Promote fair competition among health plan companies on the basis of their ability to efficiently and effectively provide services rather than on the risk status of their insurance pool; and
- Help maintain the viability of health plan companies by protecting them from the financial and marketplace effects of enrolling a disproportionate number of high-risk individuals.

For additional information on Risk Adjustment, contact:

Minnesota Department of Health,
Health Economics Program
(612) 282-6367

Discussions concerning risk adjustment began in Minnesota in 1993. Informal groups representing health plans, consumers, providers, and state agencies held several meetings to discuss the need for a risk adjustment mechanism in the context of health reform. As a result of these meetings, the 1994 MinnesotaCare Law created a Risk Adjustment Expert Panel and a Risk Adjustment Association. The commissioners of Health and Commerce submitted a report to the legislature in 1995. The commissioners' report was accepted in large part by the legislature, including the requirement that risk adjustment systems for the state-run public programs be developed and implemented by January 1998.

Since the passage of the 1995 MinnesotaCare Law, progress has been steadily made toward developing and implementing risk adjustment in the state-run public health care programs. The Minnesota Department of Health and the Minnesota Department of Human Services have been given the responsibility to recommend a risk adjustment mechanism for prepaid, public funded health care programs including Medical Assistance, General Assistance Medical Care, and MinnesotaCare. Statewide implementation of the prepaid medical assistance program (PMAP) is scheduled for 1998. In addition, a pilot program for MA disabled persons is scheduled to begin in 1998.

During 1996, the Minnesota Department of Health and the Department of Human Services will continue to work toward implementation of risk adjustment in the state-run public programs. The departments are in the process at this time of assembling the data bases necessary to evaluate each of the models of risk assessment as well as exploring the various options available for administration of the payment adjustment process, and its links to the rate setting process.

Prescription Drugs

The Prescription Drug Study, mandated by the 1993 MinnesotaCare Law and conducted by the Minnesota Department of Health, reviewed the prescription drug market, including current drug pricing strategies, and recommended specific cost containment strategies. It also included an overview of the drug provisions included in President Clinton's Health Security Plan, a comprehensive literature review, and an overview of state programs (such as Medical Assistance) involved in the purchasing and/or delivery of pharmaceutical drugs.

For additional information - Senior Drug Program, contact:

Minnesota Department of Health,
Health Economics Program
(612) 282-6367

In 1995, a senior drug discount program was established to provide prescription drugs to senior citizens at a reduced price. An annual enrollment fee of $5 would have covered administrative costs for the program.

The Departments of Health, Administration and Human Services actively pursued the implementation of the Senior Drug Discount Program and sought input from retail pharmacies, manufacturers, and other stakeholders on program modifications necessary for effective implementation. The departments encountered many difficulties in designing and administering this program and the program was never implemented. Included in the 1996 Supplemental Health and Human Services Budget Bill was a provision directing the departments of Health and Human Services to design a drug program for seniors with

income of 200 percent of federal poverty guidelines or below. The design of this program will be reported to the Legislature by October 1996.

Expanded Provider Network

As of January 1, 1995, all health plan companies must offer an expanded network of allied, independent health care providers to their enrollees. Under this provision, which was included in the 1994 MinnesotaCare Law, any allied health care provider who meets credentialing standards, agrees to the terms of the plan's provider contract, and agrees to comply with all managed care protocols must be accepted as a provider in the expanded network. Health plan companies with 50,000 or fewer enrollees, staff model HMOs, Medicare, MA, GAMC, and MinnesotaCare are excluded from this requirement.

The expanded network may be offered as a separate product, and separate premium rates and cost-sharing requirements may be charged by health plans. Providers in the expanded network must be paid at the same rate as providers in the plan.

24-Hour Coverage Plan

Minnesota has focused on a limited approach to 24-hour coverage — coordination of employer-sponsored health coverage and workers' compensation medical benefits. Under a 24-hour medical plan, delivery of medical care would be simplified, with the employee receiving treatment for a work injury in the same manner as for any other condition, without regard to the history of the illness or injury.

