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State of Minnesota

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Committee on Small Business

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Chairwoman Velazquez and members of the committee, thank you for inviting me here today to discuss state efforts on health care reform and, in particular, one of the most important issues facing our state and nation: rising health care costs.

The Challenge of Rising Health Care Costs

Although small businesses have unique challenges affording health care coverage for their employees, businesses of all sizes will be facing a major financial crisis if we do not change the current health care delivery and financing system.

The Congressional Budget Office (CBO) projects that total health care spending will rise from 16 percent of GDP in 2007 to 25 percent in 2025. These increases are burdening our economy, causing hardships for millions of Americans, and are clearly unsustainable.

Government is facing the same crisis. At the state level, rising Medicaid budgets continue to consume more and more of our state budgets – a result of increases in public program enrollment and higher costs per enrollee. We anticipate that the share of our state budget devoted to health care will increase from 18 percent in 1998 to 27 percent by 2011. Spending more state dollars on health care means less funding available for education, infrastructure, and economic development – significant issues for the state's business climate and competitiveness.

In Minnesota we are working hard to address these issues and we are fortunate to have the lowest rate of uninsured, some of the lowest medical care costs, and some of the highest quality health care in the country. Yet, even with these advantages, we are challenged.

Minnesota's historically high rate of employer-based coverage has been primarily responsible for its low rate of uninsurance. However, between 2001 and 2007, the percentage of Minnesotans with health insurance through an employer fell from 68.0% to 62.5%.[1] Although enrollment in our public insurance programs helped offset some of the decline in employer-sponsored insurance, our uninsured population, while still lowest in the nation, has grown.

This recent erosion of employer-based health insurance is of special concern to policymakers in our state. Most of the decline in our employer health insurance has been

[1] Minnesota Department of Health, Minnesota Health Insurance and Access Survey, 2001 and 2007.

the result of declining access: fewer Minnesotans have a connection to an employer that offers coverage, and those who do are less likely to be eligible to sign up for coverage.

The problem is especially pronounced for small businesses facing unique challenges in attracting and retaining their workforce, operating with minimal administrative resources, and operating on thinner margins. They often face even tougher challenges in dealing with the health care system and are especially vulnerable to health care cost increases.

Rising health care costs force hard choices between discontinuing coverage for employees and keeping businesses operating. Smaller employers are less likely to offer health insurance, and each year the percent of small businesses no longer offering health coverage is steadily growing.[2] In the end, spiraling health care inflation makes small business less competitive in the marketplace, and as a result, our overall economy is less competitive in an increasingly global market.

As you know, this is a particular concern because of the critical role of small business nationally, and in every state. In Minnesota, small businesses are a huge driver of the state's economy and account for roughly 97 percent of all businesses.[3] They play an integral role in adding new jobs, innovation, and increasing the overall vibrancy of our economy. We need to preserve the vitality of small business for our economy to thrive.

We can begin by working to reign in runaway health care costs. Accomplishing this goal is possible, but it will require fundamental, lasting changes in how health care is delivered and financed.

The current health care system is fundamentally flawed and will never provide both the quality and efficiency we need until it is transformed. Today, we pay primarily on a fee for service basis, meaning we pay for the volume of services delivered, rather than the value – the quality or the outcomes – of the services provided. This often leads to excessive, repetitive or even unsafe care.

One widely cited study reported that, on average, patients receive the recommended care they should be getting only 55 percent of the time.[4] In Minnesota, only one in ten persons with diabetes is receiving optimal levels of care for their health condition.

If business owners only shipped the correct product fifty percent of the time, or if manufacturers could only meet specs in one of every ten cases, they probably wouldn't be in business long. So why is a lackluster level of performance tolerated in health care? It shouldn't be and it needs to change.

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[2] Employer Health Benefits, 2007 Summary of Findings, Exhibit D. The Kaiser Family Foundation and Health Research and Educational Trust at http://www.kff.org/insurance/7672/upload/Summary-of-Findings-EHBS-2007.pdf

[3] Minnesota Department of Employment and Economic Development 2006 census data. Small employer defined as those with 100 or fewer employees.

[4] Elizabeth McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," The New England Journal of Medicine (June 26, 2003).

Minnesota's current health care reform efforts

It has often been noted that "What is measured improves" and that "What is measured and rewarded, gets done." These are true in health care as in any other endeavor.

