Health Care Delivery in the Twin Cities

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The discussion in this section is presented in two parts. The first part contains descriptive data on the health care system in the Twin Cities. In some cases, data are only available on a statewide basis, and this is noted in the discussion. The second part summarizes the recent health care reform legislation passed by the state of Minnesota. It attempts to identify the components of the legislation that have influenced the recent reconfiguration of health care delivery in the Twin Cities, as described in subsequent sections.

THE TWIN CITIES' HEALTH CARE SYSTEM

I Health Services Use and Expenditures

Personal health expenditures per capita for 1992 were reported to be $3,166 for Minnesotans, compared with $3,286 nationally (19). Table 3-1 compares the public/private distribution of health care expenditures in 1991 for the state of Minnesota with the national average. This comparison is based on estimates of personal health care expenditures for 1991 by payer category for Minnesota residents, using data supplied by the Minnesota Department of Health (MDH) as of April 1993. A higher percentage of health care dollars was spent by the public sector in Minnesota than in other states, with state and local spending constituting a much higher percent of public spending, indicating higher expenditures for Medicaid and local assistance than the national average.

To assess Twin Cities' expenditures on health care, it would be desirable to compare health insurance premiums in the Twin Cities with those in other metropolitan areas, focusing on levels and changes over time. However, there are no published data

TABLE 3-1: Public/Private Expenditures in the State of Minnesota and the Nation (1991)

	National (%)	state of Minnesota (%)
Private	56	48
Public	44	52
Federal	30	30
State/local	14	22

SOURCE Health Care Financing Admmistration, Off Ice of Actuary Off Ice of National Health Statistics, "Standardized Per Capita Rates of Payment, " Baltimore, MD, 1994

series that permit such a comparison, while controlling for differences in standards of benefit coverage and size of groups by metropolitan areas. Two widely quoted studies that attempt to do so have important limitations.

In assessing the relative cost to consumers of health care in Minnesota, Milliman and Robertson, Inc. reported that Minneapolis/St. Paul was the second to the lowest metropolitan area in health care costs, at 18 percent below the national average in 1991 (45). The highest metropolitan area that year was Miami/Fort Lauderdale, with costs that were 38 percent above the national average, while the lowest area was Charlotte, NC, with costs that were 22 percent below the national average. The Milliman and Robertson, Inc. estimates include costs related to hospital inpatient services, hospital outpatient services, surgery, office visits and other medical encounters, radiology, pathology, and prescription drugs (45). Not included in calculating costs were wellness benefits, such as periodic examinations and immunizations. The Milliman and Robertson, Inc. report data are based on indemnity insurers, not including Medicare and Medicaid coverage or HMO coverage (45). They also report that their data are compiled from publications such as the American Hospital Association and the claims experience of several major insurers. Therefore, it is difficult to determine the actual sources of the Milliman and Robertson data, or whether they pertain to expenditures by insurers for care, or the costs of delivering care.

Foster Higgins compared indemnity plan premiums and managed care premiums using data from 2,448 employers in selected U.S. cities for 1992. Their data are collected nonrandomly from clients and large emplyed groups. As with Milliman and Robertson, sample sizes generally are not adequate to make statistically valid comparisons across metropolitan areas. Moreover, the data are not adjusted for systematic differences in benefits and demographics across employers in different cities. Foster Higgins reports that average premiums per employee for HMO plans are consistently lower in all the cities examined (table 3-2). Preferred provider organization premiums are higher for some cities compared with indemnity plan premiums. Minneapolis/St. Paul has both the lowest average indemnity plan premiums and the lowest HMO average premium cost per employee compared with other reported cities, subject to the caveats noted above (29).

Data from the Cost of Living Index for Selected Metropolitan Areas, compiled by the Association for U.S. Chambers of Commerce (ACCRA), shows the Minneapolis/St. Paul, MN-WI Metropolitan Statistical Area (MSA) in 1992 to have a composite cost of living index equal to the average for the nation, but a health care cost of living index 8 percent above the national average ('65). This contrasts sharply with the results reported by Milliman and Robertson, where the Twin Cities ranked [18] percent below the national average in medical costs. Given these contradictory data, along with questions about the validity of the data used in making comparisons, it is difficult to accurately assess whether expenditures for health care in the Twin Cities are higher or lower than in other metropolitan areas.

