CENTER OF THE AMERICAN EXPERIMENT

Updated November 20, 2014

HEALTH CARE:
STATE SOLUTIONS IN AN ERA OF FEDERAL CONTROL

Peter Nelson

Peter Nelson is the Director of Public Policy at Center of the American Experiment. Peter received his law degree from the University of Minnesota Law School where he was a member of the Minnesota Law Review.

EXECUTIVE SUMMARY

THE MINNESOTA POLICY BLUE PRINT
PRESCRIPTION FOR PROSPERITY

Minnesota's health care system struggles with many of the same problems as the rest of the country. In particular, high and rising health care costs have long been a top challenge facing Minnesota and the nation. Though it faces similar challenges, the state consistently leads the country in delivering broader access to higher quality care.

The primary explanation for rising health care costs lies in how health care is financed. As third party payers, private insurers and public health care programs insulate patients from the true cost of care. And because employers and the government fund the large majority of health insurance premiums, most people are also insulated from the cost of health insurance. As such, people do not weigh medical treatment costs or health insurance premium costs against their benefits or other spending priorities. Thus, there's very little consumer pressure to reduce health care costs.

In 2010, Congress passed the Affordable Care Act (ACA), also known as Obamacare. Unfortunately, the ACA puts Minnesota's health care system at serious risk. The federal law tends to double down on everything that's currently driving dysfunction in our health care system. It continues insulating people from health care costs by expanding the broken, expensive Medicaid program and mandating traditional employer-sponsored insurance. It also greatly expands costly regulatory burdens on insurers and providers. Thus, the ACA tends to aggravate problems, not solve them.

Beyond cost, the ACA, in combination with other health care trends, is diminishing patient control over their own health care, including their relationship with their doctor, their health records, and their privacy.

All the while, the federal law took problem-solving flexibility away from states—states like Minnesota that were doing many things right—by transferring control

over the most important health care regulation from state governments to the federal government.

Looking forward, the passage of the ACA makes the future of health care in Minnesota much more uncertain and challenging. Still, despite entering a new age of federal control over health care, states are not entirely powerless. The following recommendations offer state solutions to address risks posed by the ACA and to improve health care in Minnesota.

Increase competition and affordability in the health insurance market

1. Reduce barriers to employer-based defined contribution health plans

2. Convert MinnesotaCare into a premium subsidy program that empowers enrollees to afford individual health insurance.

3. Offer state employees a defined contribution health plan option.

4. Expand the insurance market from a state market to a regional market through an interstate health insurance compact.

Promote the next great innovations in health care

5. Apply for an ACA Section 1332 waiver to redesign insurance regulation and insurance premium subsidies to free insurance companies to innovate.

6. Establish a task force to develop strategies to work toward market-based pricing of provider services.

7. Pursue innovative strategies to redesign Medicaid long-term care to control spending growth through a broad waiver.

Enhance patient control over their own health care

8. Empower and engage consumers to manage and control their health care and health data better through personal health records.

THE PROBLEM

Minnesota's health care system struggles with many of the same problems as the rest of the country. In particular, high and rising health care costs have long been a top challenge facing Minnesota and the nation. Though it faces similar challenges, the state consistently leads the country in delivering broader access to higher quality care.

In 2010, Congress passed the Affordable Care Act (ACA), also known as Obamacare. Unfortunately, the ACA puts Minnesota's health care system at serious risk. The federal law tends to double down on everything that's currently driving dysfunction in our health care system. Thus, the ACA tends to aggravate problems, not solve them. All the while, the federal law took problem-solving flexibility away from states like Minnesota that were doing many things right. The ACA in combination with other health care trends is diminishing patient control over their own health care, including their relationship with their doctor, their health records, and their privacy.

Looking forward, the passage of the ACA makes the future of health care in Minnesota much more uncertain and challenging.

High costs and access limitations pose long-running challenges to the health care system

The basic health care challenges America faces today are not new. Here's how Arnold Rosoff, a business law professor at the University of Pennsylvania Wharton School, described the health care "crisis" in 1975.

> That the health care system in the United States is in a state of crisis is an observation so frequently made that it rarely generates debate any more. The high cost of care is the most dramatic problem, with health care expenditures now totaling approximately eight percent of our gross national product and expected by some to exceed 10 percent in the next few years. No less serious is the problem of availability and accessibility of care.[1]

Nearly the exact statement could be made today, except for the fact that the numbers reveal a much deeper crisis: National health care expenditures now top 17 percent of gross domestic product (GDP).[2]

In terms of access, the uninsured rate provides the main gauge of the problem. The national uninsured rate for people under 65 years old hit an historical low of 12 percent in 1978 and has hovered between 16 and 18 percent since 1990.[3] Beyond

the general problem of people lacking coverage, another major concern with access to care has been the fact that many people with preexisting health conditions cannot purchase health insurance.[4]

The main cause of rising costs hasn't been addressed

In 1982, Harvard professor Paul Starr published the seminal history of health care in America, *The Social Transformation of American Medicine*. Though many people at the time attributed rising health care costs to the implementation of Medicare and Medicaid or medical technology advancements, Starr explained the "more fundamental explanation lay in the basic incentives in the health care system, especially its financing arrangements, which Medicare and Medicaid had only reinforced." He went on to explain the problem this way:

> The tolerance of the market for higher prices allowed costs to increase. Higher incomes and higher expectations were partly responsible for that increased tolerance, but the key was the structure of financing.
>
> As third parties, both private insurers and government programs effectively insulate patients and providers from the true cost of treatment decisions and so reduce the incentive to weigh costs carefully against benefits.

