I. STATE REPORT

Reforms In Minnesota:
Forging The Path

by Lynn A. Blewett

Minnesota has forged its way through three legislative sessions to advance its bipartisan effort on health care reform. The 1992 HealthRight Act addressed issues of access by phasing in a subsidized health insurance program for children, their parents, and eventually all uninsured Minnesotans. This program now covers 70,000-plus Minnesotans and is financed through a provider tax, a cigarette tax, and enrollee premiums. However, this bill passed only with specific provisions that assured the governor and several key legislators that health care cost containment would be addressed. Although agreement could not be reached on the details, cost control was also a rallying point for the business community and led to its support of the 1992 legislation. The legislation required the commissioner of health to establish and enforce statewide limits on the rate of growth of health care spending and established the Minnesota Health Care Commission, a twenty-five-member commission of providers, payers, and consumers, to develop a detailed cost containment plan. Despite a lack of consensus that expenditure limits were an effective tool for cost containment, limited data on state health care spending, and an absence of national leadership, the commissioner of health, in consultation with the Minnesota Health Care Commission, estimated health care spending using state-level data and developed a methodology to limit its rate of growth. This approach was adopted with bipartisan support by the Democratic-controlled legislature and was signed by Governor Arne Carlson, an Independent Republican, as the 1993 MinnesotaCare Act. The 1994 MinnesotaCare Act provided additional details and refinements to the cost containment plan and required that universal coverage be achieved by 1 July 1997. A key issue for 1995 will be how to finance universal coverage.

Over the past three years there has been a firm commitment by all involved that even without all of the details it was better to get started on health care reform than to do nothing. This UpDate describes the process used to determine state expenditure limits and highlights key political and administrative problems encountered along the way.

Cost Containment Strategy

The Minnesota Health Care Commission developed a comprehensive cost containment plan with an emphasis on competition and the market along with a certain degree of regulation to assure that health care spending goals were met. The competitive aspect is based on changes in the service delivery and financing systems and focuses on integrated service networks (ISNs), prepaid health plans that compete on price and quality. The regulatory component includes provider rate setting for payers and providers outside of the ISN system, aggregate premium or spending limits for ISNs, and oversight authority based on the monitoring of statewide health care spending limits. The three key components of Minnesota’s cost...
containment plan-ISNs, the regulated all-payer option (RAPO), and expenditure limits are described below.

Integrated service networks. ISNs are the key component of the Minnesota approach. Similar to the Health Security Act’s accountable health plans, these nonprofit plans are responsible for providing a standard set of “appropriate and necessary” services for a fixed price. Participation is voluntary, and competition among plans is encouraged through the mandatory disclosure of price and quality information and standardization of health coverage. Existing managed care plans and insurance companies may form ISNs along with newly developed provider- and community-based networks, or community ISNs (CISNs), that will provide services to 50,000 enrollees or fewer. A state antitrust exemption process was established to encourage the development of ISNs in rural areas where there may be limited, if any, competition among health plans. ISNs will be required to report information on health care spending, premium revenues, reserves, and quality measures. The commissioner of health will establish a standard benefit package with up to five cost-sharing options. ISNs will be required to operate within the limits set for total revenues as outlined below.

Regulated all-payer option. The RAPO will be used to manage the costs of health care services not provided through an ISN. The RAPO is a standardized payment and utilization review system designed to regulate and monitor provider fees, utilization, and quality. A uniform fee schedule will be developed for providers, beginning with physicians and hospitals, and standardized claims and billing forms will be required. Rates will be set to meet the growth limits established by the legislature through a fee schedule for physicians based on the Medicare resource-based relative value scale (RBRVS), using a Minnesota-specific conversion factor and a diagnosis grouping system to pay for inpatient hospital services. Health plans must choose to participate in either an ISN or the RAPO system, but providers may participate in either or both. All carriers in the RAPO system will be required to meet limits in the rate of premium increases similar to those in ISNs.