Data supplied by the Health Care Financing Administration indicate that expenditures for fee-for-service Medicare beneficiaries are relatively low in the Twin Cities, in comparison with other metropolitan areas. Table 3-3 compares fee-for-service Medicare expenditures in the 20 U.S. counties with the largest enrollment in Medicare HMO risk contracts. These data show that only Volusia County, Florida, has lower AAPCC payments than Hennepin and Ramsey counties in the Twin Cities MSA. The percentage change figures show

TABLE 3-2: Indemnity Plan Premiums vs. Managed Care Plan Premiums (Selected U.S. Cities, 1992)

		Health Maintenance Organizations		Preferred provider Organizations	
city	Indemnity plan premiums per employee	Average premiums pew employee	HMO premiums vs. indermnity	Average premiums per employee	PPO premiums vs. indemnity Cost
Atlanta	$3,729	$3,311	-11 .2%	**$3,363**	**-9** .8%
Chicago	4,245	3,088	-27.3	**3,684**	-132
Cleveland	4,027	3,727	-7.4	**3,459**	-141
Dallas/Ft. Worth	3,917	3,330	-15.0	**3,837**	-20
Houston	3,627	3,575	-1,4	4,091	+12 8
Los Angeles	4,350	3,189	-26.7	4,457	+25
Minneapolis/St Paul	3,347	2,969	-11,3	3,121	-68
New York Metro	4,852	3,448	-28.9	3,871	-202
Orange County	4,276	3,124	-26.9	4,315	+0.9
Philadelphia	4,696	3,319	-29.3	3,708	-21,0
Richmond	3,578	3,074	-14.1	3,183	-11 0
San Francisco	4,531	3,092	-31.8	4,459	-16
Seattle	3,554	3,092	-13.0	3,114	-124

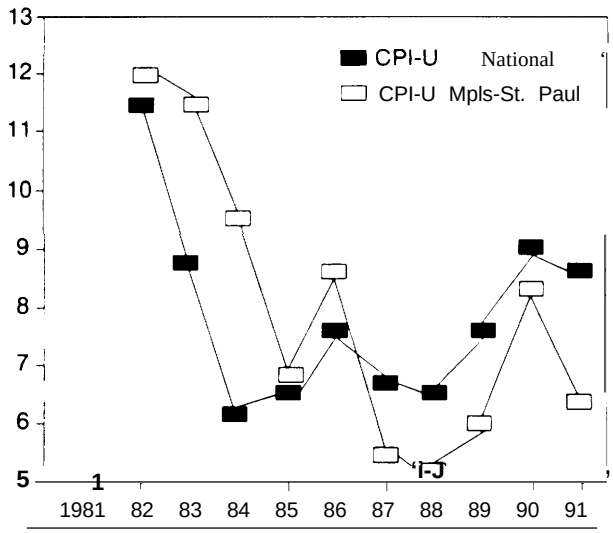
SOURCE Foster Higgins, "1992 Health Care Benefits Survey Medical Plans, " Medical Benefits, Mar 30, 1993

that Hennepin and Ramsey Counties had the lowest rates of increase from 1989 to 1994.

An indication of trends in health care prices is provided by the medical consumer price index. Figure 3-1 compares this index for Minneapolis/ St. Paul with the United States' city average. Since 1987, the Twin Cities has consistently tracked below other cities, declining almost two percentage points from 1990 to 1991, compared with a 0.3 percent decline for the U.S. city average. It is also important to compare Minneapolis/ St. Paul's overall CPI to the United States' city average to determine if the area's relatively favorable performance with respect to the medical index might be related to a favorable trend in the overall cost of living. Table 3-4 presents these comparisons for 1970 to 1992. The rate of increase in the overall CPI for the Twin Cities is approximately the same as the U.S. city average rate of change.

