Health Care for All Minnesotans

Where we are—how we got here--where do we need to go?

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over 45 years in nursing--clinical patient care, intensive care, operating rooms, nursing leadership, clinical educator– mostly in acute care hospitals, one and a half years at MDH, long-standing interest in health policy and financing health care, MA HHS administration, and flight nurse, LtCol, USAF (Ret.)

advocate a person who supports or recommends a particular cause or policy, a champion, upholder, supporter, proponent, campaigner, fighter, crusader

advocacy public support for or recommendation of a particular cause or policy

- advocacy comes naturally to nurses—it's what we do, who we are
- we believe strongly in mastering the skills and knowledge to keep patients safe under our care and assure the best possible outcomes
- we fiercely protect patients from the hazards of the OR environment, we anticipate and prevent errors, we respond to problems
- we try to make their experience as smooth and positive as we can
- I would like to expand the concept of advocacy in nursing to include working to make our health care system better for patients, families, and our society as a whole—particularly how we finance health care

Pop Quiz…….

- What percent of our health care dollar currently goes to administrative overhead in the U.S?
- How much of total health spending in the U.S. is currently financed with tax dollars?
- What year was Medicare and Medicaid passed?
- How many people in the U.S. depend on Medicaid?
- What percent of Medicaid spending goes to seniors and the disabled in Minnesota?
- What percent of children in the U.S. rely on Medicaid?

The Health Care System in the U.S……..

Costs too much, does too little, and leaves too many people out.

The healthcare industry currently consumes over 17.8% of GDP—one-sixth of a $17.95 trillion economy--yet, prior to passage of the ACA in 2010, some 30-50 million people in the U.S. lacked health insurance of any kind, were entirely dependent on public services, or went without.

- A trillion is a thousand billion $ and equals the economy of the country of Australia. Three times that of the economy of France plus Switzerland. Or California plus Pennsylvania. Anyway, a lot….

A little bit about Cassie (not her real name)……..

Cassie is a bright, engaging young woman in her early twenties, from greater Minnesota. I met Cassie a year ago when I spent some time in and around my own home town, about an hour and a half north of the metro. She works in the public library of her community of about 2500 people. I didn't know that she is a Type I diabetic, until……

We became Facebook friends and one day, some months ago, I noticed a post from her saying that the cost of her insulin had gone up to $800 per month. She said, "That's about the same cost as my rent and I can't afford to do both."

My heart sank at the thought of anyone even having to think about a choice like that, at such a young age. She is one of millions…..

For those who are guided by a faith tradition:

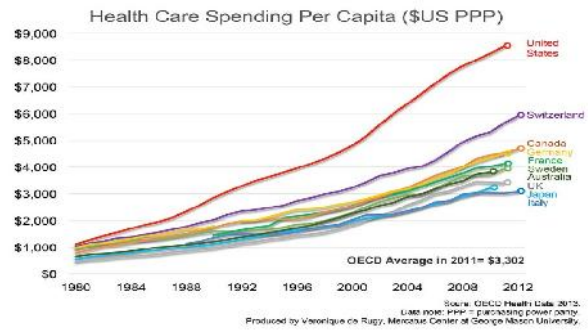
- From Matthew 25:40
  - Truly I tell you, whatever you did for the least of these my brothers and sisters, that you did for me.

Matthew 25:45 says

- When you refused to help the least of these my brothers, you were refusing to help me.

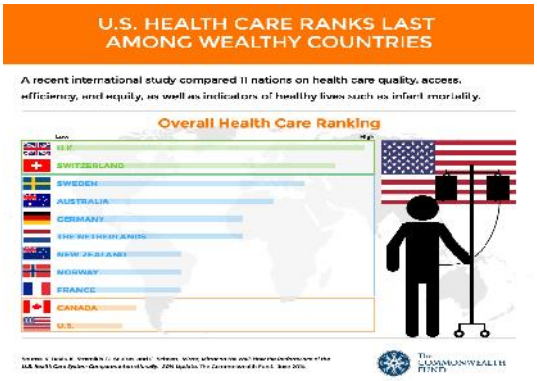
Where are we?