Expenditure limits. Statewide expenditure limits were established based on a reduction in the estimated rate of growth in health care spending by 10 percent per year for five years (1994-1998). The growth limits are based on the change in the regional Consumer Price Index (CPI) for urban consumers plus an add-on factor representing volume, intensity, and other factors contributing to medical inflation. The add-on factor was derived from the estimated overall growth rate in health care expenditures in Minnesota (estimated at 10.2 percent for 1994), and its reduction is set by statute. General inflation as measured by the multi-state regional CPI is allowed to fluctuate from year to year. The annual limits on the growth of health care costs were set as follows: (1) in 1994, CPI plus 6.5 percent, for a limit of 9.4 percent; (2) in 1995, CPI plus 5.3 percent, for a projected limit of 8.3 percent; (3) in 1996, CPI plus 4.3 percent, for a projected limit of 7.4 percent; (4) in 1997, CPI plus 3.4 percent, for a projected limit of 6.7 percent; and (5) in 1998, CPI plus 2.6 percent, for a projected limit of 6.0 percent.

Growth limits will be enforced through ISNs and the RAPO system. The initial intent was that growth limits for ISNs would be targeted to increases in aggregate premium revenue. Growth limits for the RAPO system will be tied to rates of increases in the fee schedules.

Conceptual Framework

Several recent papers have been written on global budgets and expenditure limits; in them, the terminology is potentially confusing. I make the following distinctions for the purpose of explaining the Minnesota approach: I use expenditure limit to refer to a ceiling on total health care spending for a defined period of time. An expenditure limit can be viewed as a mechanism by which the underlying cost containment policies are measured and assessed. Limits may be placed either on the rate of growth of health care spending (for example, health care...
spending must not increase by more than 5 percent) or on the absolute dollar value (for example, Minnesota will not spend more than $12 billion on health care in 1994). An expenditure limit may be set for a state, for a region, for a health plan, or for a purchasing group. While an expenditure limit reflects the overall cost containment objective, different strategies may be used to achieve the goal. For example, limits may be placed on health plan premiums or on hospital budgets, or a rate-setting approach may be used.

A global budget is one of the specific cost containment tools that can be pursued under an expenditure limit approach. A global budget is a prospectively determined revenue limit for a specific entity. This entity has the responsibility to control costs and operate within the budget allowed. The entity may be an entire state, a region, a health plan, a purchasing organization, or a provider. In proposals in which capitated health plans are the key service-delivery mechanism, the budget may be based on the actuarial price of the minimum benefit package times the number of persons enrolled in a plan or the total amount of premiums paid, including out-of-pocket payments for higher-cost plans. If a purchasing organization is responsible for the budget for an entire region, the budget may be based on the total amount of premiums paid to all plans or on a predetermined allocation distributed to all health plans. The point is that the amount included in the budget is set in advance.

Why limits at all? Underlying the concept of Minnesota’s cost containment strategy are three basic beliefs: (1) There is waste and inefficiency in the current system, (2) managed care is the appropriate vehicle to realize increased efficiencies, and (3) the competitive approach to cost containment will not work without additional regulatory oversight. It is important to keep in mind that this discussion is taking place in a part of the country where managed care is the norm. In the metropolitan area of Minneapolis and St. Paul, almost half of the population is enrolled in health maintenance organizations (HMOs) (21 percent for the entire state). Although prices for medical services in the metropolitan area are estimated to be as much as 18 percent below the national average, the area’s 10 percent rate of increase in health care spending parallels national trends. This is consistent with findings that suggest a one-time savings associated with HMOs but a similar rate of increase compared with fee-for-service plans. To afford expanded access for the uninsured, passage of legislation required specific cost containment provisions.

Initially, some of the members of the Health Care Commission proposed a plan based solely on competition. However, others, including several influential legislators, believed that health care is a unique commodity and that competition alone would not succeed in controlling costs. The compromise reached was a more narrowly defined competitive approach within a regulatory framework of rate setting and expenditure limits. The debate then centered on whether to pursue expenditure targets that would provide goals for cost containment without enforcement authority or expenditure limits tied to a more regulatory approach to enforcement. The resulting 1992 HealthRight Act included language requiring the more regulatory approach but left the details of developing the cost containment tools to the commissioner of health, in consultation with the Minnesota Health Care Commission.