With respect to inpatient utilization, Minnesotans experienced 127.4 hospital admissions per 1,000 in 1989, 8.5 admissions per 1,000 less than the national average, and had 98.2 per 1,000 fewer visits to the emergency room. Minnesotans also had fewer outpatient hospital visits (309 per 1,000 less than the national average in 1989). Length of inpatient hospital stays in the Twin Cities as compared with national rates for 1989 to 1991 are shown in table 3-5. The Twin Cities had lengths of stays approximately one half day shorter than the national average for each year reported (49).

FIGURE: 3-1: Consumer Price Index-Urban: Medical Care



SOURCE U S Department of Labor, Bureau of Labor Statistics. *CPI Detailed Report Data for January 1994,* J Mathery and TJ Mosimann (eds) (Washington, DC March 1994)

TABLE 3-3: Comparison of Estimated Fee-for-Service Medicare Expenditures in Counties with the Largest Enrollment in Medicare HMO Risk Contracts in 1994

County	State	Part A 1994 Part A 1989	Part B 1994 Part B 1989	Total 19S9 Total 1994	Percent Change 1989-94
		317.53	213.48	531.01	
Los Angeles	California	190.18	183.72	373.90	42,02
		256.52	177.83	434.35	
San Diego	California	155.57	157.84	31341	38.59
		277.49	238.76	516.25	
Broward	Florida	19940	179.71	379.11	36.17
		292.01	282.64	574.65	
Dade	Florida	218.87	202.04	420.91	36.53
		289.83	208.23	498.06	
Orange	California	180.96	181,22	362.18	37.52
		260.98	181.22	444.46	
Riverside	California	152.80	151.05	303.85	46,28
		276.98	167.08	444.06	
San Bernadino	California	154.41	138.13	292.54	5179
		248.56	169.06	417.62	
Maricopa	Arizona	160.57	121.33	281.90	4814
		315.33	145.67	461.00	
Cook	Illinois	209.91	114.80	324.71	41.97
		231.51	220.04	451.55	
Palm Beach	Florida	153.68	151.45	305.13	47.99
		237.00	119,19	356.19	
Multnoma	Oregon	187.22	95.50	286.72	24.33
		225.24	138.25	363.49	
King	Washington	179.63	99.35	278.98	30.29
		233.02	118.36	351.38	
Hennepin	Minnesota	191.98	96.79	288.77	21.68
		219.64	164.02	383.66	
Pinellas	Florida	151.77	111.95	263.72	4548
		196.32	147.40	343.72	
Volusia	Florida	140,65	102.69	243.72	41.25
		234.99	146.69	381.68	
Bexar	Texas	139.91	119.62	259.53	47,07
		268.68	107,36	376.04	
Monroe	New York	140.81	87.46	228.27	64.73
		227.24	158,32	385.56	
Pima	Arizona	150.20	110.43	260.63	47.93
		228.80	164.13	392.93	
Hillsborough	Florida	159.68	125.38	285.06	37.84
		243.44	114,35	357.79	
Ramsey	Minnesota	192.61	95.61	288.22	24.14

SOURCE Health Care Financing Administration, Off Ice of the Actuary, Data from the Office of National Health Statistics, Baltimore MD

Anderson and colleagues compared the Twin Cities, assumed to be a MSA with a competitive strategy toward health care, to Baltimore, assumed to be a MSA with a regulatory strategy toward health care, using measures of hospital productivity, cost per discharge, and hospital utilization (3). For this comparison, data on community hospital characteristics were obtained from the 1972 to 1991 editions of *Hospital Statistics* and the *Guide to Zhe Health Care Field*, both published by the American Hospital Association (1,2). Anderson and colleagues found that the annualized rate of increase in hospital costs per capita in the Twin Cities was 10.0 percent, com-

TABLE 3-4: Consumer Price Index Overall Comparisons—Twin Cities versus U.S. City Average

	CPI Averages 1970 to 1992									% Increase
	1970	1980	1985	1987	1988	1989	1990	1991	1992	1970-1992
Overall										
U S city average	388	824	107,6	113,6	118.3	124.0	130.7	136.2	1403	262
Twin Cities	374	789	107.0	111,6	117,2	122,0	127,0	1304	135,0	261

SOURCE U S Department of Labor Statistics. Bureau of Labor Statistics, *CPI Detailed Report*, (Washington, DC January, *1994)* U S Department of Labor, Bureau of Labor Statistics, CPI Division, *Summary Data,* (Washington, DC 1994)

pared with 11.2 percent nationwide. Anderson and colleagues concluded that both strategies had only a minor effect on controlling hospital expenditures percapita from 1971 to 1990(3). They found regulation to have a greater impact on hospital production processes, primarily by controlling expenditures per discharge and per day. Competition was found to have a greater impact on utilization, mainly by lowering the number of admissions per capita.

