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June 11, 2009

The Honorable Edward M. Kennedy  
Chair  
Senate Health, Education, Labor and Pensions  
Committee  
428 Senate Dirksen Office Building  
Washington, DC 20510

The Honorable Michael B. Enzi  
Ranking Member  
Senate Health, Education, Labor and Pensions  
Committee  
428 Senate Dirksen Office Building  
Washington, DC 20510

Dear Chairman Kennedy and Ranking Member Enzi:

As you move into the final weeks of discussion on health care reform proposals, we ask you to keep in mind Minnesota's unique position in the country's health care landscape. In addition, we hope the result of your work will be an equitable, sustainable, value-based payment system for any publicly supported health care program, including Medicare.

Many of the reform discussions underway use Medicare as a model or base. While more than 747,000 Minnesotans receive their health care coverage through Medicare, the impact of this program goes far beyond the beneficiaries – it affects health care delivery and the cost of health care coverage for all Minnesotans. Because payments from Medicare are less than the actual cost of care, providers must pass on the difference to the rest of our residents and employers through increased health care premiums. This cost shifting could be alleviated by creating an equitable payment system for Medicare, creating an environment where Minnesota would be rewarded for consistently providing high quality (*See Table 1*), low cost (*See Tables 2 and 3*) care in a competitive nonprofit environment, instead of being penalized with below-cost payments.

#### **Across-the-board cuts harm Minnesota**

Medicare payments are not adequate and do not keep pace with the growing costs of drugs and technology, work-force shortages, care for the uninsured, patient safety initiatives and medical liability. For example, the Minnesota Hospital Association's analysis of 2007 hospital Medicare payments versus actual costs of providing care to Medicare patients, showed a continued increase in Medicare payment shortfalls, from -\$421 million in 2004 to -\$617 million in 2007. Physician payments have failed to keep up with the cost of operating a practice. Medicare physician rates are slated to be cut by 21 percent in 2010 and will reach a cumulative total cut of 40 percent by 2016 – a \$2.5 billion hit to Minnesota alone, while practice costs over that period are expected to rise by nearly 20 percent. Enacting across-the-board cuts, without changing the existing payment inequities, would continue to penalize low-cost, high-quality states, while rewarding high-cost, low-quality states. It also means Minnesotans' health care premiums will keep rising as these costs are shifted to private payers. This is the opposite direction of where Medicare should be – leading the way in health care reform by moving the program toward value-based purchasing that rewards the cost-effective delivery of high-quality care.

### **Move Medicare toward paying for value**

Given that Medicare funding sets the stage for our nation's entire health care system, it must create strategies and payment methods to reward high quality care delivered efficiently. It must also reduce the discrepancies in payment variations among health plans, hospitals and physician clinics across the country. Only then will Minnesotans be treated equally under Medicare.

In order to pay for value:

- Medicare payments need to be equitable. For example, the Minnesota experience in Medicare Advantage must not be allowed to continue as payments to Medicare Advantage plans are modified as part of reform. The geographic variations are not fair to Minnesota beneficiaries who pay higher premiums yet receive fewer benefits than people in other states. (*See Table 2*)
- Medicare must pay the true costs of the program, including any new benefits. The current practice of having the private sector subsidize shortfalls must stop. Employers and individuals can no longer afford to cover the losses from inadequate Medicare payments.
- Hospital and physician spending should be reduced in areas of the country that exceed a certain threshold where per patient spending is compared to the national average. Benchmarking to a national average and decreasing hospital and physician payments to realign per patient spending to a national standard will, over time, reduce geographic disparities. (*See Table 3*)
- Creative solutions to improve quality and contain costs should be aggressively pursued such as the work of the Minnesota Alliance of Patient Safety, a collaborative of more than 50 organizations working together to improve patient safety and care; and MN Community Measurement (MNCM), a partnership working to improve quality by publicly reporting health care information. Since MNCM's start just five years ago, 10,000 more Minnesotans with diabetes have achieved optimal outcomes, meaning there are fewer heart attacks and amputations. In addition, Minnesota hospitals, medical groups, and health plans are leading an effort to wring unnecessary administrative costs out of health care by implementing a statewide, standard, electronic system for billing and claims adjudication. This work is expected to save millions of health care system dollars without any negative impact on the quality of patient care.

### **Creating a more equitable system**

We appreciate you keeping these concerns in mind as you develop Medicare proposals as part of broader health care reform. In order to ensure access to necessary services for all Minnesotans, the health care infrastructure must be supported throughout the state. Please support policies that build on and reward health care efficiencies in our state, and oppose those that do not. We look forward to working with you to achieve an equitable structure that will sustain Minnesota's nonprofit health care system.

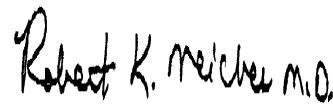
Sincerely,



Julie Brunner  
Executive Director  
MN Council of Health Plans



Lawrence Massa  
President  
MN Hospital Association



Robert K. Meiches, M.D.  
Chief Executive Officer  
MN Medical Association

cc: Minnesota Congressional Delegation  
Nancy-Ann DeParle, Director, White House Office of Health Reform