



# Julie Brunner, Executive Director, Minnesota Council of Health Plans

Interview with The Civic Caucus

8301 Creekside Circle #920, Bloomington, MN 55437

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## **Notes of the Discussion**

**Present:** Verne Johnson (chair), Dave Broden, Audrey Clay, Janis Clay, Pat Davies, Rick Dornfeld, Diane Flynn, Paul Gilje (coordinator), Dwight Johnson, Sallie Kemper, Ted Kolderie, Dan Loritz (vice chair), Tim McDonald, Eileen Smith

**Summary of discussion:** Julie Brunner, Executive Director, Minnesota Council of Health Plans, describes her organization's view of state and federal reforms now underway. In particular, she comments on the design of Minnesota's health insurance exchange and the state's method for assessing outcomes of care.

**A. Introduction of interviewee** - Julie Brunner is the executive director of the Minnesota Council of Health Plans, an association of Minnesota's nonprofit health care companies that provide health insurance coverage to more than four million people.

Before becoming the Council's executive director in January 2003, Brunner served as the deputy commissioner of the Minnesota Department of Health where she managed the development of budget initiatives, legislative proposals and general operations. Prior to that position she was county administrator for St. Louis County and director of child support enforcement for the Ramsey County Attorney's office. Her experience also includes serving as assistant commissioner for the Minnesota Department of Human Services and as a lawyer with the Office of Senate Counsel.

**B. Discussion** - The Minnesota Council of Health Plans has seven members. Member companies include Blue Cross Blue Shield/Blue Plus of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne, Sanford Health Plan and UCare. The Council focuses solely on health plan payer systems, not health care provider systems. Two members, HealthPartners and Sanford, "wear two hats," Brunner said, because they are both payers and providers of health care services.

The Council does all its work among its membership by committee. Their scope includes policy work on issues of health care reform and data analysis, lobbying on issues of concern to members, and interaction with state and federal regulators on members' behalf.

Brunner noted that Minnesota is the only state in the union where HMO's are required to be nonprofit, Brunner said. As a consequence, one well known for-profit insurance company, United Health based in Minnetonka, cannot sell HMO products in the state.

### **Minnesota aligning with the federal Affordable Care Act (ACA)**

"To say the last two years have been ramping up the treadmill speed is an understatement," Brunner told the group.

Many of the 2008 legislative reforms that were supported by the health plans are reflected in the federal Affordable Care Act (ACA), she said. There is a lot of Minnesota reflected in the ACA, which made it easier for the state to ease into the first round of changes that took place in September of 2010.

For example, the state had already adopted a law requiring insurers to include children up to 25 years old, 3 years longer than most, while the ACA set it at 26. Minnesota already had medical loss ratio requirements in place for coverage by small employers and individuals. The federal legislation's medical loss ratio restriction, which requires a provider to spend a minimum 80 percent of revenue on medical costs and not more than 20 percent for investment and administration functions, added larger employers and moved Minnesota's minimum to 80 percent

Given these previously adopted policies, the reluctance of the Minnesota Legislature to take action in response to the ACA, Brunner said, did not have a significantly negative effect upon its early implementation.

### **Patients choose care based on cost and quality.**

Brunner said that all major plans have published information on health outcomes on their websites. The information on health care quality is provided through MN Community Measurement website at [MNHealthscores.org](http://MNHealthscores.org) and is supported by the health plans and by both the Minnesota Hospital Association and the Minnesota Medical Association.

A participant in the discussion noted that while information may be available on a website, patients are not held accountable for their choices with most providers. An exception is HealthPartners, where incentives are built into health plans to make those providers that are better quality at lower cost more desirable - and there is a consequence to the customers for their choices of higher cost providers, in the form of higher co-pays.

Cost information is necessary as well as data on outcomes, Brunner said. Both are necessary in order to adopt changes to insurance resulting in payments based on relative cost and quality. She added that payment reform has been underway in Minnesota, moving away from strictly fee for service and toward efforts by payers to increase incentives to providers within their networks to keep costs low while improving quality. They give preferential status to those providers with better quality outcomes at lower costs. This restructuring of health plan incentives is often referred to as "value-based purchasing."

Innovations in payment reforms include "gain sharing" (sharing savings realized by providers) and "capitation", which involves providing a certain amount of money to a provider for the treatment of a particular condition and allowing the provider to retain whatever part of that sum is not spent.

"There is actually less fee-for-service than what people realize," Brunner said. The system is going toward these relationships where the contracts between the insurer and provider have mechanisms that reward both improved quality and cost containment.

