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HEALTH CARE REFORM IMPLEMENTATION IN MINNESOTA: MISSION ADVANCED BUT NOT ACCOMPLISHED: AN INTRODUCTION TO THE SYMPOSIUM

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HEALTH CARE REFORM IMPLEMENTATION IN MINNESOTA: MISSION ADVANCED BUT NOT ACCOMPLISHED: AN INTRODUCTION TO THE SYMPOSIUM

Thaddeus Mason Pope [*]

I. INTRODUCTION

Minnesota has long been, and remains, a leader both in the quality of its population's health and in the quality of its health care. Still, the Affordable Care Act has required and prompted massive changes. Roughly five years after enactment of the ACA, it seemed prudent to assess the impact of those changes. Accordingly, the Hamline University Health Law

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Institute[1] and the *Hamline Law Review*[2] hosted an interdisciplinary Symposium entitled "Health Care Reform Implementation in Minnesota: Mission Advanced but not Accomplished." Regional and national experts explored the real, outstanding, and upcoming law and policy issues relating to the implementation of health care reform.

On October 24, 2014, we welcomed more than 200 participants to the Carol Young Anderson and Dennis L. Anderson Center on Hamline University's Saint Paul campus. These participants included: attorneys, physicians, legislators, nurses, social workers, legal aids, government regulators, professors, students, and other allied health professionals. To enhance its value and interest to these diverse professionals, we qualified the Symposium for CLE credits by the Minnesota Board of Continuing Legal Education, for CE credits by the Minnesota Board of Nursing, and for CE credits by the Minnesota Board of Social Work.

Our guests came from a diverse range of professional settings, including: hospitals, government agencies, universities, non-profit organizations, law firms, and health insurance companies. They represented a virtual who's who of Minnesota health care and public policy organizations. Participants from the government included: the Minnesota Senate, Minnesota House of Representatives, Office of Administrative Hearings, Department of Commerce, and Department of Human Services. Participants from providers and insurers included: the Mayo Clinic, United Health Group, Medica, Minnesota Medical Association, and American Heart Association. Participants from legal services organizations included: Mid-Minnesota Legal Aid, Southern Minnesota Regional Legal Services, and more than a dozen private law firms.

These informed participants engaged in a day-long exploration of health care reform, specifically as it impacts Minnesota. They heard from regional and national experts, both scholars and practitioners, who discussed pragmatic and provocative topics. These topics ranged from access issues for vulnerable populations, to new delivery mechanisms, to the shortage of

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[1] For more information about the Hamline University School of Law Health Law Institute, please visit HEALTH LAW INSTITUTE, http://www.hamline.edu/law/hli/ (last visited June 17, 2015).

Hamline's Health Law Institute, founded in 2006, was recently ranked 13th among U.S. health law programs. *Best Grad Schools 2016,* U.S. NEWS & WORLD REP., (Mar. 2015), *available at* http://grad-schools.usnews.rankingsandreviews.com/best-graduate-schools/top-law-schools/clinical-healthcare-law-rankings. More than 50 students are pursuing one of Hamline's certificates in health law or health care compliance. The Health Law Institute and health law programming will significantly expand when Hamline Law's combination with William Mitchell College of Law more than doubles the size of the student body. *Cf.* Maura Lerner, *Hamline, William Mitchell Law Schools to Merge,* STAR TRIBUNE, Feb. 13, 2015.

[2] For more information about the *Hamline Law Review*, please visit HAMLINE LAW REVIEW, http://www.hamline.edu/law/publications/hamline-law-review/ (last visited June 17, 2015).

primary care physicians. Through symposium evaluations, attendees reported being over 90% satisfied with the conference content and speakers.[3]

In short, last October's Symposium brought various legal and health care disciplines together to identify problems, challenges, strategies, and solutions for health care reform implementation in Minnesota. This special issue of the *Hamline Law Review* is designed to recall, and indeed carry forward, the urgently important dialogues featured at the Symposium.

II. EXPRESSION OF APPRECIATION

The Symposium could not have taken place without the contributions of many people. The Law School and I wish to thank the leading scholars and practitioners who participated. We also wish to extend appreciation for the extraordinary efforts of the Health Law Institute's program manager, Kari McMartin, in planning, organizing and executing the conference. Equally noteworthy are the efforts of *Hamline Law Review*'s Symposium Editor Lukas Forseth.[4]

The development of the Symposium also benefitted from the advice and counsel of a diverse program committee representing perspectives from government, academia, insurance, and the media. The committee consisted of: (1) Lucinda E. Jesson, Commissioner of the Minnesota Department of Human Services; (2) Timothy S. Jost, the Robert L. Willett Family Professor of Law at Washington and Lee University School of Law; (3) Brian Beutner, Chair of the MNsure Board of Directors; (4) Jim Jacobson, Senior Vice President and General Counsel for the Medica Health Plans, and (5) Jackie Crosby, a reporter for Minnesota's leading newspaper, the *Star Tribune*.