It's not enough that you're sick.....

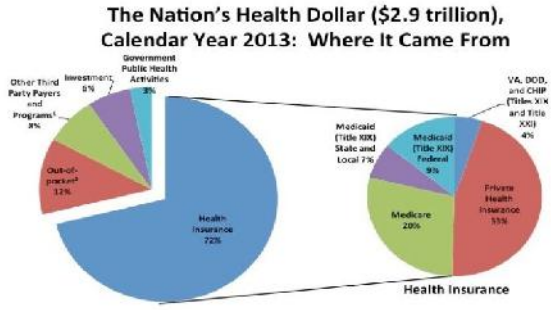


Compared to other countries.....

- the U.S. ranks 37th overall in health outcomes against other countries around the world, according to the World Health Organization, including countries like Cuba, Romania, etc.
- health outcomes/population health measures are such things as life expectancy, infant mortality rates, rates of chronic conditions such as obesity, diabetes, heart disease
- last or near last in access, e□ciency, and equity
- note that the U.S. does better in the area of specialized cancer treatment; this data is about population health



Notice that private health insurance is down to one-third.....



Two-thirds of health care in the U.S. already funded by taxes.....

- Americans pay the highest taxes for health care in the world yet find themselves with unsustainably high premiums and out-of-pocket costs (PNHP health policy experts)
- people naturally assume that our private, employment-based model covers most of us with Medicare and Medicaid making up the di□erence—it's down to about half in MN
- keeping in mind that number of people covered and money spent are two di□erent things, employment-based insurance is becoming less dominant over time
- the nature of employment—part-time, frequent job changes, small-businesses, the "gig economy", the high cost to employers—all a□ect private insurance coverage
- the number who have to shop on the individual and small group market is 5-7%
- MN just spent almost half of the budget surplus propping up the private insurance market—no strings attached—attempting to lower premiums mostly for this 5-7%

Health Care coverage in the U.S. is a patchwork:

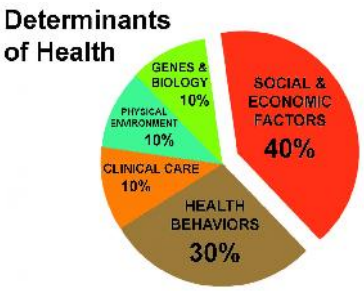
- private health insurance—for-profit and not-for-profit—employment-based or purchased on the private market; dental insurance usually separate
- public programs such as Medicaid, Medicare, Veterans' Administration
- in MN, approx. 70% of Medicaid goes to nursing home costs, and the disabled
- the Children's Health Insurance Program, since the mid-'90s--threatened
- Federally Qualified Health Centers—over 1100; US Public Health Service
- emergency medical services, emergency rooms—public and private
- county hospitals, university hospitals who receive Hill-Burton funds
- critical access hospitals in rural areas; some MVA insurance
- MinnesotaCare in our state, for low-income individuals and families
- Social Security Disability, Workman's Compensation; other disability policies
- private pay, including deductibles and co-pays; long-term care....
- we have what's known as a multi-payer system that's not a system at all

It's a crazy quilt, only with big holes in it.

What really contributes to a healthy population?

- this mix of factors believed to accurate according to our MN Department of Health
- note that clinical care only contributes 10% to the overall health of the population, yet consumes one-sixth of GDP
- personal choices 30%
- total care vs primary care spending in U.S. 95% vs 5% and 92% vs 8% in MN
- "health in all policies"

The American HealthCare Paradox: Why Spending More is Get□ng Us Less Elizabeth H. Bradley and Lauren A. Taylor



How did we get here?

A brief history of our private health insurance system....