The same holds true today. In his 2012 book, *Priceless: Curing the Health Care Crisis*, economist John Goodman describes the problem in similar terms.

> [W]e have completely suppressed normal market processes in healthcare—in this country and all over the developed world. As a result, in healthcare few people ever see a real price for anything. Employees never see a premium reflecting the real cost of their health insurance. Patients almost never see a real price for their medical care. Even at the family doctor's office, it's hard to discover what anything costs. For something complicated, like a hip replacement, the information is virtually impossible to obtain.
>
> On the supply side, doctors and hospitals are rarely paid real prices for the services they render.

While stating basically the same cause of the problem as Starr, Goodman helpfully emphasizes two points. First, insurance consumers are insulated from rising costs because employers pay the lion's share of private insurance premiums. As such, people do not weigh medical treatment costs or weigh health insurance premium costs against their benefits or other spending priorities.

Second, there is no normal, free market for health care. The power of a market is its ability to organize complex systems. No top-down approach can ever match

a market's ability to allocate resources to their highest and best use, to identify consumer demand for high quality and low prices, and ultimately to meet those demands. It's the suppression of market forces that has permitted health care costs to rise faster than inflation for a half century. Though some say markets can't work in health care, the evidence points in one direction, according to Goodman, and shows "markets can work much better than our current system, if they are allowed to do so."

Unfortunately, since the health care crisis emerged in the 1970s, America has primarily tried top-down "solutions," not market-based solutions. These top down solutions generally aim at regulating the health care system to expand access and control prices and nearly always stir up unintended consequences and fail to tackle the underlying problem. The government simply can't organize something as complex as the health care system any better than the Soviet Union could organize the delivery of basic consumer goods. Yet that hasn't stopped the government from attempting to set health care prices and dictate the type of health care people must buy. The ACA is simply the most recent and comprehensive attempt at central planning of our health care system. Predictably, none of this has "bent the cost curve."

Minnesota does not escape high and rising health care costs

How does Minnesota's health care system fare?

There is a perception health care costs substantially less in Minnesota—a perception that Minnesota mitigates, at least in part, the perverse financial incentives driving up costs.[5] However, high and rising health care costs pose just as serious a problem for Minnesota as elsewhere.

To establish a pre-ACA baseline, the Centers for Medicare & Medicaid Services (CMS) created state-level estimates of health spending per capita for the years 1991 to 2009.[6] During this period health spending per person in Minnesota grew at an average annual rate of 5.9 percent, faster than the national average of 5.3 percent. By 2009, health care spending per person in Minnesota reached $7,409, which was nearly $600 (nine percent) more than the national average.[7]

The U.S. Department of Health & Human Services Medical Expenditure Panel Survey (MEPS) shows private health insurance in Minnesota costs about the same as the national average. Between 2009 and 2012, the average family coverage premium for private sector employees cost $14,513 in Minnesota compared to $14,348 nationally.[8] Single coverage premiums in Minnesota cost $5,082 compared to $5,054 nationally.[9]

Looking forward, projected growth in Minnesota health care costs mirrors the high growth projections for the nation. Annual growth in health care spending for both Minnesota and the nation is projected to average six percent or more.[10]

This is faster than the economy is projected to grow, which means health care spending will continue to consume a larger share of GDP.[11] As a result, an increasing portion of workers' wages will go to pay for health insurance and leave families with less income to improve the house, send kids to camp, and save for retirement. State and federal governments will either have to raise taxes—again leaving less income for families—or reduce spending on other priorities like education and transportation. Most likely, they will do some of both.

Minnesota performs better on quality and access

Though Minnesota might not deliver lower-cost care, it does deliver higher quality and broader access than nearly every other state. Among the states, the Commonwealth Fund 2014 Scorecard on State Health System Performance ranks Minnesota number 1 overall.[12] The United Health Foundation ranks Minnesota as the third healthiest state.[13] Digging deeper into the United Health quality rankings, Minnesota has fewer low birth weight babies, fewer preventable hospitalizations, and fewer people with diabetes. Additionally, the state boasts the lowest percentage of people reporting poor physical health, the lowest cardiovascular death rate, and the lowest premature death rate.

The uninsured rate in Minnesota is also among the lowest in the nation. In 2013, according to the most recent Census Bureau data, the state had the sixth lowest uninsured rate.[14] As recently as 2005, Minnesota had the lowest uninsured rate.[15]

People with preexisting conditions also had better access to affordable health coverage in Minnesota. Since 1976, any Minnesotan denied coverage in the regular insurance market has been able to gain coverage through the state's high risk pool. Premiums for this coverage were capped by law at 125 percent of comparable private coverage. Though 35 states also ran high risk pools, Minnesota's pool offered the best protection. No state had more covered lives in their pool than Minnesota.[16]

A number of factors contribute to these better outcomes. To start, the people of Minnesota tend to make healthier choices. A very large portion of Minnesota workers receive coverage through their employer. Minnesota's hospitals and clinics hold a well-deserved reputation for excellence. And Minnesota health insurance companies always seem to be on the leading edge of innovating new health plan designs.