Furthermore, the Symposium benefitted not only from those generous individuals who helped plan and organize the event but also from those who helped moderate the several sessions. We thank Hamline law professors Barbara Colombo, JD, RN; Laura Hermer, JD, LLM; Jonathan Kahn, JD, PhD; and David Larson, JD, LLM. We also thank Matthew K. Steffes, President of the Hamline Federalist Society, who moderated the final plenary session. We thank Hamline University Provost Erik Jensen for his opening remarks. We give special thanks to the event sponsors, Medica[5] and the Federalist Society.[6]

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[3] The average score, based on 50 responses, was 4.6 of 5.0.

[4] Other members of the 2014-2015 *Law Review* who were centrally involved in planning and organizing the Symposium include Jon Baker and David Dahl. Members of the 2013–2014 *Law Review* centrally involved include Veronica Mason and Jeremy Lagasse.

[5] For more information about Medica, please visit MEDICA, https://www.medica.com (last visited June 17, 2015).

[6] The Federalist Society sponsored the participation of Professor Hyman.

III. PRESENTATIONS AT THE LIVE SYMPOSIUM

The Symposium was comprised of two plenary sessions and four concurrent sessions. These six sessions concerned: (A) an overview of health care reform implementation in Minnesota, (B) access and coverage issues both for vulnerable populations and related to employer-provided insurance, (C) delivery and quality issues from integration to academic medical centers, and (D) other implementation challenges like the shortage of primary care physicians.

A. HEALTH CARE REFORM IN MINNESOTA: AN OVERVIEW

The Symposium opened with an overview from Lucinda Jesson, the Commissioner of the Minnesota Department of Human Services. DHS is the state's largest agency, serving well over one million people with an annual budget of $11 billion and more than 6,500 employees. The department administers a broad range of services, including health care, economic assistance, mental health and substance abuse prevention and treatment, child welfare services, and services for the elderly and people with disabilities. DHS provides some sort of help to more than one million Minnesotans, including direct care and treatment to more than 10,000 clients every year. As Commissioner, Jesson's priorities include serving more people in their homes and communities; making the state a smarter purchaser of health care; keeping people fed and healthy; narrowing disparities; preventing homelessness; and reducing fraud, waste and abuse.[7]

Commissioner Jesson reviewed how Minnesota has long been a leader in health care. For example, it is the only state with Medicaid expansion, a health care exchange, and an improved MinnesotaCare program. It is ranked first in the nation for overall health system performance, first in healthy lives, first for overall quality of health care, and third in access and affordability.[8] Commissioner Jesson reviewed the tradition of strong public health care programs and the recent reduction of nearly 200,000 uninsured that brings the percent of uninsured to under 5%.

Commissioner Jesson discussed not only health care coverage but also health care costs. She reviewed Minnesota's Accountable Care

[7] Prior to joining DHS, Commissioner Jesson was an Associate Professor of Law at Hamline University School of Law where she founded and served as Director of the Health Law Institute. Before that, Commissioner Jesson served in local and state government both as Chief Deputy Hennepin County Attorney, and as Minnesota Deputy Attorney General. In addition, she has extensive private sector experience.

[8] COMMONWEALTH FUND, SCORECARD ON STATE HEALTH SYSTEM PERFORMANCE (May 2014); AGENCY FOR HEALTHCARE RESEARCH & QUALITY, NATIONAL HEALTHCARE QUALITY & DISPARITIES REPORT (October 2014). Minnesota is also ranked the healthiest state for seniors and the third healthiest state overall. UNITED HEALTH FOUNDATION, AMERICA'S HEALTH RANKINGS: SENIOR REPORT (2014); UNITED HEALTH FOUNDATION, AMERICA'S HEALTH RANKINGS: ANNUAL REPORT (2014).

Organization demonstration projects, using concrete examples like North Memorial's Community Paramedic Program that provides home visits to high-risk patients and helps them avoid the emergency room.

While there is a lot to brag about, Commissioner Jesson acknowledged the challenges ahead. The number of Minnesotans over age 65 will nearly double by 2030. Many of these people have not planned for how they will pay for their care. There are gaps in mental health and substance abuse treatment. For example, only 1 in 18 people with a substance abuse disorder received treatment in 2010.

Perhaps most exciting, Commissioner Jesson reported on how the state is using a three-year State Innovation Model testing grant from the Center for Medicare and Medicaid Innovation. Substantial research demonstrates that clinical care is a relatively minor factor impacting health compared to social and economic factors. Accordingly, Minnesota is using the grant to test new ways of delivering and paying for health care using the Minnesota Accountable Health Model framework. This model expands patient-centered, team-based care through service delivery and payment models that support integration of medical care, behavioral health, long-term care and community prevention services.