The general concept of expenditure limits is that the state will set broad ceilings on the rate of growth of health care spending and allow the competitive market to operate as long as state objectives are met. Minnesota limits are tied to current levels of growth (CPI plus 6.5 percent) as opposed to starting at a much lower level (say, CPI plus 2 percent). Starting at a higher level allows the limits to be used more as targets and provides, perhaps, a more reasonable goal for a changing service delivery system. The general perception is that if competition is not able to keep health care spending within the predetermined limits, the legislature is likely to pursue a more regulatory approach. Some would say that the threat of what might happen, if cost containment goals are not
met, provides additional motivation to make competition work.

Data Collection Objectives

To set limits on the rate of growth of health care expenditures, the state must (1) determine the current rate of growth, (2) set limits on future increases, and (3) develop incentives and regulatory mechanisms to hold entities accountable for meeting state-wide goals. This strategy requires that the state be able to identify the entities responsible for the growth in health care costs and to monitor health care expenditures over time. The poor availability and quality of state-level data on health care spending have made this a very difficult task.

The data issue is a thorny one. Although the Health Care Financing Administration (HCFA) publishes health care spending data each year, the national-level data do not provide the level of detail needed, in a timely manner, to effectively implement and enforce spending limits at the state level. For example, the information cannot be used to hold either payers or providers accountable for meeting expenditure limits. In addition, estimating health care spending involves manually pulling together diverse information from various data sources. This time-consuming process must be reenacted every year to keep the numbers up-to-date.

Minnesota's objective was to develop a data collection methodology and an infrastructure for collecting information on health spending for the purposes of quantifying and monitoring health care expenditures. It was felt that state-level data would be more accurate and timely, and could be tied to individual payers and provider groups for accountability purposes. In addition, the data could be used to inform policymakers on the impact of health care reform.

The primary objective is to collect uniform and consistent state-level data in a routine and efficient manner, on an ongoing basis. It is the intent that health care revenue and spending data will be collected annually from both payers and providers using consistent guidelines and data definitions. The information will be limited in the initial years but will evolve as additional sources of data are developed and submitted either voluntarily or by legislative mandate. Data definitions and collection techniques will be refined over time.

The Health Care Commission recommended using a two-step strategy for data collection: (1) a short-term initiative that provides immediate information from payers on a significant proportion of current health care spending to establish the 1991 baseline; and (2) a long-term data collection plan to monitor health care spending. The elements of health care spending are based on categories and definitions included in HCFA's national health expenditure accounts. This framework includes three basic components of total health expenditures: personal health care services, research and education, and construction and capital expenditures. The state data collection strategy focuses first on personal health expenditures and will expand to include the other categories as time and resources permit.

Short-term data collection strategy. The short-term data collection strategy was developed in fall 1992 to meet a deadline of 15 January 1993 for submitting a report on health care spending to the legislature. The information was collected from a subset of the major payers in Minnesota to determine 1989 (when available), 1990, and 1991 health care spending. Data from payers was the method chosen because these data were available, given the short time frame, and were relatively accurate. Aggregate information was collected on total health care spending by source of funds and by general spending categories. The data generated captured approximately 60 percent of all insured persons in the state. The data sources used to develop the 1991 baseline included (1) aggregate HMO spending data for all HMOs, provided in annual audited financial statements submitted to the Minnesota Department of Health; (2) aggregate information on spending for all Blue Cross/Blue Shield business provided in the state, including the Blues' self-insured business; (3) a survey of the ten largest commercial insurers in the state, representing approxi-
mately 60 percent of the commercial business; (4) data on self-insured plans provided by the three largest HMOs and Blue Cross/Blue Shield and from members of a metropolitan consortium of fourteen large employers representing an estimated 15 percent of all self-insured plans (time limitations prevented a more comprehensive survey of all self-insured plans); and (5) data on public payers collected from existing claims information for Medicare and Medicaid.

Long-Term data collection strategy. The short-term data collection strategy clearly did not capture all health care expenditures of interest, including out-of-pocket expenditures, charity care and bad debt, technology, research and education, and capital expenses. The state has several data sources that while not all-inclusive are helpful in building the process of data collection for other payers and providers. Minnesota has long-standing data collection requirements for aggregate financial data from hospitals and HMOs and detailed information on its public programs. The largest remaining gaps include information on physician services and information on commercial carriers and self-insured plans.