Even state regulation deserves some credit. As already noted, people with preexisting condition have long been able to access affordable insurance through the state's high risk pool, which appears to have contributed to a more stable insurance market.

That said, state regulations often go too far. For instance, Minnesota subjects insurers to 49 coverage mandates, the sixth most in the country.[17] The results of a recent study published in the *Eastern Economic Journal* found "that mandates seem to account for 9.3 percent to 23.6 percent of all premium increases from 1996 to 2011."[18] Part of the state's success may be tied to the fact that Minnesota leads the country in the proportion of people who manage to avoid state insurance regulations altogether. Around 70 percent of Minnesotans with employer-sponsored coverage are in self-insured health plans—plans where the employer assumes the financial risk—which are exempt from state regulation.[19]

The ACA will aggravate problems

The Affordable Care Act (ACA) was enacted in 2010, purportedly to address many of the problems discussed above. Indeed, after signing the ACA, President Obama claimed the law would expand coverage and lower costs.[20] The ACA will indeed expand coverage, but only by increasing costs and aggravating other problems. As mentioned above, health care inflation is not projected to "start slowing down" as the President said it would.

Health care costs will continue inflating because the ACA expands coverage by doubling down on the dysfunctions and perverse financial incentives that have long been the source of higher costs. First, it relies on expanding Medicaid—a state and federal public health care program long beset with cost and quality problems. Second, it relies on mandating traditional employer-sponsored coverage. Employers play an important financing and administrative role, but traditional employer-sponsored health plans continue shielding employees from the true costs of insurance. Third, it relies on substantially increasing the regulatory burden on insurers and providers. Each new regulation adds new costs, and most will have unintended consequences.

The ACA diminishes individual patient control over health care

Beyond cost, the implementation of the ACA diminishes the individual patient's control over their health care. Here are some of the key ways the ACA reduces patient control:

- The ACA reduces the types of insurance options available to people. Mandates force people to pay for benefits they don't need.

- The ACA limits innovations that might improve the customer experience and the quality of care. Health plans must spend a specific portion of a premium on health care. This limits what they can spend to improve the customer experience in other ways, such as spending to provide consumers with more transparent information on provider prices and to integrate the health plan with personal health records.

- The ACA reduces the time doctors can spend with patients by increasing the time they must spend satisfying new administrative burdens, especially requirements related to implementing Electronic Medical Records.

- The ACA reduces the pool of doctors available to Medicaid and Medicare patients. Many doctors don't accept Medicaid patients because the program's reimbursement rates are too low. Expanding Medicaid expands doctors' incentive not to see Medicaid patients. The ACA also cuts Medicare reimbursements, which increases a doctor's incentive to opt out of Medicare.

- The ACA encourages doctors to deliver care based on the health of the population versus the health of the individual patient. A common criticism of the health care system is that it pays for volume, not value. The ACA, through Medicare demonstration projects, encourages movement toward value-based purchasing. Value-based purchasing, however, tends to require someone other than the patient, such as the government or an insurer, to define value. If the value equation isn't driven by the patient, it will likely be driven by what is generally best for the health of the population.

ACA limits Minnesota's ability and flexibility to solve health care problems

On top of aggravating the primary existing problems in the health care system, the ACA limits what states can do to help solve these problems. There's truth behind the charge that the ACA is a government takeover of the health care system. More precisely, the ACA is a *federal* takeover, an unprecedented transfer of control over health care regulation from state governments to the federal government.

While the supporters of the law claim that states remain in control of health insurance regulation, the federal government took over the most important aspects of insurance regulation. The federal government defines the following:

- when insurers must sell insurance to individuals;

- the base level of benefits insurers must provide;

- how much of an insurance premium must go toward health care expenses;

- the preventive services health plans must cover at no charge;

- how much young adults must subsidize older adults;
- the limits on the size of a deductible;
- which employers must provide health insurance; and
- the features that must be included in the new health insurance marketplaces.

With all the new federal insurance regulations, there's very little left for states to control. Thus, there's very little flexibility left to Minnesota to develop and promote state-based solutions to improve health insurance coverage.

The ACA puts Minnesota's health care system at risk

Recall how Minnesota's health care system delivers higher quality and broader access. The ACA puts Minnesota's health care system at risk because it touches every player driving Minnesota's better health care outcomes—patients, providers, employers and the state. Some risks are obvious. Patients may start having more trouble accessing their preferred doctor if health plans move to narrower networks. Providers may further consolidate and reduce what value-enhancing competition exists. State health care spending may crowd out education spending or other state priorities. Individuals and employers, especially small employers, may see dramatic rate increases. Health care quality may decline if doctors are distracted by unnecessary administrative burdens. Other consequences, because they're unintended, are not as obvious and the state will have to wait to see how the law plays out.