Over the past six years of my administration, we have taken a number of important steps to align efforts and incentives for greater transparency of health care quality and costs, and for more accountability for performance and outcomes.

For example, I created a Governor's Health Cabinet to bring together the heads of state agencies with responsibilities for health care purchasing, regulation and delivery, including especially our agencies that administer Medicaid and the state employee health benefits plan, to work together in implementing more common, reinforcing health care purchasing and measurement strategies. This is not a government takeover of the health care market, or the creation of huge single health care mega-state agency, but rather it is about reaching agreement on standard messages to send to the market and using common ways of measuring and reporting health care performance.

In addition, in late 2006 I issued an executive order creating QCare – Quality Care and Rewarding Excellence. QCare was developed with assistance of a group of health care providers, payers, and state government leaders in association with the National Governor's Association "Center for Best Practices." It sets stretch goals for health care improvement in four key care areas: diabetes; heart disease; preventive care; and hospital safety. The QCare executive order also instructs the heads of our state Medicaid program and the agency that is responsible for the state employee health benefits plan to add provisions to their contracts with health plans and other vendors to help meet the goals.

The Governor's Health Cabinet concept was expanded to include the private sector and other employers of all sizes with the establishment of the "Smart Buy Alliance"[5], representing together nearly 3/5 of the Minnesota market. The Alliance was named the "smart buy" because the goal is not to simply gang up and drive discounted prices for some that ultimately shift costs to others. The goal is to buy smarter by collectively sending similar signals to the market, especially in seeking out and rewarding "best in class" health care providers; adopting and utilizing uniform measures of quality and results; providing easy access to information for consumers and purchasers; and promoting use of health information technology.

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5 For further information about the Smart Buy Alliance, see reports by the Commonwealth Foundation, including *Minnesota's Smart-Buy Alliance: A Coalition of Public and Private Purchasers Demands Quality and Efficiency in Health Care at:* http://www.commonwealthfund.org/innovations/innovations_show.htm?doc_id=278285 and *Value-Driven Health Care Purchasing: Case Study of Minnesota's Smart Buy Alliance* at: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=515815

I also signed into law this past legislative session the creation of a multi- Health Care Transformation Task Force to further explore and develop ways to bring about needed change, and to reduce the rate of health care cost increases for all Minnesotans, including small business.

As a result of these efforts, Minnesota's Medicaid program, the state employee health benefits program, and nine private sector employers have instituted one of the largest state-based health care pay-for-performance efforts in the nation through a program known as Bridges to Excellence. Together they represent one-seventh of all Minnesotans. Under this program, health care providers who demonstrate superior outcomes with patients with certain chronic diseases receive special recognition and financial bonuses.

Greater alignment of appropriate incentives and practices is also needed to dramatically improve the use of health information technology. Unlike the financial, transportation, and other sectors of the economy, health care has lagged far behind in its use of IT solutions to improve patient care and to reduce the logjam of millions of routine health care administrative transactions each year. The result is poorer, more costly care for patients with everyone paying the bill, not to mention the continued hassle factor and waste in just administering the system.

To help move health care into the twenty-first century, I signed legislation last spring that requires all health care providers to implement electronic health records by 2015. I also signed legislation requiring all providers and payers to exchange routine administrative transactions electronically, in a single standard format, by 2009. In September 2007, we announced the Minnesota Health Information Exchange - a public-private nonprofit, including our state Medicaid program, and other large health plans and health care providers, to connect doctors, hospitals and clinics across health care systems so they can quickly access medical records needed for patient treatment during a medical emergency or for delivering routine care.

These efforts to increase the use of health IT are being undertaken to ensure better patient care and outcomes, in order that more of each dollar spent will be devoted to quality patient care, and to produce significant savings across the health care system.

These and other health care reform efforts and accomplishments are important, necessary first steps to help lower the cost of health care, engage consumers in a meaningful partnership in their care, and make our health care markets operate more effectively. However, they are not sufficient to fully transform the health care system and additional steps are needed.

Next steps toward reform

First, we have to improve the health of our population. This is a long term strategy, but one that has the largest potential payoff. We need to have a concerted and coordinated effort to reduce health risks causing needless loss of life and productivity. We need to reverse the obesity epidemic, lower smoking rates, increase physical activity and reduce

levels of alcohol consumption. If current trends continue, more and more Minnesotans will be at risk of preventable chronic diseases. If we want to control costs, we need to stop adding more people with preventable chronic diseases to the health care system.

