

Minnesota's journey toward universal coverage

Notes from the history of the
Minnesota Council of Health Plans

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Why Dr. Ellwood's patients were crying



One evening in south Minneapolis, in the ward of a children's hospital, a pediatrician heard his patients crying themselves to sleep, scared and homesick.

It was 1960, and the doctor was **Paul Ellwood**. He was a pediatric neurologist who'd got his start as a physician at the [Sister Kenny Institute](#), caring for children suffering the agonies of acute polio. After the Salk vaccine became available to treat that dreaded disease in 1955, Ellwood found himself running a children's

hospital with fewer sick children to admit. The more effectively his staff treated their remaining patients, the more quickly they'd go home — leaving the hospital with more beds to fill.

“There's something perverse about the incentives in this business,” [Dr. Ellwood thought](#). “The better we do clinically, the poorer we do financially.” To make ends meet, Dr. Ellwood started admitting children with learning disabilities — children who might not have needed to be in the hospital at all. That's when, making his rounds, the doctor found himself walking through a ward of children from five to ten years old, hospitalized for no good reason, who were weeping inconsolably. The doctor's little son, safe at home, could have been one of them.

“What are you doing here?” he asked himself suddenly. “These economic incentives are so powerful to fill these beds that you're harming these children. Just like your own.” Decades later, Dr. Ellwood would recall, “that was my first real exposure to the powerful perverse incentives in health care. Suddenly the health system became my patient.” The treatment Dr. Ellwood prescribed would change American health care forever — and lead to the birth of the organization we now know as the Minnesota Council of Health Plans. Today, our health system is still in need of care, and the treatment Dr. Ellwood prescribed so long ago can still help us heal it.

The birth of the HMO

Dr. Paul Ellwood proposed to heal the broken American health system by aligning economic incentives with the wellbeing of patients. As he [envisioned it](#), the health care of the future would be provided by institutions “that would compete on the bases of price and quality and that would combine insurance and health care in a single organization.” The idea was simple, and some innovative companies — like Kaiser in California and Group Health here in Minnesota — were already putting it into practice. Why not make this kind of organization the national standard, rather than the exception?

Over the years, Dr. Ellwood’s vision caught the attention of policymakers nationwide. By 1970, President **Richard Nixon** and Senator **Ted Kennedy** were working together to apply Dr. Ellwood’s ideas to the growing Medicare program. They asked him to name the sort of health-care model he envisioned. The name Dr. Ellwood came up with wasn’t catchy, but it was descriptive: Dr. Ellwood called it a “health maintenance organization,” or HMO.

The HMO idea was controversial in the 1970s, nationally dominant in the 1980s, and widely despised in the 1990s. Under different names, the basic HMO idea continues to evolve, hotly contested from coast to coast, during the current period of highly politicized health reform.

Simple in principle but complex in execution, Dr. Ellwood’s fundamental idea is still the dominant model for health care in America: making economic sense of keeping people healthy. Solving the challenges of realizing that vision brought the Minnesota Council of Health Plans into being.

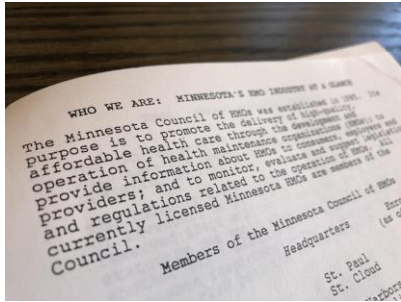
Minnesota’s pioneering HMOs

By the end of the 1970s, Dr. Paul Ellwood was a nationally renowned health care expert, but Minnesota was still his home. He founded a research shop called **InterStudy**, in Excelsior, on the shores of Lake Minnetonka. Even as the HMO idea was spreading from coast to coast, some of the most promising health policy thinking was happening right here in Minnesota. Around 1980, Dr. Ellwood brought some of Minnesota’s most progressive health policy minds together to work on the challenges of the day.

