Health Care for All Minnesota & Physicians for a National Health Program

Patient Centered Care bill (SF 1059/HF255) - How we got here and why you should support it!

Minnesota's Medicaid (aka Medical Assistance) and MinnesotaCare programs have become very complex and more expensive than necessary because Minnesota inserted HMOs and so-called "Integrated Health Partnerships" (IHPs) into those programs. The Patient Centered Care (PCC) bill will simplify those programs and greatly lower their costs by removing the HMOs and IHPs.

In 1966, when Minnesota implemented Medical Assistance, it was relatively simple and run by the Department of Public Welfare (DPW) until 1984 when DPW became the Department of Human Services (DHS). It was simple compared with today's program because DPW and DHS did not funnel money through insurance companies, but instead directly paid doctors and hospitals that treated the enrollees. But in 1983, Minnesota's governors and legislators made decisions that turned Medical Assistance, and eventually MinnesotaCare, into complex and unnecessarily expensive programs. The decision to insert HMOs into Medical Assistance and MinnesotaCare lacked evidence to support the claim that doing so would contain costs, improve quality and decrease disparities. Further, those claims do not appear to have ever been rigorously reviewed.

In 1983, HMOs were inserted into Medical Assistance, and in 1996 into MinnesotaCare (which was enacted in 1992). In 2010, without asking why HMOs had failed to save money and without inquiring whether Integrated Health Partnerships could cut costs, IHPs were still inserted into the programs.

So, by 2012, these two programs contained not one but <u>two</u> layers of middlemen – HMOs and IHPs beneath. Both layers added large administrative expense. The HMO layer adds administrative costs equal to about **15%** of total spending.

The IHP layer adds start-up and administrative costs, but we have little research on the total spending. HMOs reduce costs between 0 to 5% by denying services, although good research is sparse. Apparently, there's no research on whether IHPs reduce utilization. **Ten to 15 percent** is, therefore, a reasonable estimate of money saved by removing HMOs from our public programs: **15%** in reduced administrative costs minus **0-5%** in increased costs due to increased utilization that will probably occur once HMOs can no longer tell doctors how to practice medicine.

Of course, the Minnesota Council of Health Plans opposes the removal of their members from MinnesotaCare and Medical Assistance. Their main argument is that only HMOs "coordinate care," and if HMOs are removed, patients will get no care coordination. We urge you to reject that argument for two reasons: 1) insurance companies do not "coordinate care"; doctors and nurses do; 2) DHS funnels extra payments through the HMOs to provide collective services called "care coordination services." If DHS can do that for the HMOs, why can't DHS instead do that for the doctors and hospitals that treat Medical Assistance and MinnesotaCare patients once the HMOs are removed? That's precisely what the PCC bill will do: the bill instructs DHS to pay primary care doctors an extra fee for coordination services.

Removal of HMOs and IHPs from the programs will have three other benefits in addition to reducing costs: (1) improved quality of care for patients; (2) reduced burnout among doctors;

and (3) easier monitoring for the legislature to track our tax dollars.