- e□orts to create a national health plan go back over 100 years
- President Theodore Roosevelt proposed national health insurance, then lost in the 1912 election, after which ...
- further e□orts were blocked by anti-socialist/anti-German sentiment around WW I, by the AMA, and over time, the for-profit side of health care
- Baylor's plan marketed to teachers in Texas 1920s— became Blue Cross
- the rise in the American hospital system, more trained sta□, treatments and medicines, improved education for physicians, and the
- transition of care from the home to hospitals all increased costs
- the Great Depression made the need for insurance more clear, and the economic conditions in place during World War II greatly expanded it

History of private health insurance in the U.S., continued....

- unable to raise wages to compete for workers, factory owners o□ered fringe benefits, including health insurance, to compete
- employment-based health insurance is more or less an accident of WW II wage and price controls; FDR had intended national health insurance to be part of the New Deal but the political climate at the end of the 40s ....
- after the war, employers, unions, and worker groups emphasized private health insurance as integral to employee benefit packages
- Truman tried for national health insurance and was again blocked by the AMA saying it would make doctors "slaves" and likened it to communism
- by the 1960s, approximately 70% of the population were covered by private health insurance plans, solidifying the employment-based model
- then, rising costs ushered in 40 plus years of attempts at cost-containment, including the HMO concept as Nixon's attempt to address these costs

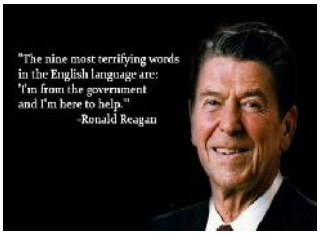
How did we get here? Continued.....

- people with good jobs had insurance, almost everyone else looked to the government, or went without, unless you could pay yourself, which was increasingly di□cult
- among those left out were seniors, those in low-paying jobs, those unable to work
- JFK proposed "Medical Care for the Aged" (opposed by the AMA) LBJ picked it up and
- Medicare and Medicaid finally passed in 1965; Medicare was reasonably well-accepted by conservatives and liberals as a benefit earned by a lifetime of hard work
- the debate over whether health care is a right or a privilege heightened with rise in costs associated with health care as a science, not a charity, and the underlying tension in this country between rugged individualism and the common good
- the spike in drug costs, and Pres. George W. Bush's desire to secure the senior vote in Florida in 2004, led the GOP to pass Medicare Part D in 2003, which went into e□ect in 2006, adding $70 billion in costs initially, an unfunded mandate, now over $850 billion

Echoes from the past..... (hired by the AMA)

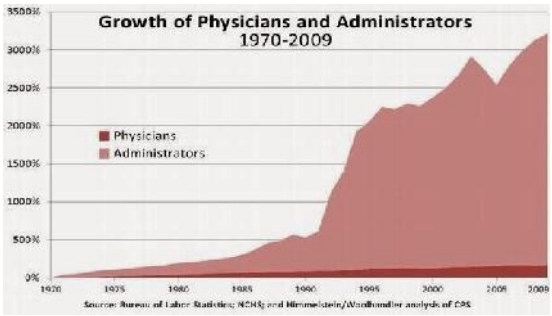
In 1961, Ronald Reagan speaks out against "socialized medicine".

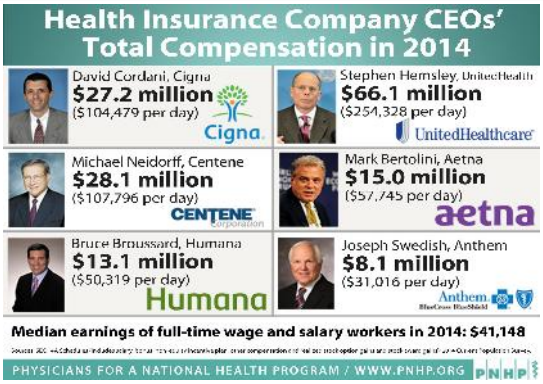
"From (Medicare) it's a short step to all the rest of socialism.....Write those letters now (to Congress) and call your friends and tell them to write.... If you don't do this and I don't do this, one of these days we are going to spend our sunset years telling our children and our children's children, what it was once like in America when men were free."