The people who came to that meeting were representatives from Minnesota’s most forward-thinking health-care institutions. These companies were all nonprofit organizations, without earnings or shareholders to worry about. Most were co-ops, owned by their members. All of them were HMOs, organized to improve health and lower expenses by bringing health insurance and medical care together.

Long-time residents of Minnesota might remember the early HMOs whose members attended that meeting. Group Health was a nonprofit health-care cooperative founded in the Twin Cities. Up north in in Virginia, Iron Rangers trusted their health care to MORE HMO. Back in Hennepin County, Physicians Health Plan was owned and operated by the same doctors who cared for its patients. HMO Minnesota, Share Development Corporation, American MedCenters — these pioneering HMOs were putting Dr. Ellwood’s vision for health care into practice here in Minnesota.

The Minnesota HMO Council: founding challenges



By 1986, our state's HMO pioneers had officially come together as the **Minnesota HMO Council**. They agreed never to discuss how they set premium prices, how they negotiated with hospitals and clinics, or how they defined the groups of people they would serve. Healthy competition was crucial to their success. But they wanted to

collaborate on everything that didn't directly affect the price or quality of their work — and there were plenty of challenges for them to work on.

The minutes from the HMO Council's meetings in the mid-eighties make clear the gravity of the problems they were facing together:

- *Economic barriers to care*, especially for poor people and those who lived outside the Twin Cities area
- *Rising expenses*, as doctors and hospitals pressed for increased reimbursement
- *Federal policy* that prioritized tax relief and military spending over health care
- *A national epidemic*, badly mismanaged by the federal government

Today, that list of challenges might sound familiar. Despite decades of progress, care is still out of reach for too many Minnesotans who are poor live in rural areas. The expense of health care is rising faster and higher than people in the 80s would have thought possible. Once again, the federal government is dramatically shifting its focus away from social programs toward other priorities. And the opioid

epidemic, [even more lethal than AIDS at its worst](#), is ravaging the nation while the federal government does little to help.

The history of the Council suggests some practical ways experts in health policy can work together to address these challenges. We did it before, and we'll do it again.



The problem of Medicaid in Minnesota



After President **Lyndon Johnson** signed Medicaid into law in 1965, states had to figure out how to use the federal program to provide health insurance to their residents who were poor. Minnesota took an unusual county-based approach, figuring that counties would understand best how to administer public benefits for their own residents.

By the 1970s, Minnesota counties were struggling to implement Medicaid. Doctors and hospitals were refusing to participate, impatient with the difficulty of working with state and county agencies and dissatisfied with Medicaid reimbursement rates. Accordingly, many people who got their health insurance through Medical Assistance, Minnesota's Medicaid program, struggled to find

the care they needed — if they could get it at all.

Nancy Feldman explains what happened next.

“Even in the early 1970s,” Nancy says, “Medicaid was getting big enough that a county-based system just couldn’t be managed. So we began the development of a centralized state systems for paying Medicaid claims and managing the county-based network of Medicaid providers. It was a big, big job. Once we centralized things, it became obvious that many people just weren’t getting care. Medicaid payments to providers were abysmal — and it was hard to get providers to participate.” So what was the state to do?

That’s where the members of the Minnesota HMO Council came in.



How HMOs helped save Medical Assistance



“Before managed care,” recalls **Kathy Lamp**, “you could really see that people with Medical Assistance could not get the care they needed. They might be *eligible*, but they could not get care. Providers wouldn’t serve them, because of reimbursement. There was really a constant pressure on the Department of Human Services to keep providers in the program to serve people.”

So DHS started to wonder: What if the state asked HMOs to administer Medical Assistance on the state’s behalf — the same way they *already* administered health insurance benefits and care-management services for thousands of Minnesotans already?