B. ACCESS AND COVERAGE

The first of the Symposium's two "tracks" focused on access and coverage. This track consisted of two back-to-back panel sessions. One panel addressed access issues for low-income and vulnerable populations. The other addressed issues with employer-based health insurance.

1. Low-Income and Vulnerable Populations

Ralonda Mason, JD, is the Supervising Attorney for Mid-Minnesota Legal Aid - St. Cloud. She focuses on public assistance programs including health care programs. She has worked extensively in the implementation of health reform, serving on the Governor's Health Reform Task Force and leading Project Care, an education and enrollment outreach initiative in Central Minnesota.[9] Ms. Mason addressed health access issues for low-income populations both from her perspective as a member on Governor Dayton's task force and as a provider of legal services.

Fatema Haji-Taki, JD, works in the Health Care Eligibility and Access division at the Minnesota Department of Human Services (DHS) where she develops, analyzes, and implements health care eligibility policy and supports operational initiatives across Minnesota Health Care Programs. She plays a significant role in implementing Medicaid eligibility policy

[9] Ms. Mason is a graduate of the University of Notre Dame and Southern Methodist University School of Law. She has been advising clients and providing administrative advocacy on health care issues for more than 25 years.

provisions of the Affordable Care Act and serves as subject matter expert on health care policy for noncitizens.[10]

Ms. Haji-Taki addressed the intersection of health care policy and immigration law. Minnesota has continually been at the forefront of providing coverage for noncitizens, and filling coverage gaps at the state level. An example of Minnesota's progress includes exercising a state option to expand Medicaid to undocumented pregnant women. The Affordable Care Act and Minnesota's decision to expand Medical Assistance have significantly expanded health coverage options for lawfully present noncitizens.

Furthermore, strong advocacy by DHS, legislators, and advocates, to implement MinnesotaCare as the state's Basic Health Plan will continue to provide a low coverage option for noncitizens in Minnesota.[11] But despite Minnesota's progress to cover noncitizens, big challenges remain. Language, cultural barriers, and confusion about eligibility are just a few of the hurdles that some immigrant communities still struggle with. Thus, it is crucial for DHS and stakeholders to work collectively to ensure that all Minnesotans have access to affordable health care.

At the time of the Symposium, Matt Burdick was the Public Policy Director at NAMI Minnesota (National Alliance on Mental Illness).[12] NAMI is a grassroots advocacy organization dedicated to improving the lives of children and adults living with mental illnesses and their families. Mr. Burdick advocated on mental health issues both at the state legislature, and with state administrative agencies, in the areas of health care, human services, housing, and criminal justice. He coordinated NAMI Minnesota's grassroots advocacy efforts.

Mr. Burdick discussed the huge gains by people with mental illness as a result of health care reform, as well as the substantial work that remains

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[10] Ms. Haji-Taki brings diverse experience, specialized expertise in health care, and a strong commitment to social justice. Prior to working at DHS, she served as a MNsure Outreach and Enrollment Navigator at Health Access MN and as an attorney for the Immigrant Law Center of Minnesota. Her work included researching and analyzing health care eligibility policies, as well as conducting statewide outreach events with a specific focus on immigrant populations. Ms. Haji-Taki also assisted consumers with enrollment by explaining, discussing, and interpreting coverage options to facilitate plan selections. She has also worked as a Legal Fellow at the Battered Women's Legal Advocacy Project in Minneapolis and Acting Pro Bono Director at the Immigrant law center of Minnesota. Ms. Haji-Taki earned her Juris Doctor (J.D.) from Northeastern University School of Law in Boston, MA. She also holds a Bachelors of Arts (B.A.) in Political Science and Global Studies from the University of Minnesota.

[11] CENTERS FOR MEDICARE AND MEDICAID SERVICES, BASIC HEALTH PROGRAM BLUEPRINT, *available at* http://www.medicaid.gov/basic-health-program/downloads/minnesota-bhp-blueprint-december.pdf.

[12] Mr. Burdick is now Legislative and Stakeholder Relations for Chemical and Mental Health Services, Minnesota Department of Human Service. He holds a bachelor's degree in Sociology and Political Science from Augsburg College.

to ensure that people with mental illness can access appropriate care when and where they need it.

On the one hand, state and federal health care reform efforts have had a dramatically positive impact on the lives of children and adults living with mental illness. Expanded eligibility for Medicaid, mental health parity, and other recent reforms greatly expanded access to mental health treatment and services.

On the other hand, challenges to accessing mental health care persist. Many people with mental illnesses are still uninsured or underinsured. There is a severe shortage of mental health providers (both here in Minnesota and across the nation). And the mental health service delivery system remains underdeveloped, fragmented, and rife with gaps and bottlenecks.