The cost of private insurance to the health care system:

- administration accounts for 31% of health care expenditures
- insurance companies, employers, providers all incur costs
- billing, coding, marketing, executive and other pay, shareholder return, managing benefit plans, plus.....
- burden on providers – pre-authorization, documentation, responding to additional requests for information, overhead
- by contrast, Medicare administrative costs are under 3%.....
- CMS pushes important patient safety standards.....
- many Medicare plans and most Medicaid HMOs are administered by commercial insurance companies, raising costs
- the private health insurance market has grown from a $1 billion industry in 1950 to $8.7 billion in 1965, to $ 848.7 billion in 2010





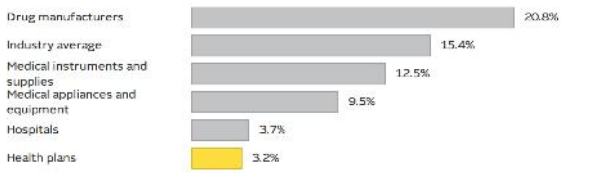
The biggest drivers of cost, besides admininstrative.....

- drugs – as much as 20%, inpatient and prescription
- devices
- diagnostics
- fees
- technology
- fraud, malpractice
- preventable errors
- overuse of the health system not a driver of cost in the U.S.

Not just to pick on those insurance company execs.....

We might need to develop the will to address this.....

Health sector profit margins



Source: Yahoo! Business

Hospital charges are unregulated and unintelligible....

- modern hospitals and health care facilities use thousands of amazing products, devices, drugs, diagnostics, and technical advances to provide life-saving and life-changing care today
- most of us wouldn't want to go back to a time when these were not available, or available to only a few but unaffordable care is the same as rationing
- we all have stories about the $5 aspirin and the $45,000 knee, but
- how do we know what anything should cost without some regulation
- hospitals mark up products and services anywhere from 200 to 1000%
- for-profit systems are the highest but all are using these processes
- much of this came about as a result of "healthcare as a business" which took off in the 1980s—hospitals hired consultants to help them maximize reimbursement—this is when prices really became unrelated to costs

The Medical-Industrial Complex: Market Failure

- when you hear talking points such as "we need to get the government out of health care and let the market work" please remember this:
- treatment is more profitable than a cure; amenities are marketing tools
- most people have no real choice of providers or facilities—networks
- prices are almost impossible to find—"it depends"—uninsured pay most
- economies of scale and competition tend to drive prices up, not down
- monopoly power, buying out the competition, also drive prices up
- lack of standard billing processes, aging technologies, can drive prices up
- prices will rise to whatever the market will bear; costs are passed on

Reference: An American Sickness: How Healthcare Became a Business by Elisabeth Rosenthal

OK, so what? Why does all this matter?

- medical expenses account for 60 - 72% of all personal bankruptcies*
  *most of these people have health insurance
- the rate of uninsured peaked at 18% of adults in mid-2013 (down to 12.9% in late 2015, varies by state, three years into the ACA)
- uncompensated care, 6% of total hospital expenses, $39.1 billion in 2009 (by 2015 dropped to the lowest level in 26 years, 4.2%, $35.7 billion)
- the cost of premiums, co-pays, and deductibles in the private market, for "skin in the game" policies, are putting actual access to care out of reach
- medications may be unaffordable; providers are under stress
- with employment-based insurance, when you lose your job, you lose your insurance
- true costs of health care are buried in cost of goods, property tax, income tax, wage suppression, cost-shifting to the insured and private pay, premiums
- the "opportunity cost" means less money for basic needs, saving for education, planning for retirement, public investment in social programs and infrastructure

Continued……

- affects our ability to compete in global markets—adds approx. $1500 to the cost of manufacturing each car, for example (industry knows)
- costs to small businesses are very high, due to smaller risk pools ….
- the cost of health care/insurance stifles entrepreneurial activity
- wage increases in the past 30 years have largely been consumed by the cost of health insurance benefits for employers and employees
- cost-containment strategies involving networks limit choice
- people avoid seeking care, including prevention and management of chronic care, increasing personal suffering and overall costs
- **millions of people are one diagnosis or job loss from financial ruin**
- an estimated 36-40,000 deaths/year are attributed to lack of insurance