It started as a demonstration project called the “Prepaid Medical Assistance Program,” or PMAP. Many later Council leaders were involved in the design and expansion of that program. **Lois Wattman** was on the committee that designed the program from scratch. **Patsy Riley** worked on the design and implementation of the program, too: “I was driving around in wintertime,” she recalls, “hugely pregnant, hoping I wouldn’t have this baby in Duluth!” Thanks to the policy expertise and sheer mileage of people like Lois and Patsy, the demonstration worked well — so well, **Lois** explains, that “quickly PMAP translated from demonstration of Medicaid managed care into standard DHS policy.”

Why Medicaid managed care worked for Minnesota

Managed care companies administer health insurance

In the 1970s, the operational details of Medicaid administration were stretching the state’s Department of Human Services too thin. **Kathy Lamp** remembers: “DHS personnel had to do all the prior authorizations, the claims payment — they had to do all of that work. And delays added to providers’ complaints.” HMOs specialized in doing the daily, unglamorous work of making sure the claims got paid, every time — and they did it well.

Managed care companies have strong relationships with doctors and hospitals

By law, people who get their health insurance from Medicaid were always entitled to see any participating doctor — but no doctor was required to take Medicaid. When Kathy was working for Anoka County, in the mid-1990s, “there was one family physician in the whole county who would take Medicaid.” Minnesota decided to ask HMOs to expand their existing networks to serve people on Medical Assistance.

Nancy Feldman recalls the thinking at DHS: “The health plans already have networks. It would be so much easier for the state if the health plans could deal with providers — and extend their networks, which they’ve developed for commercial business, to cover the Medicaid members also. And then you have expanded access.” Those networks still make wellbeing possible for most of us — in Medical Assistance and far beyond.

Managed care companies compete to make health care better

Over the past 30 years, managed care organizations have competed to bring care within reach for many more Minnesotans — especially people who live outside the Twin Cities or who are poor. And that competition in public programs, starting with Medicaid, made Minnesota a national model of innovation. “Not only were health plans able to put together the contractual relationship,” explained **Patsy Riley**, “but we could also bring the social providers and the other types of ancillary services that people require. We were, and are, uniquely positioned to be able to do that.”

To attract enrollees, the Council’s members worked hard to earn their trust with new kinds of connections to health care: translators, mobile dental clinics, car seats and more. “Everybody had the same contract with the state,” **Kathy Lamp** explained, “so there was a lot of competition for enrollees. HMOs would build strong alliances with providers, have a better transportation system, provide care in other languages. That is good, healthy competition.” And it made Medical Assistance work better for Minnesotans — as it still does today.

CHP and the journey to universal coverage

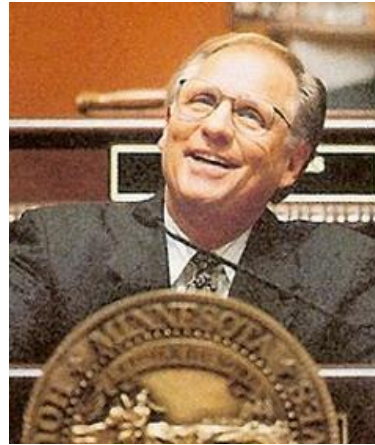
By the end of the 1980s, members of the Minnesota Council of HMOs was driving some of the nation’s most ambitious, innovative and progressive state health policy.

Jan Malcolm says that’s because there was a common understanding of the importance of health care — not only among the Council’s members, but more broadly. “In Minnesota, we had a really engaged community around policy — employers, unions, health plans, and so on. There was a high level of literacy in the community about why health policy was important,” she remembers. Together, members of the Council and their colleagues worked together to answer a simple question: “How are we going to insure more people?”

Answers to that question were contentious — as they still are — but collaboration between health insurers and other community leaders led to real progress throughout the 1980s and 90s. First, Minnesota expanded Medicaid to cover more expecting mothers and children. The pioneering Children’s Health Plan, which went into effect on July 1, 1988, was the first program of its kind in the nation. “Minnesota is a little bit different,” said **Ann Wynia**, Minnesota House majority leader, in an [interview](#) at the time. “When we see a problem, we know we have to solve it.”