2. Employer-Based Health Insurance

Jean Marie Abraham, PhD, is the Weckwerth Professor of Healthcare Administration Leadership and Associate Professor in the Division of Health Policy and Management, University of Minnesota. She is a health economist with thirteen years of experience focusing on questions related to health insurance provision, information use, and competition in insurance and hospital markets.[13]

Professor Abraham provided background information on key attributes of employer-based health insurance in the United States, including offer rates, eligibility, and premiums. She identified and discussed the economic incentives and disincentives created by the Affordable Care Act as it pertains to employer based coverage. Moreover, she outlined how the ACA is expected to affect employees' demand for coverage as well as employers' decisions to offer insurance, and their determination of eligibility and coverage generosity.

Julie Brunner, JD, is the Executive Director of the Minnesota Council of Health Plans, an association of Minnesota's seven nonprofit health plan companies: Blue Cross Blue Shield, HealthPartners, Medica, PreferredOne, Metropolitan, Sanford, and UCare. The Council's members provide health coverage for more than four million individuals. The Council

[13] Professor Abraham's primary teaching responsibilities are with the Master of Healthcare Administration program, in which she instructs courses in statistics for health management decision-making and health economics. Dr. Abraham is well-versed in U.S. health policy including provisions within the Patient Protection and Affordable Care Act. During academic year 2008–2009, she served as the senior economist on health issues for the President's Council of Economic Advisers in Washington, D.C., under both the Bush and Obama administrations. Professor Abraham holds a Bachelor's degree in Economics and Political Science from the University of Arizona and a PhD in Public Policy and Management from Carnegie Mellon University.

is active in the areas of community health and prevention, health care quality improvement, and health care public policy.[14]

Ms. Brunner assessed the ACA's impact on Minnesota's health insurance marketplace, including data on the continued decline in enrollment in fully insured group coverage. She shared components of the ACA that had the broadest impact on employers and individuals as well as requirements where Minnesota was ahead of the rest of the nation. Ms. Brunner also shed light on the challenges with implementation over the past four years and thoughts on what we can expect the future to hold.

Autumn Amadou-Blegen, SPHR, MAHRM, has been the Director of Human Resources and the main decision maker on employee health benefits at several small, rapid-growth Minnesota-owned companies, two in the rapidly expanding craft beer market. At the time of the Symposium, she was Human Resources Director for Surly Brewing Company.[15] Ms. Amadou-Blegen was tasked with obtaining insurance for the growing number of employees at Surly. Drawing on that experience, she discussed the challenges in obtaining health insurance from the perspective of a small Minnesota employer.

C. DELIVERY AND QUALITY

The second of the Symposium's two "tracks" focused on delivery and quality. Like the access and coverage track, this one also consisted of two back-to-back panel sessions. One addressed integration beyond accountable care organizations. The other addressed issues with academic medical centers and the triple aim.

1. Integration Beyond Accountable Care Organizations

Minnesota has been particularly innovative in moving health care from a traditional focus on treating the sick and injured to a focus on keeping the healthy people healthy. Four Minnesota leaders centrally responsible for this move addressed four key aspects of this growing transformation: (1) promoting primary care and prevention; (2) developing new models for coordinating and delivering care; (3) using information technology; and (4) reforming provider payments to promote outcomes.

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[14] Before becoming the Council's executive director in January 2003, Julie Brunner served as the Deputy Commissioner of the Minnesota Department of Health where she managed the development of budget initiatives, legislative proposals and general operations. Prior positions include County Administrator for St. Louis County and Director of Child Support Enforcement for the Ramsey County Attorney's Office. Her experience also includes serving as Assistant Commissioner for the Minnesota Department of Human Services and lawyer with the Office of Senate Counsel.

[15] Ms. Amadou-Blegen is now Human Resources Manager for Summit Brewing Company. She obtained her Master of Arts in Human Resources Management with a focus on Work/Life Balance from Concordia University in 2012, and obtained her SPHR in early 2014.

Specifically, the panelists discussed recent initiatives that assure a focus on early intervention and prevention, as well as measures that allow people to remain in their own homes for as long as possible. Finally, they outlined efforts to further integrate the medical and county delivered services (like food) that are provided to our Medicaid populations.

