Recommendations to the Health Care Financing Task Force

Submitted by the Board of Directors of the Minnesota Chapter of Physicians for a National Health Program

August 25, 2015

In a document entitled "Principles of Health Care Reform," Minnesota PNHP has presented the most important principles that should guide the task force in its deliberations. In this letter we make recommendations to the task force regarding specific issues. These recommendations are based on the aforementioned principles, and are tailored to meet the task force's statutory mandate.

The legislature instructed the task force to address these four "options" for publicly financed programs: sustainable financing, coverage, purchasing, and delivery (see DHS's summary here http://mn.gov/dhs/hcftf/about/).

We begin with four recommendations about process, and then turn to recommendations about each of the four options.

RECOMMENDATIONS REGARDING PROCESS

We urge the task force to adopt these four rules of procedure. The rules maximize task force accountability and public understanding of the task force's decisions. The first three rules are mutually reinforcing.

1. **Evidenced-based health policy**. To enhance its own accountability and to facilitate a clear public debate, the task force should, to the extent possible, base its diagnoses of problems and its solutions to those problems on empirical evidence drawn from the peer-reviewed literature. If the evidence for a position the task force wishes to take is mixed, weak, anecdotal, or non-existent, the task force should state that fact.

2. **Clear language**. To enhance its own accountability and to facilitate a clear public debate, the task force should avoid jargon to the extent possible and clearly define the terms it uses. The phrase "payment models that support and reward coordination of care" (taken from subdivision 2 of the authorizing statute) is an example of a statement containing jargon needing clarification. "Accountable care organization" is another example. Clear definition of terms will enhance the ability of the task force, the legislature, and the public to determine whether the task force's diagnoses and recommendations are evidence-based. Conversely, diagnoses and recommendations bristling with vague jargon make it difficult to evaluate the underlying evidence base, if any.

3. **Minority report**. To enhance its own accountability, to facilitate a clear public debate, and to strengthen the incentive to follow the first two procedural rules mentioned above, the task force should adopt immediately a policy of encouraging a minority report along with the majority report to be issued next January. Knowing that a minority report is possible, the majority will have even more incentive to ensure its diagnoses and recommendations are persuasive, which is to say, evidence-based and clearly described. If consensus is not possible, the public should be apprised of that fact and allowed to see the issues about which the task force could not reach agreement.

4. **Consistency with principles**. The task force should adopt a set of principles guiding its work. We recommend it adopt the three procedural guidelines listed above as well as the principles identified in the PNHP principles document. The task force should consult these principles routinely.

RECOMMENDATIONS REGARDING SPECIFIC ISSUES THE TASK FORCE SHOULD DISCUSS

In this section we recommend specific issues that the task force address. The issues are divided into the four "options" described by subdivision 1 of the statute which created the task force.

Sustainable financing.

The task force should state that "sustainability" must be achieved by lowering the total cost of public programs, not merely by pouring more resources into the programs.

At minimum, the task force should define "total costs" to mean *all monetary* costs incurred by *all* payers (employers, providers, insurers, patients, and government agencies), including administrative costs.

Ideally the task force should consider more than monetary costs in assessing sustainability. These include the longer-term costs that are more difficult to convert to monetary terms, such as further consolidation of the system and burn-out of doctors and nurses caused by excessive demands for documentation and ever-diminishing autonomy. A system that drives doctors and nurses from their professions and which further consolidates the insurance and medical sectors cannot be said to be sustainable. Policies which shift more and more insurance risk to, and impose more costs upon, clinics and hospitals directly encourage consolidation among them, which in turn induces more consolidation among insurers. The new competitive bidding process almost certainly encourages consolidation within the insurance industry.

Calculating all monetary costs will require the task force to inquire about costs current policies impose. In view of the task force's limited time and resources, *we recommend that the task force select one or two existing state policies (for example, report cards that purport to measure quality, or ownership of electronic medical records)and estimate the total cost of those policies*

before recommending any solutions based on those policies. "Value-based purchasing" is an example of a recommendation that would require the continuation of mandated data reporting to support report cards and the use of electronic medical records.

Coverage.

We support unifying Medical Assistance with other public programs for the purpose of reducing the complexity of these programs and reducing the cost of administering them.

Purchasing and delivery.

We have been deeply concerned about the growing size and unaccountability of the state's insurance industry and its largest hospital-clinic chains. These problems – consolidation and lack of accountability – have been encouraged directly by policies adopted by the state legislature and Congress over the last several decades, and indirectly by lackluster interest in these issues exhibited by the legislature and DHS.

DHS's recent decision to exclude UCare and South Country Health Alliance from public programs illustrates the absence of accountability, and it probably illustrates as well the problem caused by the enormous size of the largest insurers. We say "probably" because no one at this date outside of DHS knows why DHS made the decision it made. We urge the task force to investigate DHS's decision to exclude UCare and South Country and to consider the results of this investigation when making recommendations about "purchasing and delivery" as well as "sustainable financing."

It is entirely possible that UCare's bid (we mean hereafter South Country as well when we refer to UCare) was higher than those of competing insurers. If so, we suspect the primary reason was that the larger insurers use their market power to extract discounts from the providers they own or contract with that are larger than any discounts UCare can extract. *We recommend the task force (1) determine the discounts that the largest insurers extract from providers, and then (2) decide whether Minnesota should continue a policy that determines provider reimbursement rates based on the market-share of the insurers they deal with.*

But we also entertain the possibility that UCare insured sicker and poorer, and therefore more expensive, patients, and that DHS's risk-adjustment method is too crude to compensate UCare accordingly. *We recommend that the task force determine whether UCare insures more expensive patients and whether DHS has the ability to adjust bids accordingly.*

What is indisputable is that DHS's process for making these decisions is impossible even for UCare to understand (cf. UCare's lawsuit against DHS). *We recommend the task force investigate DHS's criteria for awarding contracts and the transparency and cost of the process it uses.*

We recommend that after the task force has investigated the three questions posed above, *the task force recommend a new method of purchasing and delivering health care for Minnesota's publicly insured residents that meets the principles outlined by PNHP, that reverses consolidation, that guarantees all health care professionals and hospitals will be paid the same fee for the same service, and that ends the secrecy over where our tax dollars go.* Guaranteeing a uniform rate of payment to all providers would remove the most important incentive for insurance companies to seek gigantic size. That in turn would remove the most important incentive for hospitals and clinics to seek gigantic size.

The method of purchasing and delivering health care recommended by the task force should indeed be new. Merely replacing "HMO" with another vaguely defined concept such as "ACO," for example, should not be construed to be new. ACOs as they are currently defined are no more transparent than HMOs have been, and would have all the incentives HMOs have had to get big, to extract discounts from providers that exceed those of other ACOs, and to conceal the disposition of tax dollars delivered to them.

Finally, we urge the task force, throughout its discussion, to stay focused on the reason the task force has been asked to discuss sustainable financing, coverage, purchasing and delivery: To improve the health and happiness of the people who live in Minnesota. That is the ultimate goal. The ultimate goal is not to provide income for the multiple layers of organizations that benefit from delivering health care.