"The biggest fee-for-service system in the country is Medicare, and it is also the most inflationary. Any national strategy eventually has to bring Medicare into the mix," Brunner added. In Minnesota's case, the state is seriously disadvantaged on Medicare reimbursement rates. Nothing included in the ACA addressed this disparity.

### **Designing a health insurance exchange**

By January 1, 2014 a Minnesota health exchange must be operational; otherwise, the state defaults to the federal government's health exchange model. Minnesota's insurance exchange could well consider a "tiered" system of health plans, Brunner said. "Tiering" is a method for health plans to create incentives for patients to choose the more effective and efficient providers over those that are lower quality and more costly, through varied levels, or tiers, of co-payments or other means. The exchange will also be a portal for Medicaid recipients, and will incorporate the rebuilding of the Medicaid eligibility system.

The state will need legislation to set up an exchange, she said, and the administration's efforts are now underway. A health exchange task force has convened under the authority of the Commerce Commissioner, and work groups have been organized under the task force to design the exchange's structure and components.

Some key aspects that need legislative authority include an ongoing funding source and any desired changes to insurance law. Insurers are not required to sell in the exchange; therefore, the exchange needs to include incentives for insurers to participate. Options for funding the exchange include fees on payer participation, contributions by people who use the exchange, or a tax on the premiums of products sold on the exchange. The last option, the tax, would require legislative approval.

Brunner said she believes the vision of the people designing the exchange is to find ways to highlight and feature those plans that offer better value to consumers. Many innovations currently underway in the private market could be featured in the exchange.

### **Prevention could bring the greater savings.**

Chronic diseases are not treatable by hospital services, a participant observed, and the discussion of getting better value for the care for sickness seems to be within the medical hospital framework. It doesn't include a discussion of prevention of illness in the first place.

No, it doesn't, Brunner agreed. The money available for the State Health Improvement Program - a public health effort - has shrunk from \$40 million to \$5 million. Those who are talking about lowering health costs aren't always talking enough about prevention.

## **Measuring outcomes.**

Overall quality of care is measured in Minnesota by clinical outcomes, patient satisfaction, the use of technology such as electronic medical records, and administrative costs.

A few years ago health plans, in collaboration with the Minnesota Medical Association (MMA), launched **MN Community Measurement** (MNCM) to provide the necessary performance measurement and public reporting of health care quality data. Its aim is to gather the statewide data that will enable providers to improve care and help patients to make better healthcare choices.

While the measures are developed by groups of physicians, some take issue. Some physicians don't want to be held accountable for a patient who, for instance, continues to smoke as the doctor attempts to treat his/her diabetes.

Knowledge of the price of health care is, of course, necessary to the assessment of value. Could you imagine, a participant asked, an issue of Consumer Reports on cars absent the price data? While there will presumably be something about price in the exchange, there is debate Brunner said, over the inclusion of "costs" and "charges" - there are costs to the provider, and then there are charges to the insurer. These figures could be the same or different, so the debate continues over which to use.

Payment reform can add consistency to pricing. For example for a hip replacement a "bucket" of the total cost of care is determined not for a single procedure, but the full cost to resolve the issue. Payers are asking providers to decrease that total cost of care without decreasing quality.

"We have a very good base to build from for assessment," Brunner said. The cornerstone of it is MNCM. "It's an independent data base not controlled by government, or any one of the stakeholder systems. That's the place to start."

The state contracts for many things, a participant observed. If there's a great private effort underway why doesn't the state just contract with them?

"That is absolutely a smart idea," Brunner replied. "We believe if there is an independent, credible asset that exists, the state shouldn't set up a competing institution."

Brunner's team has been somewhat frustrated in that the development of the exchange has not been as open as they think it should be. However, Brunner is optimistic. A parallel measurement system, duplicating what already is up and functioning within the state, is unnecessary and costly, she continued. She understands part of the exchange task force work will focus on some linking to existing resources. "We need to be really smart and strategic. That's in the Minnesota tradition. The Affordable Care Act requires that there is information on cost and quality, and we are already well positioned with a really strong private effort."

## **C. Conclusion -**

"I've been working for 40 years, Brunner said in closing. The past two years have been the most professionally challenging for me with the passage of the ACA. But it's exciting," she added, "things are changing and with some work the state can make important progress toward improving both the cost and quality of the delivery of healthcare throughout the state."

The chair thanked Brunner for the visit.