Keith Halleland, JD, is a founder and shareholder of Halleland Habicht PA, where he co-chairs the health law practice and is a founder of the firm's affiliated consulting company, Halleland Health Consulting. Halleland's practice focuses on regulatory compliance, business transactions, and health care policy.[16]

Frank Fernández, JD, serves as Vice President of Government Programs and President and Chief Executive Officer of Blue Plus for Blue Cross and Blue Shield of Minnesota. His role focuses on leading all local government businesses, including operations, compliance and program management for Medicare, Medicaid, and the Federal Employee Program.[17]

John Locastro is the Vice President of Central Region Sales for Sandlot Solutions. Sandlot Solutions is a health care information technology company jointly owned by Santa Rosa Consulting, Inc. and North Texas Specialty Physicians (NTSP) that provides a next generation health information exchange (HIE) and data analytics tools and services for streamlining data sharing between providers, hospital systems and health plans in order to improve patient outcomes and reduce the cost of care.[18]

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[16] Mr. Halleland serves as general counsel for the Health Care Compliance Association (HCCA), as well as the Society of Corporate Compliance and Ethics (SCCE). Halleland formerly served as a judicial clerk to the Honorable Miles W. Lord, chief judge of the United States District Court for the District of Minnesota. He has published numerous articles and is active in the Minnesota State Bar Association, Health Law Section; the American Health Lawyers Association; and the Minnesota Chapter of the Federal Bar Association. Mr. Halleland also is active in many community and nonprofit organizations and currently serves on the advisory board for the Health Law Institute at Hamline University Law School and the advisory council of the Humphrey School of Public Affairs, as well as chairing the board of directors of Way to Grow. Halleland is a graduate of the University of Iowa and the Seattle University School of Law.

[17] Mr. Fernandez joined Blue Cross in 2005 as an attorney for government programs and Medicare. He was elected President and CEO of Blue Plus in 2010. Mr. Fernandez serves on the board of MII Life Inc., co-chairs the Blue Cross Diversity Council and serves as board vice president of CLUES, a nonprofit service organization that serves the Twin Cities Latino population. He holds a bachelor's degree in political science with a concentration in Latin American studies from Arizona State University and a law degree from Hamline University School of Law. He was named one of the "25 on the Rise" by the Minnesota Hispanic Chamber of Commerce in 2007. He also has been recognized by several organizations, including Los Jovenes de Salud, for his support of Latino youth in the Twin Cities.

[18] Mr. Locasto is a graduate of the University of Memphis. Sandlot Solutions' customizable products and services allow health care providers easy access to patient information from a variety of sources and formats community-wide to more effectively enhance care coordination, disease management and quality measurement while preparing for Accountable Care and other payment models.

Jeffrey L. Tucker has more than 27 years of experience in health care. In April, 2010, he was elected President and CEO of Integrity Health Network, LLC, an entity resulting from the merger of Northstar Physicians Network (129 physicians) and Northland Medical Associates (40 physicians).[19]

2. Academic Medical Centers and the Triple Aim

Ann Marie Marciarille, JD, is an Associate Professor of Law at University of Missouri-Kansas City (UMKC) School of Law specializing in health care law. Her research interests include health care antitrust, health care regulation, and a particular interest in health care organization and finance. Before joining UMKC, Professor Marciarille had a long career as a health law attorney, including serving as a health care antitrust prosecutor for the California Attorney General's office and several years as a legal services attorney specializing in health care matters.[20]

Professor Marciarille explored the tension between what we have asked academic medical centers (AMCs) to be and what we are asking them to become. AMCs in Minnesota and elsewhere are grappling with their own internal transformation under health care reform as they pursue their traditional goals of clinical care, research, education, and community health. Simultaneously, they must confront the role they play in the health insurance marketplaces—often as relatively high cost providers.

Professor Marciarille argued that we, as citizens, must decide what it is we want from AMCs and at what price. Although this is not a problem peculiar to Minnesota, it is framed nicely by the commercial insurance products being sold through the Minnesota Exchange, where, southeast Minnesota's higher cost Exchange-offered health insurance products have sparked a conversation about the future of AMCs in a post health reform world that will have resonance throughout the Midwest.

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[19] Mr. Tucker joined Northstar as Director of Network Development in 1997, with responsibilities that included development of the group purchasing program, and oversight of the malpractice risk management, utilization review, and quality improvement areas. He has chaired committees at the care system level; was an active founding member of a regional health care technology consortium; lead the development of a group purchasing program, and sat on the technology advisory committee for a large malpractice carrier. In 2009-2010, Mr. Tucker played an integral role in combining two long-established names in health care, creating a new entity to respond to market forces and offer an alternative to the big corporate systems.

[20] Professor Marciarille is a Phi Beta Kappa summa cum laude graduate of Amherst College and a cum laude graduate of Harvard Law School. She also holds a Masters in Theology, specializing in ethics, from Harvard Divinity School. Professor Marciarille has published articles on Medicare reform, Medicaid reform, health care finance reform and health care provider quality issues. Professor Marciarille taught Health Law, Health Care Reform, Health Care Regulation and Finance, Elder Law, Disability Law and Public Health Law at the University of California, Hastings College of the Law, Boalt Hall/Berkeley Law School, and Pacific McGeorge School of Law.