Aggregate data from HMOs (and eventually ISNs) and hospitals will be collected from modified versions of existing annual financial reporting forms. New surveys were developed for commercial insurers, Blue Cross/Blue Shield plans, self-insured plans, and clinics. Although the state is not able to mandate that self-insured plans submit expenditure data because of the federal Employee Retirement Income Security Act (ERISA), a survey was sent to all third-party administrators in the state requesting information on a voluntary basis. The large self-insured employers in the state were contacted to request their voluntary participation, and Blue Cross/Blue Shield and the large HMOs also agreed to provide aggregate information on their self-insured business.

Setting Initial Expenditure Limits

Setting expenditure limits on the rate of growth of Minnesota health care spending involved three key tasks: (1) determining the growth rate in health care spending for 1990-1991; (2) estimating the rate for 1994; and (3) developing the methodology to set future expenditure limits. One of the issues presented early in the process was accuracy-how accurate is the existing information on health care spending, and how accurate does it have to be to set limits? At the outset the information collected represents only a portion of total health care spending and uses only a two-year period to estimate the growth rate. For example, if out-of-pocket costs are increasing faster than the rate of covered health care services, the estimates will be biased downward. However, the estimates were consistent with other national estimates, the law mandated that limits be set, and it is understood that refinements will be made as better data become available.

The subset of aggregate payer data on personal health care expenditures was used to estimate baseline health care spending for personal care services in Minnesota of $10.5 billion and a 1990-1991 growth rate of 10.8 percent, compared with the national trend of 11.0 percent for a comparable set of services over the same time period.

The estimate of the 1994 growth rate was based on a policy decision involving a compromise between various forecasted rates. The three methods used to estimate growth rates for 1994 were (1) applying the trend projections developed by HCFA to the state-specific rate for 1990-1991 to produce a 1994 growth rate of 10.7 percent; (2) applying a trend based on a general measure of inflation as measured by the CPI to produce a rate of 9.7 percent; and (3) applying the national gross domestic product (GDP) price deflator for a rate of 9.8 percent. The state also is working on a forecasting methodology based on actual and estimated levels of health care expenditures. Current trend estimates using this forecasting methodology were in the range of 9 to 10 percent. The commissioner of health, with the advice of the Health Care Commission, recommended a 10.2 percent growth rate for 1994, the midpoint of the estimates. The rationale underlying this decision was that
the estimate of 10.7 percent, using the national trend as the base, included considerations for spending increases as a result of utilization, intensity, and other factors as well as an adjustment for general inflation. The method using the inflation-only adjustment did not allow for any other adjustments unique to the health care system. The combination of the two approaches acknowledged the need to adjust for such factors but also was consistent with the goal of bringing the growth in health care spending more in line with general inflation.

The final task was to develop a methodology for estimating limits on the rate of spending growth. Several methodologies were considered, but the methodology adopted provided for a trend reduction based on inflation adjustment plus a percentage add-on for utilization, intensity, and other factors unique to the health care industry. We refer to this methodology as the “CPI plus X” methodology. The intent was to develop a methodology to set state expenditure limits that had some basis in forecasting health expenditures but that could be set in statute and not allow for retroactive adjustments. The underlying concept is that health care expenditures are made up of two basic components: general inflation (CPI), and factors associated with the health care industry—namely utilization, intensity, demographics, and other factors (the X percent). The CPI plus X methodology allows for the inflation component to change from year to year and sets a reduction in the adjustment for other factors. This methodology includes a fixed element that allows for budgeting at the plan level and addresses the state’s concern about litigation by proposing a predetermined methodology.

To set the limits in statute, the rate of inflation was estimated over the period from 1994 to 1998 based again on a compromise using various assumptions in estimating future rates of inflation. Based on the assumption of a modest increase in inflation, and assuming a 10 percent reduction in the total trend each year, the X percent was determined. This approach brings the expenditure limits to CPI plus 2.6 percent by 1998.

Enforcing expenditure limits. The next challenge is to develop the details of the specific cost containment policies for the ISNs and the RAPO system to meet the statewide expenditure limits. Minnesota is now in the process of designing the two systems and the enforcement mechanisms associated with each.

