For the Minnesota Legislature, 12 pertinent elements of any constructive health care reform

“A wise man begins at the end while a fool ends at the beginning” is a proverb worth considering in any discussion of health care reform. Minnesota legislators on both sides of the aisle have been meeting with stakeholders to determine what such an endpoint might look like. Allow me to explore 12 pertinent ideas about our health care crisis, several of which have already inspired bill proposals.

1) We must transform the health care discussion, making a clear distinction between insurance against unpredictable, calamitous occurrences and, on the other hand, routine care that can be foreseen and budgeted for, such as preventive dental visits, tetanus shots or screening tests. There is a real difference between wants and needs, and a reasonable perspective distinguishes between a catastrophic need and an elective desire.

2) We must blow open the doors of the internal financial workings of our healthcare system by expanding transparency across the board — on prescription-drug pricing, physician and hospital charges, facility fees, trade secrets between insurers and big clinics, and profiteering by middlemen such as pharmacy benefit managers. Only with clear information can patients truly become “their own best champion” regarding health care. We must outlaw any contractual rules that keep patients in the dark as to what they are spending or how many dollars will come from their own wallets. (A bill proposal on these matters has been submitted.)

3) We must candidly discuss the potential benefits of tort reform. Don’t let trial lawyers tell you that the threat of malpractice litigation does not much affect the manner or frequency with which doctors order tests, consults, surgeries or medications. “Defensive medicine” is a fact of life with our “who’s to blame” legal lottery system when undesired outcomes occur. And this reality drives up health care costs exorbitantly. Doctors will go to great lengths to avoid gut-wrenching malpractice suits — more tests and consultations are our best defense. In many European countries, a patient experiencing a poor result appeals to a compensation board that determines fair reparation, while a separate medical disciplinary board imposes any necessary sanctions against the physicians or facilities involved.

4) We must trim the costly and overexpanded benefit sets required for qualified insurance plans under the Affordable Care Act. A Cadillac plan designed to provide all Americans everything they want whenever they want it cannot be sustained without dramatic adverse impacts — inflated utilization, long waiting times, reduced quality of care, and rigid, unfriendly triage protocols. On the other hand, what’s needed is a basic safety-net package of care truly

allowing all to seek critical medical cares — for chest or abdominal pain, vomiting or stroke symptoms, diabetes and insulin, etc. — without fear of losing their homes or going bankrupt. Now is the time.

5) We must terminate required coverage for low-value screening services when the potential for harm exceeds the likelihood for benefit. For example, research clearly demonstrates that doing a screening colonoscopy on a 90-year-old carries far more risk than it's worth. It is unfortunate that our current system calls on patients to push back against the ever-present tendency for more tests. Patients often veto cookie-cutter orders for low-value testing and unnecessary prescriptions, and our system will benefit from initiatives empowering patients. Additionally, hospice and palliative options are powerful tools for patient advocacy and control, which help avoid harmful interventions.

6) We must create a Prescription Drug Affordability Commission to review any new drugs coming on the market costing more than $30,000 a year or any existing trade name drugs increasing in price by more than $10,000 in a year. Generic drugs increasing more than 25 percent or $300 per year also should be reviewed. The commission would provide for stakeholder testimony and allow drug manufacturers the opportunity to justify their prices. If the commission does not agree that such prices are reasonable, it could set a ceiling price above which no public or private plan could pay more. (A bill proposal has been submitted.)

7) When people have a personal stake in expenditures, they have an incentive to be wise stewards of health care dollars. That is, we spend money more wisely when it's our own money. A 10 percent coinsurance payment often prompts people to reassess the need for a potentially unnecessary test, surgery or prescription. Single-payer models run the risk of minimizing the value of patient decisionmaking and causing dramatic increases in utilization. The Canadian single-payer system — which does not cover medications, vision, hearing or long-term care — has seen payments shift to the private sector to the tune of 30 percent. Single-payer has become multi-payer. Similarly, British citizens now confront the reality that their National Health Service is faltering as thousands of patients had surgeries postponed for months or years while enduring long waits to see their family doctors. Emerging trends reveal the value of high-functioning public-private partnerships such as those Minnesota has traditionally enjoyed.

8) The relationship between patient and physician can be transformed, helping patients "champion" their own health care instead of being forced into a "one size fits all" recommendation. The Direct Primary Care (DPC) model of 24/7 access to a primary care doctor accompanied by a monthly fixed fee provides broad-based, low-cost outpatient care for patients. (A bill proposal has been submitted.)

9) Our state can and should provide a safety net of basic care for all Minnesotans, including nonelective hospitalizations, appropriate emergency room visits, vital mental health services including suicide and opiate hotlines, cancer care, and hospice care. All but about 6 percent of Minnesotans have some form of insurance coverage, and most without coverage are already

eligible for medical assistance, MinnesotaCare or subsidies. Auto-enrollment (which Medicare already uses) coupled with presumed eligibility (which hospitals already use) may be useful tools.

10) The schedule of advance premium tax credits (APTC) for individuals buying insurance on the MNsure exchange is limited to people with an adjusted gross income (AGI) of 200 percent to 400 percent of the federal poverty line. The subsidies limit annual premiums for silver plans to 9.6 percent of AGI for couples earning less than about $64,000. However, couples earning $70,000 receive no subsidy at all. This “rate cliff” means they pay as much as 20 percent of AGI for comparable plan premiums. We can fix this by providing a state-based tax credit such that all individuals buying insurance on the exchange will have annual premium costs limited to no more than 9.6 percent of their AGI. (A bill proposal has been submitted.)

11) Medical Assistance and MinnesotaCare are vital to providing a government-based safety net for many people. But our discussions must recognize that commercial health insurance mightily subsidizes U.S. health care, which allows such low-reimbursement government programs to exist in their current form. Adding more people to public plans holds great potential for unintended consequences — including closures of clinics and hospitals in outstate Minnesota.

12) Pre-existing conditions are life-changing and seldom the result of patient choices. A 4-year-old girl diagnosed with diabetes will incur unfathomable medical costs during her lifetime. For far too long our system has rewarded healthy people with low insurance premiums while damning those with fragile health to a life of constant access and affordability struggles. Nobody, Democrat or Republican, wants to see anyone with a pre-existing condition go without care because it is unaffordable. Any solution for our ailing health care system must include protection for patients with pre-existing conditions.

Twelve ideas culled from constituents and legislators around the state. Will solving the health care puzzle be easy? No. Does it matter? More than we know.

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