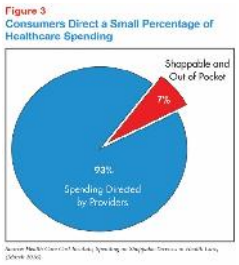
All of which begs the question of whether insurance is the way to finance a health care system……

- we spend $billions a year in the administrative overhead associated with our multipayer system, including over $500 billion to 1300 health insurance companies that have nothing to do with actual health care
- insurance company efforts to manage their costs using nurse care coordinators and physician utilization supervisors—duplication of effort, potentially confusing for patients and very burdensome for providers
- most of us buy insurance with a defined liability limit, determined by insurance company actuaries, for something we hope will never happen
- we will all need health care at different times in our lives—sometimes predictable, often not—with costs often impossible to limit or control
- a unified system across a large risk pool could cover more, cost less, and free up resources for individuals, families, government, and businesses for other important priorities, including research on costly chronic diseases

Cost-containment strategies over the last 40 years….

- strategies have included certificates of need for new equipment, facilities, service-line development, purchase of expensive specialty equipment
- diagnosis related groups (DRGs) and capitation strategies
- health maintenance organizations, preferred provider organizations
- managed care, gatekeeper requirements, utilization review
- emphasis on early discharge, outpatient and ambulatory care services
- pre-authorizations, denials, life-time caps, formulary controls, supply chain
- accountable care organizations, networks, integrated health plans
- patient safety and reducing preventable errors—a good thing
- consumer-directed care, cost-sharing—deductibles, co-pays
- costs have continued to rise—for-profit side, fee-for-service, etc.

The rise in popularity of consumer-driven insurance—so-called "skin in the game" policies: to contain costs…..



- high deductibles, co-pays, the cost of premiums, to discourage use of health care, as a cost-containment strategy, is based on the idea that Americans just go to the doctor too often and if they would just become better shoppers….
- this is simply not borne out by the facts—Americans go to the doctor less often than people in other countries and we have not meaningfully addressed prices charged in the U.S.
- networks and lack of price transparency

This is not a third world country—this is happening here. Thousands of people line up to get care they cannot afford any other way, in the United States of America, even after passage of the PP & ACA. Dental care is one of our biggest needs.

As we've discussed, efforts to implement universal coverage in the U.S. go back more than a century.

- around the turn of the last century, attempts to require compulsory health insurance were proposed, seen by business as too expensive
- politicians labeled universal medical coverage, similar to the system implemented by Kaiser Wilhelm II, "German socialist insurance"
- FDR intended national health insurance to be part of the New Deal, concerned about Social Security, unemployment insurance passing
- again, the AMA firmly opposed, as well as conservatives in Congress
- Teddy Roosevelt, Harry Truman, Richard Nixon, Bill Clinton, all tried
- physicians, insurance companies, hospital associations, GOP have consistently and vigorously opposed, spending $billions to influence

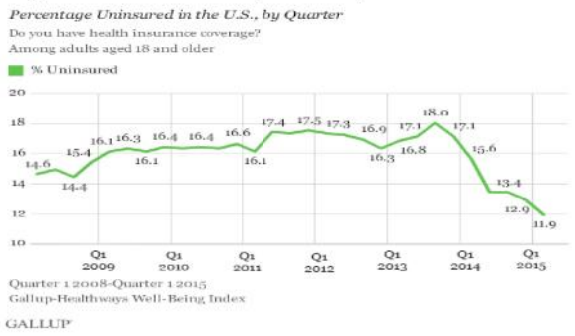
The Patient Protection and A□ordable Care Act of 2010 .....aka Obamacare

- with almost one-third of Americans covered by public programs, rising rates of uninsured, health care costs continuing to rise, and
- unemployment in 2008 at 11% and Democrat majorities in the House and the Senate
- newly elected President Obama pressed forward on a campaign promise of health care reform, passing the PP & ACA in Mar 2010
- market-based (Heritage Foundation) in hopes of some GOP support
- emphasis is on health insurance regulation and expanded coverage (but not prices)
- premium subsidies for low income individuals, families
- encourages movement away from fee-for-service to reduce costs
- included important **patient protections** against practices historically used by insurance companies to control their costs and maximize profits
- protections such as guaranteed issue, removal of lifetime caps, dependent coverage, etc.