The Children's Health Plan showed the practical benefits of bringing health care within reach for more Minnesotans. Soon afterward, the state legislature sent newly elected governor **Arne Carlson** an ambitious bill to provide health insurance, for everyone in the state, using a single-payer model. The trouble with this expansive vision, then as now, was how to pay for it without bankrupting the state. Governor Carlson [vetoed the bill](#) — but he liked the idea behind it.



Could Minnesota's health care leaders find a way to expand health insurance to more Minnesotans *and* pay for it?

The Minnesota Council of HMOs thought so. They rolled up their sleeves and got to work.

MinnesotaCare: a “huge idea”

“The Council picked up the challenge,” **Jan Malcolm** remembers. “We asked: How do we get *closer* to a universal coverage system?” The summer of 1991, a handful of Council policy wonks got together on a pontoon boat and roughed out a plan. “I remember when we came off the boat,” **Lois Wattman** laughs, “and had to present our grand plan to the CEOs. They said, ‘That’s a *huge* idea.’” They didn’t entirely mean “huge” as a compliment.

The startling idea that Lois and her colleagues presented was a policy recommendation that, after much discussion, would form the heart of the MinnesotaCare Acts of 1992, 93 and 94. Republican governor Arne Carlson signed those bills into law. When he signed the first of those bills into law, [the governor said](#), MinnesotaCare “significantly redefines and broadens the definition of the quality of life in Minnesota.”

MinnesotaCare was as ambitious as Governor Carlson made it seem. The [legislation](#) included everything the Affordable Care Act would one day include, and more.

- It established the MinnesotaCare program we know now, but that was just a start.
- MinnesotaCare included a commitment to make sure every Minnesotan had health insurance, whether through work, a government-supported program or on their own. The policies had to include a “universal standard benefit set.”
- It established a sustainable financing mechanism, the Health Care Access Fund, funded by tax on health insurance premiums and medical bills.
- The legislation included ambitious insurance reform policies — most of which came from the HMO Council itself. It included a guarantee that companies with 2 to 50 employees could get insurance, guarantees that policies would be

renewed, strong protections for people with pre-existing conditions, requirements to devote most premium funds to care, and a future commitment to setting premiums based on where people live rather than their health status.

- MinnesotaCare took geographic access to health care seriously, particularly outside the metro. There was investment in rural health and medical school, and innovative thinking about rural health care co-ops.
- The law took strong steps to slow the rise of medical bills, including caps on the amount of medical bills the state could pay, partnerships between insurers and medical professionals called “Integrated Service Networks,” an option to set the price of care across all different insurers, and provisions to fight consolidation and preserve competition among different insurers.
- Finally, the law invested in making care better. It required data collection on the care people get, a way to rate new devices, medicines, vaccines and procedures. It also included means to help make sure doctors had the latest scientific information to help them improve their patients’ care.
- **Lois Wattman**, who was on that pontoon, recalls that

conceiving and implementing MinnesotaCare was a team effort. “We had everyone — doctors, nurses, hospitals, health insurers, public health, employers, labor — all around the same table to design how we would implement this MinnesotaCare legislation,” she says. “It was a consensus body; we just spent hours and hours and hours negotiating.” Health policy isn’t easy now — and it wasn’t easy then, either.



The HMO backlash



Many of the greatest reforms of MinnesotaCare legislation didn't survive the 1990s. The new millennium brought a backlash against managed care.

The expansion of managed care throughout the American health system really did hold medical expenses [steady](#) through the HMO era of the late 1980s and 1990s. Managed care was so successful at containing medical bills that they started to seem unnecessary — in Minnesota as elsewhere in the nation.