Still, despite entering a new age of federal control over health care, states are not entirely powerless to address these risks and to work toward real health care solutions. The rest of this report outlines steps Minnesota can and should take to improve health care.

WHAT MUST BE DONE

Moving forward, states can continue to lead. Specifically, Minnesota should focus on increasing competition and affordability in the health insurance market, maintaining an environment that promotes the next great innovations in health care, and enhancing patients' control over their own health care.

Increase competition and affordability in the health insurance market

Though health insurance markets are now primarily regulated at the federal level, there are certain strategies the state can implement to increase competition and thereby increase affordability. One of the main factors driving higher health care costs discussed above is that people with employment-based health insurance are rarely exposed to the cost of health insurance and, therefore, never need to weigh the cost of insurance against other priorities in their lives. The state should focus on advancing the individuals' roles in shopping for and ultimately owning their own health insurance. In addition, there are steps the state can take to encourage more insurers to compete in the market.

Recommendation 1: Reduce barriers to employer-based defined contribution health plans

Employers play an important role in providing access to affordable, high quality health insurance and will continue to do so. The federal tax code's preference for employer-sponsored coverage, however, creates a strong incentive for one type of employer-based health plan model. Under this model, the employer makes all the decisions and the individual employee is insulated from the consequences of those decisions. Employers should be allowed to rebalance their health plans to give individuals more choice and ownership over their health plans, while still maintaining the tax preferences available to traditional health plans. This more balanced approach is called a defined contribution (DC) health plan.

In a DC plan, the employer provides the employee with a defined (fixed) dollar amount each month, which the employee can then use to shop for a health plan on the individual market. Private retirement plans long ago successfully shifted to this model. Most people are familiar with 401(k) retirement plans; a DC health plan would be structured similarly.
Both the employer contribution and any employee contribution, if necessary, should be made pre-tax. Because the health plan is purchased on the individual market, employees own their health plans and do not lose them when they switch or leave jobs.

Unfortunately, there are both state and federal barriers to DC health plans. To reduce these, the state should take the following two steps:

1. *Allow insurance brokers to advise employers to switch to a DC health plan.*

At the state level, an outdated law—according to some interpretations— restricts insurance brokers from advising lawmaker to switch from a traditional group health plan to a DC health plan to fund individual health insurance premiums. This law should be repealed.

2. *Create a new type of group insurance coverage to accept pre-tax contributions from employers that easily converts group coverage to individual coverage (and individual coverage to group coverage) with changes in job status.*

The federal barrier to a DC health plan is more serious. Federal agencies issued guidance last year which generally prohibits employers from making contributions to fund *individual insurance coverage* through a DC health plan.[21] The reason for the prohibition is largely to protect against employers dropping group coverage, either because they have sicker, more expensive employees or because they want to double dip on tax advantages available to employer contributions and tax subsidies available to individuals in the exchange.[22] The guidance basically states that an employer health plan can be integrated with *group* insurance coverage, but cannot be integrated with *individual* insurance coverage.

The state should create a new type of group insurance coverage that employers can fund with pre-tax contributions under a DC health plan. To gain the benefits of individual choice and individual ownership over health insurance coverage, this new group coverage should easily convert to individual coverage and then back to group coverage. To do so, people covered by the new group coverage should be in the same risk pool as people with individual coverage, and benefits and cost sharing should be identical. In effect, this would be a merger of the individual and group markets.

Helpfully, the ACA specifically allows for at least the individual and small group markets to be fully merged together.[23] A partial merger where small and even large employer groups could choose to pool with either the individual market in a DC health plan arrangement or remain with the traditional group markets may also be possible.[24] A partial merge would not upset current group insurance arrangements and would allow large groups to participate. However, giving employers a choice could lead to an adverse selection problem where healthier groups tend to pick one pool and less healthy groups pick the other. These benefits and risks would need to be weighed carefully.

Furthermore, the Minnesota Department of Commerce will need to provide a clear regulatory framework to establish that this new type of group coverage satisfies the ACA's health plan requirements at issue. In doing so, the state should be sensitive to the federal concerns behind the prohibition on employers making pre-tax contributions

to individual health plans. To the extent the federal government has reason to worry about employers "abusing" the tax code, the state can fix the problem when politicians at the federal level cannot by banning employers from contributing to health plans sold through the state insurance exchange. This sensitivity should help avoid any push back from the federal government.

Recommendation 2: Convert MinnesotaCare into a premium subsidy program that empowers enrollees to afford individual health insurance.

MinnesotaCare is administered through private managed care health plans. However, MinnesotaCare is not a traditional insurance product, and like every government health plan, it reinforces the perverse financial incentives that increase health care costs. Providing a premium subsidy would empower people to own true individual insurance coverage that they could continue owning as their income rose above MinnesotaCare's income thresholds.

Recommendation 3: Offer state employees a defined contribution health plan option.

The state should offer a DC health plan option for state employees. The advantages to empowering individuals to choose and own their health plan is no different for state employees. Currently, the average premium for a state employee with single coverage is $503 and the average premium for an employee with family coverage is $1,480.[25] The state covers the full amount for single coverage and $1,333 for family coverage, on average. These amounts are more than enough to provide meaningful coverage options through DC health plan.