Insurance Regulation—the 10 Essential Benefits of the ACA comprehensive benefit package = insurance

1. ambulatory patient care
2. emergency services
3. hospitalization
4. laboratory services
5. mental health services and addiction treatment
6. rehabilitative services, devices
7. maternity, newborn care
8. pediatric services
9. prescription drugs
10. preventive and wellness services, chronic disease treatment

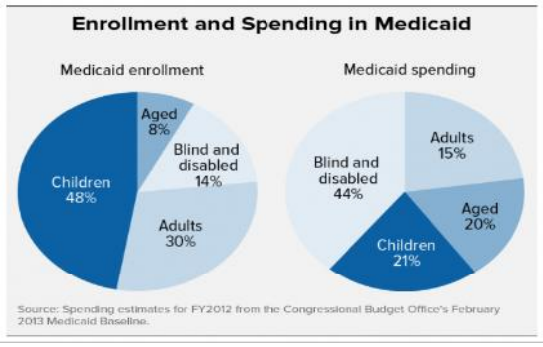
Change in number of uninsured prior to and post-ACA



MinnesotaCare, Medicaid

- public programs in MN include MinnesotaCare, Medicaid, (Medicare)
- MinnesotaCare began in 1994 as a modest health insurance plan for low-income individuals and families.... works as a public option for MN
- preserved as part of the ACA and greatly improved with passage of the MNsure law, in accordance with the insurance regulations that require ten essential benefits for comprehensive care, other ACA provisions
- Medicaid expanded further under the ACA with federal subsidies
- both are public programs, both risk being privatized by GOP majority, forcing people into the una□ordable private insurance market
- rates of uninsured will go back up, increasing costs to individuals and the public, along with the cost of uncompensated care

Who depends on Medicaid? One in five of us, as it turns out.....



Republican proposals—AHCA, BRCA—House, Senate.....

- repeals ACA mandates, premium, cost-sharing subsidies
- retains health insurance marketplaces; imposes late enrollment penalty
- encourages use of health savings accounts—tax deductible
- allows states to apply for waiver for essential benefit set—gaps in coverage
- per capita cap on federal Medicaid funding; block grants to the states
- elimination of the ACA small business tax credit
- repeal of cost-sharing and actuarial value for tiers to allow "flexibility"
- modifies age variation for premiums to allow 5 to 1 ratio, the "age tax"
- repeals funding for public health prevention and wellness initiatives
- eliminates the essential benefit set to reduce premium costs

Economic and social impacts of GOP health care bills:

- cuts to Medicaid of over $800 billion and block grants to states…
- reductions in Medicaid eligibility estimated to result in loss of coverage for over 22 million people by 2026
- overall rate of uninsured estimated to go back up to over 49 million
- uncompensated care costs to hospitals will rise, rural hospitals that depend on public programs will be hardest hit
- out of pocket costs and insurance premiums expected to rise, despite claims that "allowing the market to work" will bring costs down
- opposed by the AMA, the ANA, the AHA, the ACP, the AARP, literally dozens of professional, social services, and patient advocacy groups
- Note: the ACA is as close to a market-based plan as you can get, left the private insurance industry intact, does not regulate prices, mirrors the Heritage Foundation proposals for health care payment reform

Where do we need to go?

Our ideological and political landscape……

"Government is not the solution to our problems, government is the problem."

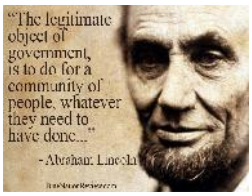
Remember the ten scariest words in the English language?

- 35 years of anti-government rhetoric
- an historical tension between individual liberty and the common good has been exploited …….. to make this problem nearly impossible to solve……
- until we agree that health care is a basic human right and a fundamental need …
- this may be shifting, paradoxically thanks to the PP & ACA, people now expect….