Insurance Coverage and Uninsured People

In 1990, fewer people were uninsured in Minnesota than the national average, ranking seventh lowest among states, in part reflecting a relatively generous Medicaid program. According to one source, approximate] y 6.5 percent of Minnesotans were uninsured for health care services at any given time in 1990. Approximately 4.5 percent were uninsured for the entire year and 8.6 percent were uninsured for at least one month in 1990 (42). This compares with approximately 14 percent (34.7 million) uninsured nationally in 1990.1

More recent data from the March 1992 Current Population Survey indicates that approximately 10.1 percent were uninsured in 1993 in the Minneapolis/St. Paul metropolitan area, in comparison with 15.4 percent nationwide and 17.6 percent in metropolitan areas with over one million persons (18).

TABLE 3-5: Length of Inpatient Hospital Stay, Twin Cities

	989	990	99
National	6.6	6.6	6 5
Twin Cities	6.2	61	5 9

SOURCE Minnesota Department of Health, Health Economics Program unpublished data Minneapolis MN 1993

People without insurance in Minnesota are more likely to be male and younger than people who are insured. Uninsured adults in Minnesota are less likely to have a high school education, more likely to have lower incomes, less likely to be married, and more likely to be nonwhite than those insured by group plans. In 1990, only 28 percent of the uninsured people in Minnesota had incomes that were below the Federal Poverty Line (FPL). However, 71 percent had incomes that were below 200 percent of the FPL. Only 3 percent of the insured group were below the FPL, with 20 percent at 200 percent below the FPL (42).

Enrollment in Managed Care Plans

In 1992, in the Twin Cities metropolitan area, 44 percent of the population were enrolled in HMOs. Total enrollment by HMO in Minnesota at the beginning of 1992 is presented in table 3-6. Medica Choice was the largest HMO, followed by Group Health and MedCenters. The majority of enrollees, 82 percent, are in commercial plans, with 12 percent in Medicare and 6 percent in

[1]Estimates from different surveys may differ due to the way the question is asked. Therefore this comparison should be interpreted cautiously.

TABLE 3–6: Twin Cities HMOs-

HMO	Headquarters	Parent, owner or manager	Year opened	1991 Enrollment	History/Status
Blue Plus	Eagan	Blue Cross and Blue Shield of Minnesota	1974	69,884	Changed name from HMO Minnesota in 1988. Absorbed Coordinated Health Care HMO in 1988 Affiliate Minnesota Health Plans, Inc., merged into Blue Plus, effective Dec. 31, 1990
Group Health	Minneapolis	Group Health, Inc	1957	294,969	Includes Group Care, nonfederal!y qualifled HMO, In 1992, announced intent to merge with MedCenters Health Plan,
MedCenters	St Louis Park	Aetna Health Plans	1973	258,839	Formed by merger of MedCenter Health Plan and Nlcollet-Eitel Health Plan in 1983 In 1992, announced intent to merge with Group Health.
Medica					
Medica Choice	Minnetonka	United HealthCare	1975	352,378	Formerly known as Physicians Health Plan (PHP) Combied with Share Health Plan to form Medica, effective Jan. 1, 1991.
Medica Primary	Minnetonka	United HealthCare	1973	28,637	Formerly known as Share Health Plan.
Metropolitan Health Plan	Minneapolis	Hennepin County Bureau of Health	1983	28,712	Created for Medicaid Demonstration Project and Voluntary AFDC Managed Care Program. ,
NWNL Health Network	St Paul	Northwestern National Life Insurance Co	1984	19,586	Founded as Senior Health Plan Acquired and renamed by NWNL in 1987.
UCare	Minneapolis	University of Minnesota, Department of Family Practice	1989	10,709	Created for Medicaid Demonstration Project