Recommendation 4: Expand the insurance market from a state market to a regional market through an interstate health insurance compact.

The state should allow Minnesotans to buy health insurance across state lines with our Midwestern neighbors through a regional insurance market, such as but not limited to a "Health Care Choice Compact" under Sec. 1333 of the ACA. An interstate health insurance compact would create uniform regulatory standards across member states that allow individuals to purchase health insurance products from these other states. This compact would operate much the same way as the Interstate Insurance Product Regulation Commission, an organization that "serves as a central point of electronic filing for certain insurance products, including life insurance, annuities, disability income, and long-term care insurance to develop uniform product standards, affording a high level of protection to purchasers of asset protection insurance products."[26] A similar compact would provide consumers with access to more competitive health insurance products without sacrificing consumer protection standards.[27]

Promote the next great innovations in health care

Too often, state and federal regulations stymie innovations in health care. Health benefit mandates, limits on cost sharing, and other health insurance regulations on health benefits restrict health insurers from innovating new insurance products. Physicians, clinics, and hospitals also must be freed from stifling regulation and bureaucracy to use their intelligence and creativity to develop and adopt new strategies to deliver higher quality care at a lower cost.

Recommendation 5: Apply for an ACA Section 1332 waiver to redesign insurance regulation and insurance premium subsidies to free insurance companies to innovate.

The ACA's federal takeover of insurance regulation leaves little left to states to regulate and little room for insurers to innovate. However, the ACA does give states the opportunity to apply for a "Waiver for State Innovation," otherwise known as a Section 1332 waiver. Under a 1332 waiver, Minnesota may request to waive the ACA's requirements related to qualified health plans, essential health benefits, limits on cost sharing and deductibles, metal level categories, actuarial value, and insurance exchanges. In addition, states can request to waive IRS regulations on premium tax credits, the employer mandate, and the individual mandate. The law encourages states to combine this waiver request with other requests to waive Medicaid and Medicare regulations. Altogether, this waiver provides an opportunity to redesign both insurance regulation and insurance premium subsidies.

Of course, there are strings attached to receive a waiver. The state plan must provide coverage that is at least as comprehensive as the essential health benefits now required, coverage and cost sharing that is at least as affordable as ACA coverage, coverage to a comparable number of residents, and must not increase the federal deficit.

Vermont officials plan to use this waiver to move toward a single-payer system, but there is no reason the same waiver could not be used to move toward market-based health care. Here are some important improvements a state could make through a 1332 waiver:

- Limit MNsure, the state insurance exchange, to qualifying people for public programs and subsidies, which would protect the insurance market from any duplicative and distortionary behavior on the part of MNsure.
- Reduce disincentives to work found in the current structure of premium subsidies.
- Redesign premium subsidies to focus on the truly needy by, for instance, imposing an asset test to qualify.

- Give insurers more freedom to set minimum health benefits.
- Empower employers to design their own health plans.
- Eliminate the mandate on individuals to buy insurance.

Recommendation 6: Establish a task force to develop strategies to work toward market-based pricing of provider services.

A common criticism of the health care system is that providers tend to be paid a fee for each service they deliver, which perversely rewards them for delivering higher volume, not higher value. There's some truth to this, but fee-for-service payment is not the problem. The problem is that the prices (fees) set for each service are usually cost-based prices, not market-based prices. The price of each service tends to be set by Medicare which bases the price on the cost of delivering the service. Medicare pricing tends to guide pricing in the rest of the market.[28] When services are priced on their cost, the price fails to reflect the consumer demand for the service or any additional value the service might deliver. Cost-based pricing also fails to put pressure on reducing the price because the price and the cost of the service are one in the same. As a result, cost-based pricing fails to reward innovations that deliver lower costs and higher value.

Prices for provider services should be set by the market, not by the government. A market sets prices based on cost, demand, and value. This pricing rewards entrepreneurs who innovate ways to lower costs or provide services that better align with what consumers want. Moving toward market-based pricing is easier said than done. Health care pricing and provider payment systems are incredibly complicated. Furthermore, Medicare presents a powerful influence over prices and, therefore, a powerful obstacle to market-based pricing. To wade through the complexity, the state should establish a task force to develop a strategy to work toward market-based pricing.[29]

Recommendation 7: Pursue innovative strategies to redesign Medicaid long-term care to control spending growth through a broad waiver.

According to the report of the Minnesota Budget Trends Study Commission, "The aging of the population means that a larger share of the population will become eligible for and begin using expensive long-term care services under the Medical Assistance program."[30] Due to this rising demand and the substantial portion of state spending already devoted to long-term care, the state should renew its focus on innovating new ways to finance and deliver long-term care.

In a bipartisan effort, the state recently sought to redesign Medicaid long-term care through the Reform 2020 initiative. Despite only modest savings projected from the

initiative, it represented a positive step forward. Unfortunately, the federal government approved only two of twelve Reform 2020 elements.[31] While the federal government's waiver rejection is a substantial setback, Minnesota should redouble efforts to innovate and redesign Medicaid long-term care. The status quo is simply not sustainable. These efforts should focus on developing waiver proposals for the next presidential administration.