Professor Marciarille introduced participants to the establishment of AMCs in the United States and their two dominant delivery and finance models: a fully integrated model and a split/splintered model. The former was the child of 1960s enthusiasm over wholly integrated care. The latter is expressive of 1990s interest in separating the clinical enterprise from other goals.

The Mayo Clinic serves as the modern example of a relatively older AMC nonetheless subject to the modern pressures of horizontalization and consolidation. The Mayo Clinic's influence on exchange-offered insurance products in southeast Minnesota highlights the concerns that the financial management of AMCs raise in this new world. Health care and health insurance are full of cross-subsidizations and so it is that the margins from clinical care at AMCs have historically been used to subsidize research, education, and work on community health. AMCs, in short, have different cost structures. The struggle is to determine if, in a post health reform world, we should either embrace this cross-subsidization as just, or discard it as perverse. Even those within the AMC world cannot fully agree. This makes it all the more important to study and discuss.

Matthew Anderson is Senior Vice President of Policy & Strategy of the Minnesota Hospital Association. He addressed the risks and rewards of detangling graduate medical education financing from hospital payment methodologies. Teaching hospitals deliver hands-on clinical training experiences for physicians and an array of other caregivers during their journey from students to practitioners. These training experiences come at a cost to the teaching hospitals.

Medicare and Medicaid payment methodologies evolved to account for these costs, at least in part, by providing supplemental add-on payments to teaching hospitals' reimbursement rates. But none of these supplemental payment streams fully compensate teaching hospitals for their actual costs of providing medical education and training experiences. Therefore, many teaching hospitals negotiate higher reimbursement rates from commercial insurers.

This multi-faceted, indirect and complex cost recovery system presumes a traditional fee-for-service payment environment in which individual patients have little incentive to compare providers based on costs. New payment reforms use measures of efficiency or costs of care to vary hospitals' reimbursement amounts, so these supplemental payments and higher negotiated rates create significant challenges for the long-term viability of residency and clinical programs. Teaching hospitals find themselves at a competitive disadvantage because they appear to be more expensive, less capable of earning shared savings or other incentives for low-cost care, and more vulnerable to narrow-network plan designs.

Without addressing the different functions of the care delivery payment system and building a medical education financing structure that is separate from calculations of providers' costs of care, teaching hospitals will

face mounting pressures to reduce or even eliminate their training programs. On the other hand, detangling medical education funding from care delivery reimbursement could make medical education funding more vulnerable politically if it is not regarded as part of the Medicare or Medicaid programs. Therefore, new financing systems need to be accompanied by policies or safeguards that establish long-term sustainability and predictability so teaching hospitals can appropriately plan ahead and make reliable commitments to the residents, nurses, pharmacists, and other professionals who agree to train in their facilities.

Deborah R. Farringer, JD, is an Assistant Professor of Law at Belmont University College of Law. She teaches Health Law, Health Care Fraud and Abuse, Health Care Business and Finance, and Health Law Practicum. Prior to joining the faculty at Belmont, Professor Farringer served as Senior Associate General Counsel in the Office of General Counsel at Vanderbilt University.[21]

Professor Farringer discussed the origins of the Triple Aim and its impact on the development of ACOs under the ACA.[22] She then analyzed why academic medical centers and other integrated delivery systems such as the Mayo Clinic, which are leaders in research, innovation, and quality care, are opting out of a model of care in the ACO structure that was designed with the goal of functioning more like these entities.

D. OTHER IMPLEMENTATION CHALLENGES

The final session of the Symposium addressed three other implementation challenges: (1) access to coverage does not mean access to

[21] At Vanderbilt, Professor Farringer's practice focused primarily on transactional matters for Vanderbilt University Medical Center, including analysis of contracts for compliance with applicable health care laws such as the Stark Law, Anti-kickback Statute, Civil Monetary Penalties Law, and the False Claims Act, physician practice acquisitions, joint ventures, general corporate governance and corporate maintenance issues, hospital operations, and real estate leasing and purchasing issues. Prior to her role at Vanderbilt University, Professor Farringer was an associate at Bass, Berry & Sims PLC where she practiced in the firm's Healthcare Industry group. Professor Farringer graduated summa cum laude from the University of San Diego with a B.A. in History and received her J.D. from Vanderbilt University School of Law where she was a member of the Order of the Coif. While in law school, Professor Farringer served as the Senior Notes Editor for the Vanderbilt Law Review. Immediately following law school, she completed a judicial clerkship for Judge H. Emory Widener, Jr. of the United States Court of Appeals for the 4th Circuit in Abingdon, Virginia. Professor Farringer is a member of the American Health Lawyers Association and is also licensed to practice in the state of Tennessee.