Over time, the Minnesota legislature dismantled MinnesotaCare piece by piece — much as Congress is dismantling the Affordable Care Act now. Meanwhile, HMOs got a bad national reputation for “kicking people out of the hospital,” aggressively interfering with medical care, and generally making medicine worse. “The health

plans went from being the cool little upstarts with novel ideas, willing to innovate in a collaborative way,” [Jennifer Clelland](#) reflects, “to being the driving force in the industry, with the large presence that they have now. That shift made health plans less nimble — and also brought more attention to them. If you were dissatisfied with something in health care, that meant you almost by definition that the health plans were responsible.”

[Jan Malcolm](#), one of the chief policy architects of MinnesotaCare, recalls this time of retreat from managed care with sadness. “It was tragic,” she says. “We never quite got the incentives lined up right. We didn't have enough time. Then the market started to revert back to what it knew.” And what the market knew was perverse system that had horrified Dr. Ellwood back in 1960: a “fee-for-service” medical industry that relied on human sickness and suffering to generate money, one pill and procedure at a time.

As the 20th century came to an end, the era of managed care seemed over. Fee-for-service medicine was still being practiced, even when it hurt patients. Too many of us were getting dangerously uncoordinated care, wearing the mask of “consumer choice.” Medical expenses spiraled out of control.

Reaction and Reform



The election of President **Barack Obama** in 2008 brought a new wave of reform and reaction in American health policy. We've all witnessed these events first-hand. But looking back at the history of managed care in Minnesota lets us see the recent past, since the Affordable Care Act, in a new light.

The lesson the Council's history gives is this: Health care markets, like all markets, will default to generating money — unless we deliberately make them generate wellbeing, too. And that's a hard thing to do.

The story of the Council is the story of health insurance companies figuring out how to keep human wellbeing at the center of Minnesota's medical systems — bridging the gap between health and the care.

When **Jennifer Clelland** reflects on the history of Minnesota health policy, she admits: “Sometimes, it’s frustrating. We keep butting our heads against the wall on a certain problem of public health or financing. Then all of a sudden, there’s a breakthrough when the time is right.” With a smile, she finds a better metaphor: “You plant seeds, you plant seeds — then, one day, you have the sun.” And wellbeing can flourish.

There was a breakthrough in 1960, when Dr. Ellwood realized what needed to change. There was another in 1987, when Ann Wynia worked with the Council and many others to bring wellbeing to thousands more Minnesota women and children. Another breakthrough came in 1992, when the Council convened partners from every corner of the state to implement the common dream of MinnesotaCare. There was another breakthrough in 2009, when the federal government made the greatest ambitious of MinnesotaCare the law of the land in the Affordable Care Act. And there will be more breakthrough moments, when wellbeing suddenly becomes possible for more of our friends and neighbors — as long as we keep working together, the way Minnesotans do.

Why the Council matters today

MINNESOTA COUNCIL of HEALTH PLANS

The Council's history shows how people who believe in human wellbeing can come together to make progress. Through decades of change, reform and reaction, managed care is still a force for good in Minnesota —

not just because it's a practical idea. It's the human caring and expertise of Minnesota's nonprofit health insurers that matters most. "We have the same hopes and dreams for people," says **Ghita Worcester**.

The people of the Minnesota Council of Health Plans, **Nancy Feldman** says, "have always been a respected voice, because they brought data, they brought good analysis, and really strong personal relationships. That doesn't mean they're always welcomed. But at the end, good things come out of it."

Most of all, the people who work for Minnesota's nonprofit health insurers have a deep commitment to human wellbeing. The Council's history proves it. The incentives of the health system have changed dramatically over the past four decades, and these days it can be difficult to see the humanity under the all the complexity. But the Minnesota Council of Health Plans — as an organization—has always put human wellbeing first. "The Council's members exist," says **Ellie Garrett**, "to be part of a whole system that improves the health of people in Minnesota. We all serve the same people — and that's a big and powerful thing."