Enhance consumer control over their own health care management

Recommendation 8: Empower and engage consumers to manage and control their health care and health data better through personal health records (PHRs)

As our society moves to more management of our personal lives through sophisticated mobile devices, most health care data has been pulled in a different direction, stored in mega-data banks under the control of entities which either process payment or in Electronic Health Record (EHR) banks controlled by the EHR vendor and its hospital system contractor. These records are often incomplete for many reasons, including the mobility of Americans. This data management by outside entities does little to empower or engage the consumer in his or her management of both wellness and health care.

Personal health records (PHRs) can be a powerful tool for patients to control and manage their health care and wellness. Most progress has been made recently on "wellness apps" which track everything from sleep patterns to calories burned. While some of these products may not serve clinical value, most do encourage engagement by consumers in their own health and wellness. This interest should be expanded and empowered through further development of robust, interoperable PHRs. A PHR gains even more importance in light of all the ways the ACA diminishes patient control outlined previously. A PHR is distinct from an electronic health record EHR: While a PHR is managed by the patient, an EHR is managed by health care providers or payers.

EHRs pose a number of problems. First, despite a state law requiring providers to adopt EHRs that are interoperable "for sharing and synchronizing patient data across systems," this does not appear to be taking shape.[32] Thus, an Allina doctor cannot easily access a patient's data housed in a HealthPartners' EHR. Second, EHR data are generally not easily shared and synchronized with PHRs. Thus, patients can be dependent on multiple providers' EHR systems to access and manage information. Third, EHRs are not controlled by the patient. Though most patients probably want some of their data stored by their provider and shared across provider systems, patients often have legitimate privacy concerns over some or all of their health data.

So, on one hand EHRs are not yet equipped to share enough data across provider systems and PHRs. On the other hand EHRs risk compromising patient privacy if they do store and share data the patient wants private. EHRs present at least one additional

problem: government efforts to push providers to adopt EHRs create excessive and expensive administrative burdens, especially because of the lack of national standards for interoperability.

The state should establish a new statewide policy on PHRs and EHRs to help address some of these problems and empower patients to manage their health care and control their health data better. A new policy should encourage the following changes:

- Extend the functionality of EHRs to share and synchronize data with a patient's choice of PHR. This includes a standard for the PHR that limits alteration of data in the PHR but also allows the patient control over what data can be held private and not loaded into an EHR. Integrated EHR and PHR arrangements exist, but the integration is proprietary and so patients are locked into one EHR/PHR package;

- Enable patients to control the privacy of their EHR data better, preferably through their PHR. This empowers the patient as it requires the EHR provider to seek specific, rather than blanket, permission to share the patient's personal health information; [33]

- Share and synchronize insurance claims data with PHRs. Through MyMedicare.gov's Blue Button, Medicare already provides an easy way to download personal health information and import it into a PHR;[34]

- Reduce EHR (and PHR) reporting burdens on providers. Ideally, these burdens would be eliminated for small and independent providers; and

- Identify and remove barriers to adopting industry standards for interoperability. To share and synchronize data, an industry standard for connectivity is necessary to facilitate the secure movement of data across the Internet just like there is an industry standard to guarantee leak-free movement of water across plumbing fixtures or to transfer money through ATM machines. To date, specific industry vendors have blocked progress on an industry standard for competitive reasons, despite the billions of dollars invested in EHRs.[35]

ENDNOTES

[1] Arnold J. Rosoff, "The Federal HMO Assistance Act: Helping Hand or Hurdle?", *American Business Law Journal*, Vol. 13, No. 2 (Fall 1975): p. 137.

[2] Centers for Medicare and Medicaid Services, National Health Expenditure Data (n.d.), available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html.

[3] Robin A. Cohen, *Health Insurance Coverage Trends, 1959–2007: Estimates from the National Health Interview Survey*, National Health Statistics Report No. 17 (July 1, 2009), available at http://www.cdc.gov/nchs/data/nhsr/nhsr017.pdf; and Robin A. Cohen and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–March 2013*, (National Center for Health Statistics, September 2013), available at http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201309.pdf.

[4] Note insurance coverage or lack of coverage does not directly reflect a person's access to care. Some people without coverage can access care at free or low-cost clinics. Emergency rooms must also treat anyone who shows up. Furthermore, people who would qualify for Medicaid can basically wait to sign up until they need care because Medicaid allows retroactive payments.

[5] This perception largely stems from Dartmouth University researchers who regularly find Medicare spends less per person in Minnesota. Based on this research, President Obama specifically praised the Mayo Clinic in 2009 for its high quality, low cost care. No one disputes Mayo's quality, but there is a reason why most insurers don't include Mayo in their network and why people in the city of Rochester pay far higher insurance premiums than anyone else in the state. Mayo costs more. Peter J. Nelson, *The Mayo Clinic: High quality yes, but low cost?* (Center of the American Experiment, September 8, 2009).