SOURCE Citizen's League Research, "Minnesota Managed Care Review 1992," Minneapolis, MN, August 1992

TABLE 3-7: Minnesota Primary Care Physicians per 100,000 Population by Geographic Unit and Specialty, 1988

	All primary care	Family practice	Internal medicine	Pediatrics	OB/GYN
Statewide	90.5	42,3	27.3	11,8	9 0
Nonmetro counties	552	41.7	8.3	2.2	2.8
Nonmetro counties (c 10,000 population)	48.8	43,2	3.4	1,1	11

SOURCE Area Resource File as analyzed by J Christianson, B Dowd, J Kralewski, et al , Institute for Health services Research, School of Public Health, University of Minnesota, Minneapolis, MN, 1994

Medicaid. Medicaid enrollment increased by 25 percent from 1990 to 1991 in contrast to a decrease in enrollment in both commercial and Medicare plans during the same period (54). (More detail on trends in HMO enrollment is provided in a later section of this background paper).

Health Care Providers

Table 3-7 displays the number of Minnesota primary care physicians per 100,000 population, by geographic unit and specialty for 1988. There were 42.3 family practice physicians per 100,000 population, and 27.3 internal medicine specialists per 100,000. Statewide, Minnesota had 90.5 primary care physicians per 100,000 population, which is close to the Bureau of Health Professions manpower requirements of 91.9. It should be noted, however, that Olmsted County (the location of the Mayo Clinic) has a high concentration of primary care physicians. Excluding Olmsted County from the calculation, the ratio for Minnesota is 83.1 primary care physicians per 100,000 population (52).

Nationally, the rate of growth of physicians has exceeded that of the population (table 3-8), with similar trends in Minnesota. Thus, physician to population ratios increased for both metro and nonmetro areas in Minnesota from 1975 to 1988 (table 3-9).

Minnesota ranks 10th among the 50 states in active physician-to-population ratio (66). For nonmetropolitan counties, Minnesota ranks 37th among states (64). Nonphysician providers are active in Minnesota, with approximately 700 nurse practitioners and 159 practicing physician assistants cunently practicing in the state (52).

Availability of Inpatient Care

The Minnesota Department of Health reports 7,480 beds in 1990 in the Twin Cities' metropolitan area, as compared with 10,193 beds in 1971 (54). The Department of Health reports that the number of beds per 1,000 population dropped from 5.1 to 3.0 during this time period and occupancy rates fell from an average of 73.6 percent in 1971 to 43.6 percent in 1990. Another data source reports a slight increase in the percent occupancy of hospital beds in the Twin Cities from 1985 to 1991, as calculated using staffed beds and licensed beds (table 10) (44). From 1982 through August 1993, six Twin Cities' hospitals containing more than 2,021 beds closed. These data are consistent with the decline in hospital beds experienced nationwide.

DEVELOPMENT OF MINNESOTACARE

Within the past decade, Minnesota has enacted a number of reforms to improve access to health care services and control health care costs. In 1987, the Minnesota legislature passed the Childrens Health Plan (CHP). This was followed by a second major reform in 1992, originally called the Health Right Act and later renamed the 1992 Minnesota Care Act. The 1992 Act was followed by the 1993 Minnesota Care Act and the 1994 Minnesota Care Act.

Implemented in 1988, CHP provided outpatient acute care services to non-Medicaid-eligible, low-income pregnant women and children under age six. CHP was expanded in January of 1991 to include all low-income children through age 19.

TABLE 3-8: The Supply of Physicians in the United States in Seiected Years, 1963-1986

	1963	1973	1978	19s3	1986
Total physicians	276,475	366,279	437,486	519,546	569,160
Physicians per 100,000 population	146	174	196	218	232
Average annual percent increase in physicians (from previous year shown)		2.9	3.6	3.5	31
Average annual percent increase in population (from previous year shown)		11	1.2	1,3	1.0

SOURCE U.S Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, *Seventh Report to the President & Congress on the Status of Health Personnel in the M/led States*, DHHS Pub No HRS-P-0D-90-1(Rockville, MD HRSA June 1990)

Then in 1992, the state of Minnesota enacted the Health Right Act, now called Minnesota Care. This bill built on CHP and provided subsidized health insurance coverage through a program known as the Minnesota Care Program. A cigarette tax increase and a 2 percent provider tax were used to finance the program and other health reform-related activities (11).