For additional information on 24- hour coverage, contact:

Minnesota Department of Health,
Health Economics Program
(612) 282-6367

The Minnesota Legislature has been interested in 24-hour coverage since 1992 when it required the commissioners of Commerce and Labor and Industry to study the feasibility of providing medical coverage currently furnished through the workers' compensation system through other health insurance mechanisms, including group insurance and universal health insurance plans. The resulting report, published in 1993, noted that although 24-hour coverage has merit for reducing costs, implementation of even a limited 24-hour coverage plan would require dramatic changes to the existing health care and workers' compensation systems.

The concept of 24-hour coverage was again raised by the 1994 Legislature. The 1994 Legislature required that, by January 1996, the commissioners of Health and Labor and Industry develop a 24-hour coverage plan incorporating and coordinating the health component of workers' compensation with health care coverage.

Stakeholders and the commissioners of Health, Commerce and Labor and Industry recommended that 24-hour coverage be implemented on a pilot project basis, in order to assess its effects before broader implementation. The 24-hour pilot project is designed to allow for, and indeed encourage, innovation and flexibility in the provision of health care benefits under workers' compensation and general health coverage.

Tax Deductibility for the Self-Employed

The 1992 law increased from 25 percent to 100 percent the portion of health insurance premiums that may be deducted by the self-employed from their state income tax. This measure will assist farmers and other self-employed individuals, who often face high premiums due to their lack of purchasing power, to afford health insurance.

Access to Medicaid Providers

Another access measure in the 1992 law focuses not on access to health insurance, but on access to health care itself. Enrollees in our Medicaid (MA) program had experienced significant access problems due to the reluctance of providers to serve them. The 1992 law took two steps to remedy this access problem. Provider reimbursement rates, particularly for primary and preventive care, were increased by up to 25 percent, in order to narrow the gap between the financial rewards for treating privately insured patients and Medicaid patients. Additionally, providers were required to serve MA and MinnesotaCare patients as a condition of doing business with the State Employees Health Plan and the Worker's Compensation program, which are generally viewed by providers as more financially desirable groups. Furthermore, health plan companies were required to participate in these programs as a condition of licensure.

Rural Health Care

The MinnesotaCare laws have expanded the responsibilities of the Office of Rural Health and Primary Care (ORHPC) within the Department of Health to serve as a resource for education, community development, policy analysis, data collection, and research on rural health issues. The ORHPC works cooperatively with public and private community organizations and other government agencies to implement programs promoting access to quality health care in rural Minnesota. To strengthen the rural health care system, the MinnesotaCare laws included the following strategies:

For information on rural health, contact:

Minnesota Department of Health,
Office of Rural Health
(612) 282-3838

- A program through the University of Minnesota to increase the number of primary care physicians by 20% over the next eight years;
- A program to increase the number of nurse practitioners practicing in rural areas of the state;
- A provider loan repayment programs for urban and rural underserved communities;
- Subsidies for isolated, financially distressed rural hospitals;
- Planning and transition grants for rural hospitals;
- Technical assistance on federal rural health care programs;
- A program to establish rural community health clinics that make greater use of midlevel practitioners;
- A statewide database of health services personnel;
- Technical assistance to facilitate the development of Community Integrated Service Networks (CISNs);
- Provider recruitment and retention initiatives;
- A substitute physician demonstration project; and
- A summer health care internship program.

Medical Education and Research

Minnesota lawmakers recognize the importance of medical education and research to the state and its economy. As part of the 1993 and 1994 MinnesotaCare Acts, legislators asked the commissioner of Health to study the costs and financing of medical education and research.

The commissioner established the Medical Education and Research Costs (MERC) Advisory Task Force, representing key stakeholders, to assist in the study. Preliminary reports were released in 1994 and 1995. In February 1996, the Minnesota Department of Health released recommendations based on three years of research and debate on the issues of funding for medical education and research activities.

The long-term success of any health care system depends on the renewal of its work force and continued investment in health care research. The state's medical education and research infrastructure significantly influences Minnesota's health care system and overall economy.