Another factor driving this perception is the fact that Minnesota now has the lowest health insurance premiums in the individual market in the country. Yet these low rates are likely an aberration. Until the end of the year, many of the highest risk, most expensive people remain insured through the state's high risk pool. Moreover, the 2014 premiums offered by the lowest cost insurer in the individual market proved too low to sustain and so the insurer recently announced they will drop out of the state's insurance exchange in 2015. Paul Demko, "Reform Update: Exit of PreferredOne from MNsure raises practical and political questions," *Modern Healthcare*, September 19, 2014, available at http://www.modernhealthcare.com/article/20140919/NEWS/309199964. Furthermore, Minnesota insurers have substantial reserves, which would allow them to raise rates more conservatively and gradually. Jackie Crosby, "Minnesota health plans pile up big reserve," *Star Tribune*, July 15, 2013, available at http://www.startribune.com/business/215609981.html.

[6] Centers for Medicare and Medicaid Services, National Health Expenditure Data, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/res-tables.pdf.

[7] Higher than average spending is due to Minnesota's very generous Medicaid program. In 2009, Minnesota spent $9,851 per Medicaid enrollee, far more than the national average of $6,826. By contrast, the CMS data show Minnesota spent less per enrollee on Medicare ($8,941 versus $10,365) and about the same per enrollee on private health insurance ($3,649 versus $3,766). Clearly, Medicaid pushed Minnesota over the top.

[8] Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey*, Table X.D. Premium distributions (in dollars) for private-sector employees enrolled in family coverage at the 10th, 25th, 50th(median), 75th and 90th percentiles, private-sector by State; United States (various years), available at http://meps.ahrq.gov/mepsweb/. Survey data produced suspiciously high estimates for average family premiums in 2008 (Minnesota ranked 50th lowest) and suspiciously low estimates in 2013 (Minnesota ranked 10th lowest). Thus, these data were not used. AHIP surveys produce similar results.

[9] Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey*, Table X.C. Premium distributions (in dollars) for private-sector employees enrolled in single coverage at the 10th, 25th, 50th(median), 75th and 90th percentiles, by State; United States (various years), available at http://meps.ahrq.gov/mepsweb/. *See also* Center for Policy and Research, America's Health Insurance Plans, *Small Group Health Insurance in 2010: A Comprehensive Survey of Premiums, Product Choices, and Benefits* (July 2011), available at http://www.ahip.org/Small-Group-Report-2011.aspx; Center for Policy and Research, America's Health Insurance Plans, *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits* (October 2009), available at http://www.ahip.org/Individual-Health-Insurance-Survey-2009/.

[10] Minnesota Department of Health, *Minnesota Health Care Spending and Projections, 2012* (June 2014), available at http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/healthspending2014.pdf. The latest projections published in Health Affairs estimates health spending will grow 5.6 percent in 2014 and average 6.0 percent annual growth from 2015 to 2023, increasing health care expenditures as a share of GDP to 19.2 percent. Andrea M. Sisko et al, "National Health Expenditure Projections, 2013–23: Faster Growth Expected With Expanded Coverage And Improving Economy," *Health Affairs* (September 2014), available at http://content.healthaffairs.org/content/early/2014/08/27/hlthaff.2014.0560. Similarly, PricewaterhouseCoopers projects 6.8 percent spending growth in the employer-sponsored market in 2015. Pricewaterhouse-Coopers, *Medical Cost Trend: Behind the Numbers 2015* (June 2014), available at http://www.pwc.com/us/en/health-industries/behind-the-numbers/.

[11] Between 2014 and 2024, the CBO projects GDP will grow at an average annual rate of 4.5 percent. Congressional Budget Office, *Economic Projections: August 2014 Baseline From An Update to the Budget and Economic Outlook: 2014 to 2024* (August 27, 2014), available at http://www.cbo.gov/publication/45066.

[12] David Radley et al., *Aiming Higher: Results from a Scorecard on State Health System Performance, 2014,* (The Commonwealth Fund, April 30, 2014), avail-

able at http://www.commonwealthfund.org/publications/fund-reports/2014/apr/2014-state-scorecard.

[13] UnitedHealth Foundation, America's Health Rankings, *2013 Annual Report*, available at http://www.americashealthrankings.org/reports/Annual.

[14] U.S. Census Bureau, *Health Insurance in the United States: 2013* (September 2014), available at http://www.census.gov/hhes/www/hlthins/data/index.html.

[15] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage: 2005* (August 2006), available at http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2005/index.html.

[16] This is in part due to the fact that most states allowed higher premiums. By law Minnesota capped premiums at 125 percent of comparable private coverage, whereas most other states capped premiums between 150 and 250 percent of private rates. Also, some states capped the number of people allowed to be in the high risk pool.

[17] James Bailey and Douglas Webber, "The Political Roots of Health Insurance Benefit Mandates," Mercatus Center Working Paper #14-14 (May 2014), available at http://sites.temple.edu/jamesbailey/files/2013/10/PoliticsOfMandates10-29.pdf, *citing* Susan Laudicina, Joan Gardner, and Kim Holland, *State legislative healthcare and insurance issues: Technical report* (Blue Cross and Blue Shield Association, 2011). *See also* News Release, Council on Affordable Health Insurance, "CAHI Identifies 2,271 State Health Insurance Mandates," (April 9, 2013), available at http://www.cahi.org/cahi_contents/newsroom/article.asp?id=1115 (finding Minnesota has the fourth most insurance mandates in 2012).