For ISNs, the original legislative intent was that limits be placed on the annual rate of growth of total revenues received from purchasers and enrollees, after adjustments for changes in enrollment and risk. Enforcement would include aggregate premium revenues as opposed to product-specific revenue limits to allow plans some flexibility to manage their budget across all products. Enforcement would include either financial penalties or a reduction in the allowable rate of increase in premium revenue for the following year based on the amount overspent. The intent was that the spending limits be used as upper bounds on increases in premium revenues. That is, competition is expected to constrain the rate of premium growth without government intervention. However, the issue of revenue limits is now being debated.

The limits applied to the all-payer system (RAPO) will be applied to the fee schedules established. The state will develop methods of volume control and establish targets based on Medicare’s method of physician payment. Any increases or decreases in expenditure growth will generate offsetting changes in fees. Hospitals’ fee schedules will be based on a Minnesota-specific diagnosis-related group (DRG) approach. Linking these systems to the expenditure limits poses additional challenges in system design.

### Implementing Expenditure Limits

As Minnesota moves forward on health care reform, its health policymakers have confronted many difficult issues and technical challenges. Designing the conceptual approach to health care reform in 1992 was a challenge, but working out the details of a system that will affect the livelihood of payers and providers and have a direct impact on consumers is perhaps a more difficult
task. The details have, in fact, required Minnesota to slow down its implementation timetable for some reform initiatives. The initial implementation date for ISNs was 1 July 1994, but the proposed 1994 Minnesota Care legislation delayed full implementation to 1 July 1997, so that the details could be developed with appropriate public input and comment. A few of the key issues related specifically to the expenditure limits are discussed below.

Data limitations: payers. There are two primary payers for which data collection is of primary concern: commercial carriers and self-insured businesses. The information now available from commercial carriers has several holes. It was difficult if not impossible for many carriers to provide the number of enrollees per month. Many have information on subscribers but do not have details on whether the subscriber purchased individual or family coverage and, if family coverage was purchased, the number of dependents enrolled. At least for the time being, commercial carriers will have to make an actuarial estimate of the total premium revenue and total expenditure per member per month and continue to revise their data systems to accommodate the need for additional information.

The second large gap in payer data is self-insured businesses. Because of federal ERISA preemption, self-insured plans are not regulated by the state, and states cannot mandate data submission. In addition, there is no centralized list of self-insured plans to facilitate a mailing to enlist voluntary compliance. It is estimated that self-insured business represents approximately 34 percent of all insured persons in Minnesota. Thus, tracking health care spending without the self-insured data misses a significant percentage of total health care expenditures. This past year a survey was sent to 160 licensed third-party administrators (TPAs) to voluntarily submit data for their self-insured business. Again, it is difficult to determine if this sample will be representative of self-insured plans throughout the state. For example, this method will not capture businesses that do their own claims processing. Information will continue to be collected on self-insured businesses from Blue Cross/Blue Shield plans and HMOs.

It should be noted that the unsuccessful lawsuit brought against the State of Minnesota by the Twin City Pipe Trades Welfare Trust (and several other labor union trusts) over the 2 percent provider tax used to fund the MinnesotaCare subsidized insurance program included a count challenging the collection of data. The proper scope of ERISA preemption is very much apart of the national health care reform debate. From a state’s perspective, it is difficult to reform the health care system with so much left out of the equation: It is estimated that more than one-third of the state’s population (or 44 percent of privately insured persons) are enrolled in self-insured plans. At a minimum, ERISA should be modified to allow states to collect information on health care spending.

Data limitations: providers. Several provider groups felt strongly that relying on payer-level data to set expenditure limits would miss several components, namely bad debt, charity care, and out-of-pocket costs. In response, a survey of physician clinics was developed to supplement the existing hospital financial information; it requires information on bad debt and charity care. Additional information on out-of-pocket costs is collected through the payer surveys, which report enrollees’ copayments and deductibles. But again, this information is not all-inclusive. Clearly, additional resources will be required to collect and monitor trends in out-of-pocket spending.