Abraham Lincoln on the role of government……

"The legitimate object of government, is to do for a community of people, what-ever they need to have done, but can not do, at all, or can not, so well do, for themselves in their separate, and individual capacities. ….. embraces all which, in its nature….requires combined action, as public roads and highways, public schools, charities, pauperism, orphanage, estates of the deceased, and the machinery of government itself."

Government is where we can come together, as a people, leaving no one behind.



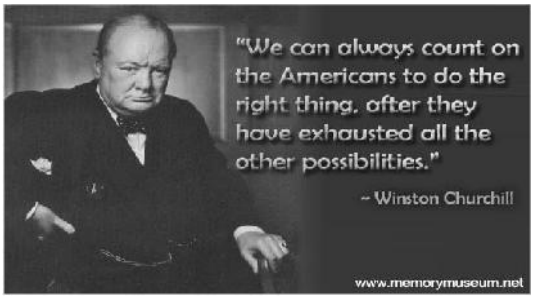
We have already decided that it is e□cient to do a lot of things together, as a society. Examples of public programs and services:

- public schools
- police and fire protection, EMS
- water, sewer, and trash pick-up
- highways, roads, bridges
- snow removal services
- the military, including the coast guard; national weather service
- the criminal justice system
- CDC, FDA, USDA, consumer protections department
- public libraries, public parks
- FEMA disaster relief, state and local disaster relief
- community colleges, technical schools, land grant universities
- public health and human services
- Medicare, Medicaid, Social Security
- departments of agriculture, energy, pollution control
- business subsidies, patent o□ces

Remember the list of cost containment strategies tried over 40 years?

All of them implemented with high hopes and many promises that this time…..for sure, this will work. If we just do it right…..and try really hard.

No one is sure that Churchill really said this, but……



Examples of payment systems elsewhere:

- Germany: private insurance/private delivery system—insurance coverage and fees are strictly regulated; coverage if unemployed
- Switzerland: private insurance/private delivery system--regulated
- United Kingdom has a national health system. Providers are public employees. Their system includes localized public health providers.
- France: private and public insurance/privately delivered
- Canada: publicly financed/privately delivered
- U.S.: combination—public and private financing/privately delivered except for the Veteran's Administration, PHS, military

* Reference: The Healing of America by T.R. Reid

So, what can we do?

If you believe, as I do, that ……. Your health is your wealth.

- **health care is not a commodity**, to be run for profits, but rather for the benefit of people and overall population health, that health care is
- a human right and **a basic human need**, not based on ability to pay
- that any one of us is one diagnosis or one job loss away from ruin
- there are some **things we should do as a society**, as community,
- anything that **consumes one-sixth of an $18 trillion economy** ought to be done as e□ciently, e□ectively, and equitably as possible
- that **there are lessons we can learn** from other countries and our own
- **we have already demonstrated** that we can deliver high quality health care in the U.S. under an other-than-private insurance model

We all do better when we all do better. Paul Wellstone

- Starting with the end in mind…..
- if we want a system that is a□ordable, accountable, comprehensive, e□cient, equitable, simple, e□ective, safe, accessible, cost-controlled…..
- that o□ers choice, an emphasis on primary care, prevention, chronic disease management, preservation of doctor-patient relationships, health system workforce utilization…..
- publicly financed, privately delivered

HEALTH CARE FOR ALL Minnesota

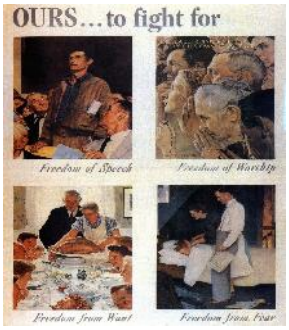
The Four Freedoms

A national health care system is the unfinished business of the New Deal.

Freedom from fear of economic ruin in case of serious illness. Freedom from want of sufficient health care based on need, not on ability to pay.

We must remove the unsustainable levels of profit from our health care system.