CONTRIBUTORS

Jennifer Clelland



Jennifer Clelland, now senior director for government programs at HealthPartners, was the first paid employee of the Council. Since then, she's led government programs at UCare and earned CHIE certification from America's Health Insurance Plans. Her history in the thick of health insurance operations makes her care deeply about the expense of the care Minnesotans need: "I think affordability continues to be a driving theme," says Jennifer. "How do we

improve the affordability of health care?"

Ellie Garrett



Ellie Garrett was the Council's first director of community affairs and operations — its second employee after Jennifer. Since then, she's been a scholar and leader in Minnesota health policy, from the Minnesota Center for Health Ethics to the Minnesota Department of Human Services. She credits her early experience at the Council for the trajectory of her career as a health policy leader: "I got to

work with Jan Malcolm and Lois Wattman — truly, some of the best policy minds in the nation."

Nancy Feldman



Nancy Feldman, past president of the Minnesota Council of Health Plans, is best known as the long-time CEO of UCare. After she retired in 2014, Nancy has established a fund to help victims of Agent Orange in Vietnam and collaborates with the Center for Victims of Torture and other charitable organizations. "If I could do one thing immediately to improve health care

in Minnesota," Nancy says, "it would be to make everybody eligible for health care. I'd do away with all the complete waste that's responsible for determining who's eligible for what." She looks to the German health system for inspiration: "In Germany, you're born, you're eligible."

Kathy Lamp



Kathy Lamp began her career working for the Minnesota Department of Human Services. Over the course of her career, she helped shape health policy in Minnesota at the county level: she implemented PMAP in Anoka County, led policy for the Metropolitan Health Plan in Hennepin County, and participated in the Council from its origins. In the future, she says,

"health insurers will be a voice for change, be more the leaders of change. If you start from the fact that people need care, everything else follows."

Jan Malcolm



Jan Malcolm, Minnesota's Commissioner of Health, is one of the most distinguished health policy leaders in the nation. She has led public policy for Allina Health, managed the Courage Kenny Rehabilitation Institute, and served as co-director of the Robert Wood Johnson Foundation's Interdisciplinary Research Leaders program. She first served as Commissioner of Health from 1999 to

2003. For her, the current state of health care in America comes "at an unacceptable human cost. It's time to talk about fundamental issues," she says, "not just tinker around the margins of health care."

Patsy Riley



Patsy Riley has devoted four decades of visionary service to the improvement of health care nationwide. In 2017, she retired Blue Cross and Blue Shield of Minnesota as chief government officer. She has contributed especially to the ongoing effort to measure the quality of care and make it better — notably as president of Stratis Health, Minnesota's pioneering

quality improvement organization. When Patsy thinks back on her long career, she admires the unique excellence of Minnesota's health policy experts: "incredibly thoughtful people who came to think creatively about how to solve really big problems for the betterment of Minnesotans." She wants to encourage more big thinking in the next generation of health care leaders.

Lois Wattman



Lois Wattman has served across the breadth of health care in Minnesota — notably, by helping design the pioneering Prepaid Medical Assistance Program (PMAP), which brought the benefits of managed care to Minnesotans who get their care through Medicaid. Her policy guidance has served Blue Cross Blue Shield of Minnesota, Allina, Medica, the Minnesota Medical Association and the

state Senate. At this time of sweeping change for health care, Lois says, "health plans have an opportunity to influence policy from the standpoint of our fellow citizens. It's not just advocacy organizations that can articulate the human effects of health policy — health plans can also advocate loudly about preserving the care their members need."

Ghita Worcester



Ghita Worcester's strategic guidance and personal values have been at the heart of UCare since its founding in 1984, when she was policy director for the group of physicians who started the organization. Since then, she has served in a wide range of leadership positions at UCare and in the broader Minnesota health care community. She is an eloquent advocate for health insurers' special duty to bring

care within reach for the most vulnerable among us. From Ghita's perspective, the health care of the future will return to the roots of managed care. "*Health* maintenance organizations," she says, "take care of *health*, whole health."