Subsequently, the 1993 and 1994 Minnesota-Care Acts established the goal of achieving universal health coverage of all Minnesotans by July 1997 and beginning in July 1997 requires that all Minnesota residents obtain and maintain health coverage (53). However, the 1993 and 1994 bills did not specify a financing mechanism for universal coverage under the Minnesota Care Program (the subsidized insurance program) and universal coverage is contingent upon the development of a financing mechanism in the 1995 legislation. The Minnesota Care Act did establish other reforms in an effort to expand coverage, including voluntary purchasing pools, a prohibition on underwriting, restrictions on the use of preexisting condition limitations, and a requirement that health plan companies offer plans that are issued on a guaranteed basis.

The Minnesota legislature has also advanced a number of reforms to try to slow the growth rate of health care spending. The 1992 Minnesota Care Act created the Minnesota Health Care Commission (MHCC), consisting of 25 members representing labor unions, consumers, providers, employers, health insurers and others, to develop a cost-containment strategy for health care reform to slow the rate of growth in total private and public health care spending in Minnesota by at least 10 percent per year over the next five years(51). MHCC delivered a cost-containment plan to the legislature in early 1993.

Based on the work of the MHCC, the 1993 Minnesota Care Act established a comprehensive cost-containment plan. In the plan, a limit on total health care spending was created and the Commissioner of Health was charged with enforc ing annual limits on the rate of increase in health care costs. The Minnesota Department of Health estimated that Minnesota Care would yield a total of $7 billion in savings by 1998. The Department aimed (in consultation with the MHCC) to have detailed legislation and regulations developed and to begin implementing the plan by July 1994. However, this target date proved to be overly optimistic. Interim controls are being used until final regulations are established.

The Minnesota ent of "Integrated Service Networks" (I SNS), to be formed by providers, payers, and/or purchasers of medical care. The intent was that ISNs would provide a comprehensive set of personal health care services to a designated population of individuals, for a prospectively set budget. The Minnesota Commissioner of Health can establish limits for total ISN budget increases, but competition among ISNs is also encouraged to control costs (50). Under the 1993 law, the State Health Commissioner can approve ISN arrangements, exempting participants from state and fed-

TABLE 3-9: Minnesota Active Physicians per 100,000 Population in Metropolitan and Nonmetropolitan Counties, 1975 and 1988

	1975	1988	Percent Change 197S88
Active physicians			
Metropolitan counties	195.5	268,4	37.3
Nonmetropolitan counties	64.3	80.4	25.1
Primary care physicians			
Metropolitan counties	88.7	108.6	22.4
Nonmetropolitan counties	44.3	55.2	246

SOURCE U S Department of Health and Human Services, Health Resources and Service Administration, Bureau of Health Professions *Seventh Report to the President & Congress on the* Status *of Health Personnel in the United States*, DHHS Pub No HRS-P-0D-90-1 (Rockville, MD HRSA June 1990)

era] antitrust liability. A recent study identified 19 organizations that are developing ISNs (37).[2]

In addition, the 1993 legislation establishes a Regulated All-Payer Option (RAPO) for providers delivering health care outside of an ISN. Providers are required to accept reimbursement at the all-payer level as payment in full for services provided to: (1) Minnesota residents; (2) persons covered by all-payer insurance; and (3) out-of-network services provided to ISN enrollees. RAPO will provide an alternative to ISNs for those who prefer to participate in a fee-for-service system and is expected to be fully implemented by July 1, 1997.

Minnesota has also enacted a number of other programs to improve coverage and reduce health care costs. The 1994 Minnesota Care Act established voluntary purchasing pools to negotiate and purchase health care coverage for employers, groups, and individuals. By July 1, 1997, large purchasing pools are expected to be available to all purchasers, regardless of employment status or group membership. Recommendations will be submitted by the MHCC to the 1995 legislative session regarding whether all or some purchasers should be required to obtain coverage through purchasing pools. Recommendations also will be made regarding the creation of a state-administered purchasing pool, which would serve all Minnesotans who do not have access to other purchasing pools (53).