Our multi-payer system does not have the power, the ability, or the will to control prices sufficient to cut overall costs, cover everyone, and reduce waste and administrative burden and overhead.



What will it take for us to reform how we pay for health care in this country and in Minnesota?

When the cost of maintaining the status quo overcomes the fear of change, perhaps we can find the will for real reform.

Frequently asked questions……

- Does that mean eliminating private insurance companies? Yes. Along with the administrative waste, denials of care, networks, out of control costs, inequities, unpredictable increases, fear of financial ruin.
- How would we pay for it? Proposals suggest a combination of taxes, contributions from businesses, and premiums based on ability to pay.
- What about the people who work for insurance companies? Similar to industries that are no longer useful, we would have to provide transition support, such as education or retraining, job search, etc.
- What about concerns about waiting and who makes health care decisions? Eliminating multi-payer waste means resources for capacity. A state-run or national health plan puts patients and doctors in charge.

How do we get to meaningful payment reform in MN?

- introduce MHP in 2017 legislative session as SF 219 Sen John Marty, and HF 358 Rep David Bly – 1332 waiver under the PP & ACA
- Gov Dayton has proposed expansion of MinnesotaCare as a public option—tabled in the state Senate and never even got a hearing in the House
- elect a governor and legislature friendly to HHS in 2018
- re-introduce and pass the MHP in the 2019 session
- HCAMN will work on education of business, faith-based, non-profits, labor, and other citizen groups, increase public awareness of the limitations of the current payment system and options for change, fundraising, liaison with legislative partners on the means for accomplishing this goal of comprehensive health care for every Minnesotan in a financially responsible manner
- here's how you can help…… public awareness and support is key

Summary:

- I've just talked where we are, how we got here, and a vision for where we need to go.
- My purpose in doing this work, as a nurse, and now as a volunteer with Health Care for All Minnesota, is to educate and engage people and build a base of support with voters who will demand and work for change.
- Informed citizens must create the electoral wins we need for a legislature friendly to health and human services.

What you can do….. Please see the To-do list….

- sign up for our email list; consider donating to support
- like our Facebook page @healthcareforallminnesota
- follow us on Twitter @hc4amn
- view the HCAMN website for http://healthcareforallmn.org
- join or start your own chapter—email info@healthcareforallmn.org
- hold a house party or group discussion with a speaker from HCAMN
- identify opportunities for HCAMN speakers to present to groups
- use social media or other ways to share information on reform
- talk to your friends, neighbors, and family—get them involved
- hold elected officials accountable—be a health care voter!

Learn More About It:

Costs of Health Care Administration in the U.S. and Canada
The New England Journal of Medicine, 2003

Fix It, Healthcare at the Tipping Point www.fixithealthcare.com

Big Pharma Market Failure www.fixithealthcare.com

Healing Health Care: The Case for a Commonsense Universal Health System by John Marty Birch Grove Publishing, PO Box 131327, Roseville, MN 55113 or mnhealthplan.org

Beyond the Affordable Care Act: An Economic Analysis of a Unified System of Health Care for Minnesota by PNHP March 2012

Physicians for a National Health Plan—PNHP www.pnhp.org/

Health Care for All Minnesota http://healthcareforallmn.org

Opportunities for Advocacy.....

- Congress failed to reauthorize the Children's Health Insurance Program (CHIP) by 30 Sep—100,000 low-income children in MN
- HHS apparently pulled Federal funds for MinnesotaCare which was associated with our request for Federal funds to help with a reinsurance program—affects over 90,000 low-income people
- all proposals to repeal/replace by the majority party in Congress involve significant cuts in Medicaid—estimated cost to MN is $8 billion over 10 yrs.
- push to change Medicare Part D to allow for negotiating prices
- Gov Dayton's proposal to allow lower income Minnesotans to "buy-in" to MinnesotaCare—tabled in the Senate, no hearing in the House
- executive order signed 13 Oct eliminating cost-sharing subsidies intended to help bring premiums down for persons purchasing insurance in the individual and small group market—est. 11,600 in MN--