[18] James Bailey, "The Effects of Health Insurance Benefit Mandates on Premiums," *Eastern Economic Journal*, Vol. 40 (Winter 2013): pp. 119-127. *See also* Amanda E. Kowalski, William J. Congdon, and Mark H. Showalter, "State health insurance regulations and the price of high-deductible policies," *Forum for Health Economics & Policy*, Vol. 11, No. 2 (2008). *But see* Tracey A. LaPierre et al., "Estimating the impact of state health insurance mandates on premium costs in the individual market," *Journal of Insurance Regulation*, Vol. 27, No. 3 (2009).

[19] Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey*, Table II.B.2.b.(1): Percent of private-sector enrollees that are enrolled in self-insured plans at establishments that offer health insurance by firm size and State: United States, 2013, available at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2013/tiib2b1.pdf.

[20] Barack Obama, Remarks by the President on Health Insurance Reform (University of Iowa Field House, Iowa City, Iowa, March 25, 2010), available at http://www.whitehouse.gov/the-press-office/remarks-president-health-insurance-reform-university-iowa-field-house-iowa-city-iow.

[21] Internal Revenue Service, Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements, Notice 2013-54, available at http://www.irs.gov/pub/irs-drop/n-13-54.pdf; and United States Department of Labor, "Application of Market Reform and other Provisions of the Affordable Care Act to HRAs,

Health FSAs, and Certain other Employer Healthcare Arrangements," Technical Release No. 2013-03 (September 13, 2013), available at http://www.dol.gov/ebsa/newsroom/tr13-03.html. *See also* Internal Revenue Service, "Employer Health Care Arrangements" (May 13, 2014), at http://www.irs.gov/uac/Newsroom/Employer-Health-Care-Arrangements.

[22] A forthcoming paper by this author will outline why federal law does not give the Obama administration the power to restrict tax advantaged DC health plans. Nonetheless, states must work within the current federal interpretation of the ACA until it is successfully challenged.

[23] Pub. L. 111-148, Sec. 1312 (c)(3).

[24] The ACA clearly allows states to continue regulating insurance when regulations do not conflict with the ACA. Pub. L. 111-148, Sec. 1321 (d).

[25] The Pew Charitable Trusts, *State Employee Health Plan Spending: An examination of premiums, cost drivers, and policy approaches* (August 2014), available at http://www.pewtrusts.org/~/media/Assets/2014/08/StateEmployeeHealthCareReportSeptemberUpdate.pdf.

[26] Interstate Insurance Product Regulation Commission, *About the IIPRC*, at http://www.insurancecompact.org/about.htm.

[27] Note that this is no cure-all for the absence of competition. Recall that the primary obstacle to competition is the fact that employers, acting as third party payers, are the primary purchaser of health insurance. Furthermore, out-of-state insurers may find it difficult to compete with the reimbursement rates Minnesota health plans negotiate with providers.

[28] This is a major simplification of Medicare pricing. Medicare pricing problems go much deeper, but that is an issue for another report.

[29] To be clear, this is not a call for value- or performance-based pricing, where a third party (an insurer or the government) measures the quality of the provider and adjusts payment based on performance.

[30] State of Minnesota Budget Trends Study Commission, *Commission Report to the Legislature* (January 12, 2009), available at http://www.mmb.state.mn.us/budget-reports-trends/324-budget-trends-reports/3060-report.

[31] Minnesota Department of Human Services, *Reform 2020 Waiver Post-Award Public Forum* [PowerPoint slides] (May 22, 2014), available at http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs16_184880.pdf.

[32] Minn. Stat. § 62J.495, available at https://www.revisor.mn.gov/statutes/?id=62J.495.

[33] According to Dr. David Nash with the Thomas Jefferson School of Population health, the future is "you would give permission to a provider to access the record you own." David Nash, Thomas Jefferson School of Population Health, Presentation to the Business Health Care Group, Milwaukee (September 30, 2014).

[34] Medicare.gov, "Download claims with Medicare's Blue Button," at http://www.medicare.gov/manage-your-health/blue-button/medicare-blue-button.html.

[35] Selena Chavis, "The Ongoing Quest for Interoperability," *For the Record*,

Vol. 25, No. 12 (September 2013), available at http://www.fortherecordmag.com/archives/0913p10.shtml ("Despite citing [federal] meaningful use requirements that promote standards such as LOINC, RxNorm, and SNOMED CT as a step in the right direction, DeMuro says the industry still needs a standard EHR infrastructure to achieve success.").


THE MINNESOTA POLICY
BLUE PRINT
PRESCRIPTION FOR PROSPERITY


THE MINNESOTA POLICY
BLUE PRINT
PRESCRIPTION FOR PROSPERITY

Center of the American Experiment
8441 Wayzata Boulevard ★ Suite 350
Golden Valley, MN 55426
AmericanExperiment.org