A universal, comprehensive benefit set will be the standard coverage for all Minnesotans in 1997. The benefit set will be the basis for coverage under state health care programs, with additional wrap-around provisions to meet the special needs of populations served by government programs (53).

The national health care reform proposed by the Clinton Administration is similar to Minnesota Care in several respects. Minnesota Care did not initially propose to provide universal coverage, as did the Clinton plan; however, the 1994 Minnesota Care legislation does support universal coverage. Minnesota Care differs from the Clinton plan in that it does not have employer mandates for the purchase of health insurance. A financing mechanism for achieving universal coverage under Min - nesota Care is still being developed.

Under the Clinton proposal, regional or corporate insurance purchasing alliances would be created to "manage competition. " The regional alliances would be mandatory for firms with fewer than 5,000 employees. Alliances would administer subsidies to eligible individuals, enforce the premium limits, and have other administrative responsibilities. Purchasing pools formed under the Minnesota legislation are currently voluntary and will not be involved in the enforcement of cost

[2]The target date of ISN implementation (July 1994) established in the 1993 legislation was postponed. The 1994 MinnesotaCare Act allows ISNs to form voluntarily after July 1, 19%, and rules governing ISNs will be adopted by Jan. 1, 1997.

TABLE 3-10: Percent Occupancy of Twin Cities Hospitals

Year	Average daily census	% Operating occupancy	% Licensed occupancy
1985	4,677.3	62.1	45.8
1986	4,517.8	61.8	45.0
1987	4,450.4	61.9	44.9
1988	4,457,1	64.0	47.2
1989	4,463.1	68.2	49.9
1990	4,422,5	66.5	48.2
1991	4,303.7	65.7	47.6

•Table 3-10 shows aggregate occupancy rate and bed capacity figures for Twin Cities hospitals The number of staffed and licensed beds were obtained from the Minnesota Department of Health, Survey and Compliance SectIon Only those hospitals for which data was available from both The Health Care Council and the Minnesota Department of Health appear in occupancy and bed capacity analyses

Occupancy rates were calculated using a combination of Council discharge data and hospital bed statistics obtained from the Minnesota Department of Health To determine percent occupancy in a given year, the average daily census was first calculated by dividing the total number of Inpatient days for Twin Cities hospitals (excluding newborns and neonates) by 36.5 days. Average daily census was then divided by the total number of either licensed or staffed beds to determine percent occupancy

SOURCE Metropolitan Health Care Council, Report on Twin Cities Hospitals from the Council of Hospital Corporations Inpatient Utilization Data Base, Minneapolis, MN, 1993

containment regulations or in the administration of subsidies.

Under the Clinton proposal, a National Health Board would enforce the health alliance average premium targets. A similar function under Minnesota Care will be provided by the Minnesota Commissioner of Health, who will be responsible for enforcing the cost controls that apply to prov iders under the Regulated All-Payer Option (RAPO) and to the ISNs. Both the Clinton plan and Monesota Care include the development of standards for quality of care and monitoring of provider compliance. Consumer empowerment through more informed decision making is also part of both efforts.

SUMMARY

There are no published data that would allow a comparison of health care expenditures in the Twin Cities to other metropolitan areas while controlling for differences in benefit. coverage and size and characteristics of groups by metropolitan areas. Two uncontrolled studies have found that health care expenditures are lower in the Twin Cities, while a third study found the opposite. Some data indicate that health care costs in the Twin Cities may be rising at a slower rate than in the nation as a whole. The medical price index in the Twin Cities was above the national average from 1981 until 1987. However, since 1987 it has been below the national average. One study found that between 1971 and 1990 the annualized rate of increase in hospital costs per capita in the Twin Cities was 10.0 percent, compared with 11.2 percent nationwide. There are fewer uninsured individuals in the Twin Cities than the national average.

Minnesota is implementing an ambitious health care reform plan designed to improve access for the uninsured and control health care costs. Like the Clinton Administration's health reform proposal, Minnesota Care relies on competition among health care organizations and government regulations to control costs. However, it differs from the Clinton Administration's plan in several important respects.