Forecasting methodology. It was originally thought that rates of growth could be forecasted with annual retroactive adjustments when more complete data were available. This would allow for continual updating and improvement in the methods used to estimate the trend. However, health plans were concerned about the stability of the expenditure limits and insisted on the need to know the state spending goals, in advance, for planning purposes. Thus, the proposed forecasting methodology was rejected. In addition, the state felt that alternative methods for forecasting expenditures would leave the state open to litigation and the possible derailing or delay of enforcement
methods. However, staff will continue to collect information and refine the expenditure limit methodology over time.

**Limits on spending or revenue?** There has been an ongoing and heated debate about whether limits for ISNs should be placed on health care “spending” or health care “revenue.” Limits on revenue translate to premium caps or limits on aggregate premium revenue. Limits on spending focus on claims paid plus administrative expenses without regard to the amount of revenue taken in. The key issue is whose spending is controlled: the purchaser’s of health care services or the health plan’s. Several health plans have argued that the trend in spending is the target of cost control and that competition will drive premiums down. Controls at the premium level look at what consumers or purchasers pay directly for health care services and allow a more direct method of controlling cost increases to consumers.

A compromise was reached whereby the commissioner of health will set expenditure limits for payers based on health care spending for the first two years of the plan, 1994 and 1995 (now extended through 1997). These first years are considered an interim period before the ISNs and RAPO are fully developed and implemented. That is, there would be no direct premium regulation in the first two to four years. In addition, all plans (excluding commercial carriers) are subject to upper limits on their reserve corridors, assuring that health plans do not build up reserves at a time when spending reductions are achieved. The commissioner of health must forward recommendations to the legislature on the method used to enforce spending limits for ISNs by January 1995.

**Risk adjustment and ISN premium limits.** One key element of Minnesota’s and other proposals that rely on capitated health plans to compete on price and quality is the ability to adjust for risk selection. The 1994 MinnesotaCare legislation relies on a mandatory reinsurance mechanism for the first year and then requires the development of mandatory risk adjustment. The approach is yet to be determined, but the concept is that ISNs that enroll a population with poorer risks will receive transfer payments from those that enroll better risks. It requires the development of a uniform mechanism and a process by which to collect and redistribute payments, either through retroactive settlements out of a commonly funded pool or through the ability to charge additional premiums. The need for risk adjustment argues for more detailed claims and encounter-level data to be able to make such adjustments uniformly and consistently across plans. A special advisory board has been set up to review and make recommendations on risk-adjustment methodologies.

**Cost shifting.** Expenditure limits and the tools to meet them have highlighted issues related to cost shifting. With limits on premiums and all-payer rate regulation (and eventually universal access), there will be limited ability for plans and providers to shift costs to other payers. There will be increasing pressure on both state and federal health care programs to fully fund themselves. In addition, if ERISA plans are the only payers outside of the system (and therefore not regulated), it will become increasingly difficult for them to control costs on their own.

A related cost-sharing issue involves HCFA’s updated Medicare HMO capitation rates. Several Minnesota HMOs, primarily as a result of the efficient Minnesota health care system, received little or no increase in their federal capitation rate. To cover its costs, one local HMO increased premiums for its Medicare enrollees by 27 percent. The increase in the total premium, which includes Medicare’s capitation and beneficiaries’ out-of-pocket premiums, was less than the 9.4 percent limit for 1994, but Medicare enrollees bore the financial burden of the increase. As states continue to work to control their health care costs, there will be increasing pressure for federal programs to find new ways to reward efficiencies or, at a minimum, not penalize them.

**Administrative costs.** Some may argue that the costs needed to set up and administer such a comprehensive program far outweigh the benefits of the impact on health care costs. There is no doubt that Minnesota’s overall reform strategy has required
additional resources to set up and administer the system. A 2 percent tax on provider and payer revenue and a time-limited tobacco tax now fund the health care reform infrastructure and subsidies for the uninsured. To date, there is commitment to health care reform, and elected officials have made the initial investment required to make it happen. However, as more of the details get worked out, additional concerns arise. For example, the benefit of a state-run rate-setting system for hospitals and physicians is unclear, especially if most of the state’s population moves into managed care.