During the 1996 legislative session, legislation was passed giving the commissioner of Health the authority to establish a trust fund for distributing medical education and research funds. However, there was no money attached to this request. The legislature did ask that MERC report back in 1997 with a specific source of funding for medical education and research and on mechanisms for the distribution of such funding sources.

For additional information on MERC, contact:

Minnesota Department of Health,
Health Economics Program
(612) 282-6367

COST CONTAINMENT

A central focus of the 1993 MinnesotaCare Law was to control the growth in health care spending. Minnesota health care consumers can expect to save billions of dollars over the next several years through the cost containment initiatives.

Delivery System Reform

The 1993 law sought to delivery health care principally through "Integrated Service Networks" (ISNs). Care delivered outside of ISNs would be governed by the Regulated All-Payer Option (RAPO).

The 1994 law then sought to provide local communities with the ability to form smaller community-based ISNs, or Community ISNs (CISNs). It also extended the implementation timeline for ISNs and RAPO by another year — 1997 — to provide time for the formation of CISNs. During the 1995 legislative session, the state's vision for health care delivery changed directions as a result of market forces. The Regulated All-Payer Option was repealed and the need for Integrated Service Networks (ISNs) came under scrutiny.

Minnesota's health care delivery system was and still is working well. It is providing high quality care in a cost-effective manner. As a result, the Administration slowed the efforts to promulgate rules governing the creation and operation of ISNs. To date, the rules have not been fully promulgated. Instead, the Administration in the 1996 Annual Implementation plan recommended that the Department of Health in consultation with the Department of Commerce, determine the feasibility of and the for change in consumer protections in regulating all health plan companies.

Report on Market Reform

The Commissioner of Health is directed by Minnesota Statute to prepare a report every two years concerning the status and operation of the health care market in Minnesota. The first report was released in 1996 including information and analysis of issues such as health care costs, trends, competitive forces influencing the market, and consumer access. This information is intended to serve as a baseline with which to monitor the effects of various reform strategies and changes in the health care system over time.

Community Integrated Service Networks (CISNs)

The 1994 MinnesotaCare Law created CISNs, which are small, community-based ISNs that will provide prepaid health care services to 50,000 or fewer enrollees. Because CISNs serve smaller populations, it is envisioned that they will provide services that are better shaped to meet the needs of the local community. CISNs operate under a modified form of the current HMO laws; they are exempt from a number of HMO requirements; and have a greater flexibility to begin operations.

As of July 1, 1994, CISNs could apply for licensure to the Minnesota Department of Health and begin providing health care to enrollees on January 1, 1995. To date, four CISNs are licensed to operate in the state.

Health Care Cooperatives

As the health care market in Minnesota changes, public and private buyers of health care services have begun to pursue new purchasing strategies, including the formation of purchasing pools and direct contracting arrangements. In turn, health care providers have in some cases begun to create provider cooperatives to market their services.

The Minnesota Health Care Cooperative Law was established to encourage cooperative efforts in health care reform. A co-op is a different form of an integrated health care system that is based on rural agricultural cooperatives and intended to provide a legal structure for innovative delivery systems.

- **Health Care Provider Cooperatives** are organizations that may comprise of individual providers, clinics and/or hospitals, for the purpose of marketing and delivering health care services to purchasers on a substantially capitated or similar risk-sharing basis. Provider co-ops are not licensed.

- **Direct Contracting** refers to a contract for health care services made between an employer or group of employers and health care providers. This is in contrast to the typical situation where employers purchase health care coverage from an insurer or from a health plan. The issue of direct contracting raises questions for the state in regards to insurance risk by groups that have not carried risk in the past and which are largely unregulated.

Antitrust Exception

The 1992 and 1993 laws further promote beneficial collaboration among providers by establishing a process to allow arrangements that would improve the cost, access, and quality of health care to be exempt from federal and state antitrust liability. Providers wishing to collaborate in a manner that may violate state or federal antitrust law can apply to the Commissioner of Health for an exemption. The commissioner will provide an opportunity for any member of the community to comment, seek advice from the Minnesota Health Care Commission and pertinent Regional Coordinating Boards, and may conduct a hearing. If the commissioner then finds that the arrangement would improve cost, access, or quality, the commissioner may grant an exemption, and will monitor the arrangement to assure that it actually benefits consumers as expected rather than merely enriching the participants. If abuses occur, the commissioner may revoke the approval.