[22] The Triple Aim is a framework for health care that, at its origin, was intended to optimize population health, care experience, and cost. *See, e.g.* Donald M. Berwick, Thomas W. Nolan and John Whittington, *The Triple Aim: Care, Health, And Cost,* 27(3) HEALTH AFFAIRS 759 (2008). It was with this Triple Aim in mind that legislators and policymakers established the framework for accountable care organizations and the Medicare Shared Savings Program.

care, (2) the shortage of primary care physicians, and (3) even more fundamental challenges.

Stefan Gildemeister is the Minnesota State Health Economist. He is also Director of the Health Economics Program at the Minnesota Department of Health.[23] He reviewed several key statistical measures compiled and published by his office at the DOH.[24] Mr. Gildemeister established that access to health care insurance coverage does not necessarily mean that the individual has access to needed health care services.

Jeremy Springer, MD, is chair of the Minnesota Medical Association's Primary Care Physician Workforce Expansion Advisory Task Force.[25] He presented an overview of the state's primary care physician workforce shortage. Due to aging, population growth, and the effect of the ACA, this shortage will exceed 60,000 physicians in 2025, including more than 1000 in Minnesota. Dr. Springer identified current causes and potential solutions to barriers related to the primary care workforce. These barriers include training and residency shortages; disparities in income between primary care and other providers; and negative perceptions of primary care among students. Finally, Dr. Springer evaluated current and potential incentives currently available to develop, attract, and retain a highly skilled and diverse health care workforce.[26]

David A. Hyman, JD, MD, is the Ross and Helen Workman Chair in Law and Professor of Medicine at the University of Illinois, where he directs the Epstein Program in Health Law and Policy. He focuses his research and writing on the regulation and financing of health care.[27] Perhaps more

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[23] Before serving in this and other positions at the health department beginning in 1998, Mr. Gildemeister conducted comparative research for a number of research institutions in the United States and Germany. He is a graduate of the New School for Social Research and the University of Bremen with a master's degree in both economics and business administration.

[24] The Health Economics Program conducts research and applied policy analysis to monitor changes in the health care marketplace; to understand factors influencing health care cost, quality and access; and to provide technical assistance in the development of state health care policy. Minnesota Department of Health, *Health Economics Program*, http://www.health.state.mn.us/divs/hpsc/hep/index.html

[25] Minnesota Medical Association, *Primary Care Physician Task Force*, http://www.mnmed.org/About-the-MMA/MMA-Committees-amp-Task-Forces/Primary-Care-Physician-Task-Force. Dr. Springer practices in the areas of adolescent health, sports medicine, and obstetrics at Park Nicollet in St. Louis Park, MN. He is a graduate of the University of Minnesota Medical School.

[26] MINNESOTA MEDICAL ASSOCIATION, PRIMARY CARE PHYSICIAN WORKFORCE EXPANSION ADVISORY TASK FORCE – FINAL REPORT AND RECOMMENDATIONS, May 2014, http://www.mnmed.org/Portals/MMA/PDFs/MMA_Primary_Care_Physician_Workforce_Expansion_Advisory_Task_Force-FINAL_Task_Force_Report-May_2014.pdf.

[27] Professor Hyman teaches or has taught Health Care Regulation, Civil Procedure, Insurance, Medical Malpractice, Law & Economics, Professional Responsibility, and Tax Policy. While serving as Special Counsel to the Federal Trade Commission, Professor Hyman was principal author and project leader for the first joint report ever issued by the Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of*

forcefully than any other presenter, Professor Hyman identified several fundamental design defects in the ACA and even challenged participants to consider whether it is sustainable, even taken on its own terms.[28]

IV. THE PRINTED SYMPOSIUM

This special issue of the *Hamline Law Review* includes six new Articles addressing the theme of the Symposium. These articles can be roughly grouped into three categories: (A) expanding access to health care, (B) improving the quality of health care, and (C) beyond health care: improving public health.

A. EXPANDING ACCESS TO HEALTH CARE

Three of this issue's six articles address access to health care. First, in *Beyond the Affordable Care Act's Premium Tax Credit: Ensuring Access to Safety Net Programs,* Mary Leto Pareja discusses the Premium Tax Credit, which eases the financial burden of the ACA individual mandate by subsidizing coverage for lower-income people. Pareja is an Assistant Professor of Law at the University of New Mexico School of Law.

Professor Pareja targets the ACA requirement that to claim the credit, married individuals must file jointly. She argues that for many, filing jointly is dangerous or difficult. While the tax code currently has some exceptions for certain victims of domestic abuse or spousal abandonment, Professor Pareja urges the IRS to expand the exceptions to other categories of individuals who face serious hurdles to filing jointly, such as long-separated spouses.[29]

Second, in *Where Do I Start? ACA Compliance in Rapid Growth Environments,* Autumn Amadou-Blegen shares her experience contemplating the impact of the ACA as the human resources director for Surly Brewing Company in Minnesota. She describes the challenges of a small, rapid growth employer with finite time and limited resources: (a) gathering information, (b) maintaining and supporting health care access, (c) attracting and retaining top talent, and (d) maintaining compliance.