Why the CPI? The goal of health care reform in Minnesota and at the national level has been to bring increases in health care costs closer to the general rate of inflation. Certainly, some unique characteristics of the health care industry might make its rate of growth higher than the rates for clothing or housing, for example. However, there is a general belief that health spending at two to three times the rate of growth in other sectors is too high. But where to draw the line is another question. Using the CPI as the basis for monitoring the effects of health care reform is intuitively appealing to legislators and consumers alike. There is no magical end number but rather a clear intent that medical inflation must come down.

Quality concerns. There is concern that while the expenditure limits may contain costs, they may do so at the expense of quality and access. The implicit assumption in implementing an expenditure limit is that there is excessive profit and/or inefficiency in the system and that these elements, not quality, will be reduced to meet the state’s cost containment goals. Health plans have added to this perception by taking out full-page ads in the local newspaper advertising their commitment to reducing certain costly procedures and preventable illnesses. A recent study by the University of Minnesota of the State Employee Health Plan, in which state employees are provided information and the ability to switch health plans once a year, showed savings of $134 per single covered beneficiary and $232 per family covered beneficiary in one year.9 The recent health reform legislation has attempted to address quality concerns by requiring all plans to report on various quality indicators. However, as the expenditure limits become tighter over time, concerns about reduced quality become more critical. Legislative language allows for the commissioner of health to monitor quality and access over time and also provides for the commitment needed to refine the methodology used to estimate the expenditure limits when more complete data become available.

Lessons For National Health Reform

There is an unlimited set of issues related to Minnesota’s health care reform initiative. Players in both the private and the public sectors have spent more than five years (and three successful legislative sessions) addressing these issues and making tough policy choices. Each session has been more difficult, as the complicated details of implementation have become more apparent. A message to those working on national health care reform from Minnesota’s experience is that reform is an iterative process. During each legislative session, more details are added and adjustments made to previous approaches. Even with the progress that Minnesota has made, the final outcome of health care reform in the state is still unclear. It will take many years of hard work and a commitment from both sides of the aisle to stick it out and keep the process going.

Minnesota health policymakers also have learned that data and information on health care spending play a key role in health care reform. What impact the reforms have in controlling health care spending can be measured only if there is accurate and timely information collected routinely and consistently across entities. The database will take several years to refine, but the information will be invaluable in informing policymakers of the trends in state health care costs.

It is difficult to imagine that the process in Minnesota could be replicated exactly in other states; each state has its own unique set of players and political climate. It is even more difficult to imagine a national plan that would meet the divergent needs of in-
individual states. But the states clearly need some national direction and leadership; this leadership should come in three key areas: (1) technical assistance and financial support for system design, rate-setting methodologies, and data collection; (2) national guidelines to define health spending data elements and data collection standards; and (3) changes in ERISA to allow, at a minimum, collection of data on health care spending at the state level. In addition, there is some concern that Minnesota, in moving too far ahead, might be penalized by national reform. Specifically, if Minnesota sees a moderation in its health care spending, the state is concerned that national reform not “lock in” existing spending differences and penalize efficiency.

Being at the forefront of state health reform has both its advantages and disadvantages. The advantage has been that Minnesota can tailor reform to its own situation. Given the uncertainty of national health care reform, Minnesota has taken the initiative to get its costs under control. The state is paving the way, and the state’s learning curve will assist others that follow in its footsteps. Given the bipartisan support of the legislature and the continued commitment of the various stakeholders through their active participation on the Health Care Commission, Minnesota will continue to address the tough challenges inherent in health care reform.

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NOTES

3. Paul Starr and Walter Zelman refer to four ways in which a budget could be defined by region: (1) the benchmark premium times the total number of enrollees; (2) total premiums paid to all plans, including out-of-pocket premium payments for higher-cost plans; (3) total spending on covered benefits for all eligible persons; and (4) total spending on health care for covered and uncovered services. See Starr and Zelman, “A Bridge to Compromise.”
6. Expenditures for long-term care were specifically excluded by the legislature in its charge to the Health Care Commission to reduce the rate of growth in health care spending by 10 percent per year. However, the commission recommended that data on long-term care costs and trends be collected and monitored along with other components of the system.
7. The 1992 HealthRight law required that 1991 be used as the baseline for health care spending.