Second, we need to continue and expand our efforts to make information more transparent and meaningful to health care providers, purchasers, and individuals. This means we must come to a consensus on what constitutes high quality care and encourage competition among providers to achieve the highest possible quality at the lowest cost. To do this, we need to expand quality measurement and price reporting while making this information even more available and understandable to consumers.

Third, we need to make it easier for small employers and their employees to be able to purchase and afford insurance coverage. We need to make sure everyone has access to advantages of paying for health insurance with pre-tax dollars. We can do this by encouraging the use of Section 125 plans and developing an easy one-stop-shop insurance exchange to help employers and employees obtain information about coverage options and to facilitate paying for and purchasing coverage.

Finally, and most importantly, we need to continue and strengthen efforts to fundamentally reform how we pay for health care. Our system too often rewards simply doing more, regardless of quality. Commonsense ideas and innovations by providers are stymied by the archaic way we pay for health care and we must move to a system that explicitly rewards value rather than quantity.

For example, a large Minnesota multi-specialty provider group, Park Nicollet Health System, achieved significant improvement in patient health, avoided heart damage and individual suffering for many, and averted 625 hospital admissions per year through a special congestive heart failure program. However, the hospital faces a projected loss of around $5 million/year because the current payment system does not provide for a rate of return on investments such as this, despite the demonstrated savings.

We need to move to a payment system that more completely and explicitly rewards quality. In Minnesota we are proposing a payment reform policy that will better coordinate and facilitate effective care, especially for people with chronic disease. We will align the incentives for providers to be lower cost, higher quality providers of care, and for individuals to choose and use providers who achieve the best outcomes at the lowest cost.

This policy reforms our payment system to provide choices, to more clearly reveal prices and quality, and to encourage more effective, stronger competition in the market. We envision a market where health care providers will establish a uniform price regardless of who is paying the bill. It will not encourage continued consolidation among health plans and providers, as our current system does but will encourage new levels of competition. It will reward innovative providers, who find ways to achieve better health outcomes at lower costs, rather than punishing them. It will give providers the flexibility to deliver the care that is right for their patients, at the right time, in the right place and setting. In

return, our payment system will reward value, and ensure that providers are responsible for delivering lower cost and higher quality care. In this new approach, consumers will be empowered with tools and information to choose among health care delivery choices and options, but will also be expected to share in the costs of those decisions.

Aligning with the federal government

States such as Minnesota are actively working to innovate and explore new approaches to solve fundamental problems in health care. It will be important is to allow states the flexibility to continue to innovate and try new ways, whether with the state's single largest health care cost item, the federal-state Medicaid program, or other programs and initiatives. I encourage Congress to continue to allow options under Medicaid for states to find creative means of covering their uninsured populations.

The availability of IRS Section 125 plans makes health care insurance more affordable by allowing employers and employees to purchase health benefits on a pre-tax basis. However, many employers and their employees have not established the Section 125 plans and are paying for health benefits with after-tax dollars, effectively increasing their cost.

In addition, as employers plan for the future, they may take desire to take advantage of opportunities to move from what is known as a "defined benefit" health benefits plan to one known as a "defined contribution", in ways that minimize perceived downsides of the transition for the employer and employees.

Oftentimes small employers are now faced with a difficult "all-or-nothing" choice – continue to offer an expensive health benefits when they can really no longer afford them, or stop offering them all together in order to stay in business. However, employers' flexibility to move to a defined contribution approach is currently limited by federal requirements such as provisions in the Health Insurance Portability and Accountability Act (HIPAA) that are in conflict with individual health insurance market issuance laws in Minnesota and many other states.

States need all the tools that they can get in their efforts to support small employers that want to continue to contribute to health insurance benefits, and we would ask Congress to examine ways it can support states and private employers in these efforts.

Conclusion

Thank you, Madame Chair, for this opportunity to present today. I commend you and this committee for taking on this tough issue. I have tried to convey the need for fundamental changes and reforms that are needed to control rising health care costs for small businesses and government. I also hope that you consider further opportunities for change. In Minnesota, we have a very strong history of public-private collaboration. I encourage employers of all sizes, including small employers, to join in this effort. I

would ask the federal government to partner with states to help restructure the payment system to ensure all Americans receive the best care for the best cost.

Again, thank you for this opportunity to present to the committee today.