Competition (2004). He is also the author of "Medicare Meets Mephistopheles," which was selected by the U.S. Chamber of Commerce/National Chamber Foundation as one of the top ten books of 2007. He has published widely in student edited law reviews and peer reviewed medical, health policy, and law journals.

[28] *See, e.g.,* David A. Hyman, *Convicts and Convictions: Some Lessons from Transportation for Health Reform,* 159 U. PENN. L. REV. 101 (2011); Richard A. Epstein & David A. Hyman, *Why Obamacare Will End Health Insurance As We Know It*, MANHATTAN INSTITUTE ISSUES 2012 No. 7 (Mar. 2012).

[29] Professor Pareja also goes beyond the Premium Tax Credit to identify other instances in which the tax code requires joint filing to claim tax benefits. She argues that the Premium Tax Credit exceptions should be extended to apply to other tax benefits like the Earned Income Tax Credit.

Third, while health care insurance coverage may often be necessary for access to health care, it is not sufficient. One reason for the disconnect is that there are insufficient physicians to provide services. Lawrence Massa and Matthew Anderson are, respectively, the President and the Senior Vice President of Policy and Strategy for the Minnesota Hospital Association. In *Detangling Graduate Medical Education Financing from Hospital Payment Methodologies,* they argue for revisions to current graduate medical education financing structures.

Without reform, they contend that teaching hospitals may face difficult choices between retaining their residency programs and eliminating those programs to bring their cost structures more in line with their competitors. This is a dangerous outcome given predicted shortages of primary care physicians. The solution, Massa and Anderson argue, is that support for medical education activities must be delinked from reimbursement for care delivery. That way, teaching hospitals can survive under new payment methodologies and transparent environments.

B. IMPROVING THE QUALITY OF HEALTH CARE

Two of this issue's six articles focus on improving the quality of health care. Daryll Dykes, MD, JD, PhD, is an internationally recognized leader in the field of spinal medicine and surgery. He lectures locally, nationally and internationally on a variety of medical and spine related topics.[30] In *Good Medicine, Bad Medicine, and the Wisdom to Know the Difference,* Dr. Dykes establishes the importance of monitoring the quality and effectiveness of health care to distinguish good medicine from bad medicine. He then reviews the history of such standardized measurement and public reporting of health care cost and quality in Minnesota.

In *Keeping Our Eyes on the Prize: Examining Minnesota as a Means for Assuring Achievement of the "Triple Aim" under the ACA*, Professor Deborah Farringer examines the potential risks of maintaining an ACO structure that is not open, available, and accessible to academic medical centers such as the Mayo Clinic. She suggests that such a structure that does not encourage participation by entities such as the Mayo Clinic will be unable to achieve the goals of the Triple Aim that the ACA set out to accomplish. Finally, Professor Farringer offers some suggestions for amendments to the ACO model. These amendments might make ACO participation possible for the Mayo Clinic and entities like the Mayo Clinic. And they can move the U.S. health care delivery system closer to its goals of achieving the Triple Aim.

[30] Dr. Dykes currently practices at the Midwest Spine and Brain Institute in Edina, Minnesota.

C. BEYOND HEATH CARE: IMPROVING PUBLIC HEALTH

As highlighted by Commissioner Jesson in her opening remarks, the health of Minnesotans is primarily determined by things other than health care. Yet, the United States invests far more in medicine and technology than in prevention and social supports. In *Civil Legal Aid Inequities as Predictors of Public Health Disparities,* James A. Teufel, MPH, PhD, and Shannon Mace Heller, JD, MPH, focus on these health determinants. Teufel is an Assistant Professor of Public Health and Associate Director of the Institute for Public Health at Mercyhurst University. Heller is Director of the Office of Policy and Planning at the Baltimore City Health Department.[31]

Teufel and Heller identify the main drivers of health disparities in the United States as people's "social resources." These include their income, wealth, education, and employment. Teufel and Heller argue that civil legal aid attorneys can improve population health by remediating social and economic injustices and harms. But a civil legal aid "justice gap" prevents more than one million individuals from receiving legal services each year. Teufel and Heller offer recommendations for addressing this civil legal aid justice gap.

V. CONCLUSION

This special issue of the *Hamline Law Review* offers balanced perspectives from different disciplines and practice settings. And it identifies priorities for empirical and legal research. We hope that the Symposium and this special issue will assist clinicians, policymakers, and industry leaders in improving health and health care in Minnesota, by informing, guiding, or prompting the development of needed public policy, institutional guidance, and individual practice.

[31] I was privileged to work with Shannon when I was a professor and she was a law student at Widener University in Delaware.