Growth Limits

Another component of Minnesota's health reform legislation is the effort to reduce the rate of growth in health care expenditures. The 1993 MinnesotaCare Law pairs delivery system reform with overall, system-wide spending limitations. These expenditure limits are designed to carry out the requirements in the 1992 law that the new system must reduce the growth rate of health care spending by ten percent per year for five years — 1994 through 1998.

Much has changed in the health care market since 1993. First, estimated growth in health care spending in Minnesota is currently 8 percent per year, down from a rate of more than 10 percent when growth limits were first developed. This moderation has occurred at the national level as well as in Minnesota, and is in a large part due to an increasingly competitive health care market and other market forces.

There are two components to "growth limits." The first is data collection and monitoring, and the second is growth limit enforcement and compliance. The data collection and monitoring component has allowed the Department of Health to monitor the rate of growth in health care spending across payers and providers. The department now has information on commercial plans, Blue Cross Blue Shield of Minnesota, and HMOs, as well as on self-insured plans (based on voluntary submission of data), hospitals, physicians, and other providers. This information is used to estimate total health care spending in the state, changes in spending patterns, and trends by payer and provider type. The information can be used to evaluate the impact on various policy changes in public and private financing.

For additional information on growth limits, contact:

Minnesota Department of Health,
Health Economics Program
(612) 282-6367

Limits on Annual Rate of Growth in Health Care Spending

Year	CPI-U + X%	Growth Limit
1994	CPI-U + 6.5%	9.4% (actual)
1995	CPI-U + 5.3%	8.2% (actual)
1996	CPI-U + 4.3%	7.4% (actual)
1997	CPI-U + 3.4%	6.4% (projected)
1998	CPI-U + 2.6%	5.7% (projected)

The enforcement component of the growth limits has not been used to date. In fact, during the 1996 legislative session, the Department of Health supported the repeal of the enforcement component, changing the growth limits to cost containment goals. The repeal did not pass during the 1996 legislative session.

Financing

Minnesota's health care reform initiatives are financed through a variety of funding mechanisms:

- ***Cigarette Tax*** -- 7-1-92 to 1-1-94: 5 cent increase in cigarette tax to be used as "start up" funds. Revenue from this tax will be transferred to the general fund beginning 1-1-94.
- ***Hospital Tax*** -- 1-1-93: 2 percent tax on gross patient revenues of hospitals and surgical centers. The amount of the tax may be passed through to third-party payers.
- ***Health Care Provider Tax*** -- 1-1-94: 2 percent tax on gross revenues of licensed health care providers including doctors, dentists, chiropractors, wholesale drug distributors, etc. The amount of the tax may be passed through to third-party payers.
- ***Tax on Nonprofit Health Service Plans & HMOs*** -- 1-1-96: 1 percent gross premium tax on HMOs, and non-profit health service companies.
- ***Premiums*** paid by enrollees of the MinnesotaCare program for the uninsured.

** Medicare, Medical Assistance, General Assistance Medical Care, MinnesotaCare, nursing home services and other specified payments to providers are not subject to the tax.

For additional information MinnesotaCare funding:

Minnesota Department of Revenue
(612) 296-0432

MinnesotaCare Future Issues

Much has changed in the health care market, both nationally and in Minnesota, since the first MinnesotaCare Act was passed. New modes of service delivery and financing mechanisms create diversity that is a stimulating force for market competition, but which also introduces complexities in monitoring and regulatory requirements.

Other issues facing Minnesota will be the future of how the state funds medical education and research, as this impacts Minnesota's overall economy; the continued coordination of traditional public health services with health care delivery systems; and the constant refining of activities now in place.

Health care reform is a continuous process in the state of Minnesota. Minnesota will continue to support a market-based approach to health reform and continue to improve the health of all Minnesotans.

For more information or additional copies, please contact:

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